ASSESSMENT OF MEDICAL RECORDS DOCUMENTATION COMPLIANCE IN A PRIVATE HOME HEALTHCARE SERVICE PROVIDER COMPANY IN CHENNAI, INDIA

Dissertation Submitted to

The IIHMR University, Jaipur

For partial fulfillment for the degree of

Masters of Business Administration (MBA)

in

Hospital and Health Management

by-

Dr. Anumeha Prateek

Under the Supervision and Guidance of

Dr. Susmit Jain

2022

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled **Assessment of Medical Records Documentation Compliance in a Private Home Healthcare Service Provider Company in Chennai, India** 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 Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature)

Name of Student: Dr. Anumeha Prateek

Date: 30th June 2022

ONE LIFE
HOME HEALTHCARE

Date: 30th June 2022

INTERNSHIP COMPLETION CERTIFICATION

CERTIFICATE

This to certify that **Dr Anumeha Prateek** in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur has successfully completed her internship at **Tattva Home Healthcare Private Limited,** Chennai from March 21, 2022 to June 20, 2022.

We wish her all the best for her future endeavors.

For Tattva Home Healthcare Pvt Ltd

Rakesh Inkollu
AGM-HR

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A Tattva Group Company

Certificate by Faculty Guide

CERTIFICATE

This is to certify that dissertation titled **Assessment of Medical Records Documentation Compliance in a Private Home Healthcare Service Provider Company in Chennai, India** is a record of the research work undertaken by Dr. Anumeha Prateek in partial fulfilment of the requirement of 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.

Faculty Guide: Dr Susmit Jain
IIHMR University, Jaipur
Date: 30th June 2022

School Dean: Dr. (Col.) Mahendra Kumar
IIHMR University, Jaipur
Date:

Abstract

Title- Assessment of Medical Records Documentation Compliance in a Private Home Healthcare Service Provider Company in Chennai, India.

Submitted by- Dr. Anumeha Prateek Guided By- Dr. Susmit Jain

Roll no. 1072

Home healthcare is referred to as professional support services that aid in assistance of living, managing healthcare concerns, medical or post-operative care, rehabilitation as well as palliative care for patients. Medical Records Departments (MRD)'s compliance in home healthcare refers to proper documentation of medical records of the patients who are taking home healthcare service from the organization.

In home healthcare, Medical Records Department (MRD)'s key parameters include Medical Officer Assessment sheet which consists of Initial demographic details, psychological details and suggested intervention, Clinical examination, Grading sheet and Consent forms. Nurse manager assessment sheet consists of patient's demographic details, Home & environment assessment, Hospitalization details, Clinical assessment sheets and Nursing care plan. Daily nursing booklet consists of Demographics, Head to toe assessment, Medication and clinical charts, Activity of daily living chart, Positioning chart, Diet and nutrition chart, Intake/output chart, Nurses chart, Emotional assessment chart, Individual checklist for equipment and consumables and Document checklist. clinical care plan sheet consists of Demographics, Patients' clinical conditions, Chief complaint, Clinical findings and Care Plan Summary.

Noncompliance in MRD of home healthcare has a vital role to play in quality management. Once the gap is analyzed, necessary steps can be taken to fill those gaps. With the rise in medico-legal issues involving healthcare organizations, accurate documentation of medical records is critical to avoiding future legal charges

The objective of this research was to access the medical records documentation compliance at One Life Home Healthcare in Chennai and to recognize the parameters utilized for documentation at their MRD and to assist the organization in detecting flaws intending to comply with Quality and Accreditation Institute (QAI) guidelines. It is a record-based retrospective study in which active and closed files of patients who were receiving or have received services from the organization were examined. This research was carried out over a period of three months, from April 2022 to June 2022. Sample size

comprised of 50 medically managed patient files were selected, including 25 files from the month of April 2022 and 25 files from the month of May 2022. Data was gathered using a convenience sampling technique and the information was gathered utilizing a standardized audit tool given by the organization in form of google sheet which included Medical Officer assessment sheets, Nurse Manager assessment sheets, Clinical Care Plans and Nursing Booklets. Main finding after comparing the data of April 2022 and May 2022 was that in the month of April, MO assessment sheets noncompliance was 48% which improved to 24% in the month of May. Noncompliance was 25% in Grading sheets in both months. Noncompliance in Consent forms sheets was 40% in the month of April, and it was reduced to 10% in the month of May. In the month of April, Nursing booklets noncompliance was 37.5% and it was reduced to 12.5% in the month of May. In the month of April, NM Assessment sheet noncompliance was 8.5% but it reduced to 5.7% in the month of May. In the month of April, 5.7% Clinical care plan sheets were improperly documented but this percentage improved to 0% in the month of May. In both April and May, there was no non-compliance in Nursing care plan. To conclude, it was found that noncompliance rate was high in the beginning of the study, but non-compliance rate decreased in MO Assessment sheets, Consent form sheets, Nursing Booklet sheets, M Assessment sheets and clinical care plan sheets by the end.

Key Words- Home healthcare, quality, palliative care, home-based care, home care services, quality of life.

Acknowledgements

I would like to thank **Mr. T.R Narayanaswamy**, GMD & CEO, One Life Home Healthcare, for considering me for this great opportunity, **Mr. Rakesh Inkollu**, Assistant General Manager- HR, **Dr. Krishna Mehta**, General Manager- Operations, **Mr. Gajendran S S**, Regional Manager- Sales, for their constant guidance and encouragement throughout.

I want to extend my heartfelt gratitude to **Dr. P.R Sodani**- President, IIHMR University and **Dr. (Col.) Mahendra Kumar**- Dean, IIHMR University for providing us with the great training and opportunities that helped me throughout my dissertation. I would also like to thank my dissertation guide- **Dr. Susmit Jain,** Associate Professor, IIHMR University for his constant guidance, enlightenment and kind words throughout the study.

At last, I would like to thank my family and friends who have been extremely supportive and motivating throughout.

Dr. Anumeha Prateek

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Abbreviations

- MRD- Medical Records Department
- OLHH- One Life Home Healthcare
- MO- Medical Officer
- NM- Nurse Manager
- CCP- Clinical Care plan
- QAI- Quality and Accreditation Institute
- ADL- Assisted Daily Living
- RN- Registered Nurse
- PCA- Primary Care Assistant
- IP- In-patient

Chapter 1. Introduction

Medical records are one of the most important aspects of today's healthcare system. It is a patient's detailed information records that are documented and kept during their visit or stay in any healthcare facility. A patient's medical record often includes a face sheet with information such as age, gender, and address, as well as patient and attendant ID proofs, medical, paramedical, and clinical records, and investigation results. Maintaining each patient's medical record is critical because it is the only source of information regarding the treatment delivered to the patient [1]. Aside from that, it's crucial in community health studies. As per Right to Information Act 2005, MCI rules and Consumer Protection Act, 1986, and some other laws, a good medical record management system is required to serve many walks of people in our community [2].

This project is on "Medical Records Department Compliance." Purpose of this study is to analyze the gaps in documentation of medical records at One Life Home Healthcare and suggest some measure in order to fill those gaps. Monthly audit of medical records documentation is an important part of the activities that are performed in any home healthcare organization for checking not only the completeness of files but also to check for quality indicators for improvement as well [3]. It also helps the organization in identifying the deficiencies in order to follow Quality and Accreditation Institute (QAI) protocols. With increasing number of medico-legal cases against healthcare organizations, proper documentation of medical records plays the most important role to avoid any future legal allegations [4]. In this study, the gap is analyzed to identify the steps that are to be taken to fill them. Time-to-time training for home healthcare personnel and regular audits can improve the quality of services provided to the patients to a significant amount. Along with that, it also adheres to the standards of QAI. In QAI schedule, there is a separate audit parameter for MRD [5]. The quick list of QAI audit for medical records contains the following: -

For Medical Officer assessment, key parameters that are kept in mind are initial demographic details, history of present illness, past history, grading sheet and consent forms. For Nurse manager's assessment, key parameters include- patient demographic details, home & environment assessment, hospitalization details, clinical assessment sheets and nursing care plan. For nursing staff assessment, demographics, head to toe assessment, medication chart, clinical chart, invasive line chart, IV fluid chart, positioning

chart, hand over checklist, drug chart, activity of daily living, document checklist are some key parameters to be kept mind.

1.1 AIM

Aim of this study mainly focuses on how medical records are documented in the home healthcare sector, what are the loopholes and steps to be taken to fix it.

1.2 OBJECTIVES

Objectives of this study is to examine the environment of One Life Home Healthcare, Chennai, to acknowledge the parameters used here for documentation, to identify the gaps in medical records documentation and to suggest few measures that might fill the gap.

1.3 Organization Profile

One Life Health Care, founded by N. Ramachandran, former promoter of India Cements Ltd., and T.R. Narayanaswamy, GMD and CEO of Tattva Group. The company intends to provide professional competence and new thinking to this rapidly increasing industry. They are thriving to become India's first Integrated Specialty Home Health Care Company to deliver services on a PAN India level. Brand Philosophy of the company is "Live Well Always". The company strives to be a reminder of the good aspects of healing during such times. One Life is a trusted partner helping individuals by delivering the highest quality of care services. Mission of the company is to serve the people by providing world class home healthcare services through their clinical experience and innovation. Their vision is to be the preferred home healthcare provider for patients, caregivers, and healthcare professionals, delivering seamless service and best-in-class clinical outcomes so that they can "Live Well Always." Services provided by the company are post-hospitalization care, senior care, chronic disease management, physiotherapy, skilled nursing and at-home medical visits by expert doctors [10].

1.4 UNDERSTANDING DOCUMENTATION PARAMETERS

Certain factors are employed for recording of IP medical records, according to the active file audit checklist/toolkit. Compliance and non-compliance are used to evaluate these documentation parameters. If a parameter has a high percentage of non-compliance, it should be the focus of the organization's efforts to eliminate it. These options apply to both open and closed files. These are the most important factors to consider:

Parameters	To be Found in	Explanation
Face Sheet	Active and closed files	It contains patient's general information including name, age, sex, address, time of admission etc.
All consent forms	Active and closed files	It contains all consent forms including general consent form, AMA consent form etc.
Grading sheet	Active and closed files	It contains grade of the patient depending of severity of patient condition, morse fall risk assessment etc.
NM Assessment	Active and closed files	It contains patient details, environmental assessment, IV tube assessment etc.
Nursing care plan	Active and closed files	It contains NM and MO's name and sign etc.
Nursing booklet	Active and closed files	It contains patient's daily head to toe assessment, drug chart, daily summary, positioning chart, handover details, nursing staff signature, employee id etc.
Clinical care plan	Active and closed files	It contains patient as well as attender details, patients' condition, comorbidity, patient's clinical care plan etc.
Transfer form	Closed files	When a patient is transferred from home to hospital, this document is filled out and kept in the

		patient record to explain why the patient was shifted and to make it easier for the hospital personnel to continue the proper treatment.

Chapter 2. Review of Literature

S. No	Authors	Year	Title	Study Description	Purpose	Conclusion
1.	Chidiadi Obioma	2017	Improving the Quality of Nursing Documentation in Home Health Care Setting.	This study is about documentation of pertinent information that improves communication of information to other health care providers during care coordination. It also demonstrates the level of care given to patients in health-care settings. The project material included ideas and tools for an organization to consider when implementing nursing documentation training for clinical staff. Professional development opportunities provided by the initiative improved the content of nursing care reflected in patient visit notes and aided in the documentation of vital information for care coordination.	The goal of this quantitative, descriptive study was to improve nurses' documentation abilities in terms of the material they documented and to give instruction to fill knowledge the provision of high-quality care, to improve the efficiency of administration and operations, to facilitate appropriate utilization of home healthcare services and	To sum up, this study looked into techniques to train nursing staffs to document nursing care effectively. The training also raised nurse knowledge of important information to document, as well as how it influences communication and care coordination with other health-care providers.

					to ensure appropriate payments for the benefit, and to improve efforts to detect fraud and abuse.	
2.	K Srinivasulu, V Tejaswini Namburi, AB Sai Samhitha	2016	A study on documentation of medical records.	In the healthcare industry, documentation is critical as it must be completed on time, precisely, and thoroughly. This research involved 100 case sheets.	To demonstrate the necessity of properly documenting patient medical records and the disadvantages of a badly recorded medical record.	Because inadequate documentation can not only land someone in jail, but also save them from it, proper documentation, organisation, and maintenance is the responsibility of not only every practising doctor, but also all members of a healthcare organisation, including

						the MRD of every institution.
3.	Edith R Gjevjan, Ragnhild Helleso	2009	To study how community nurses addressed patient care in the EPR and the comprehensiveness of their documentation.	A total of 91 patient records were used in the investigation. The data was examined in three stages. The unstructured material was first systematized, then the text was formatted according to the nursing process, and finally the comprehensiveness was assessed using a validated instrument.	To identify areas of improvement in documentation by nurses in home health care setting.	To conclude, patients' communication needs are not addressed by home health care nurses, who are attentive to patient engagement. When compared to the steps of the nursing procedure, the documentation is lacking. One question that emerges is if the nursing process is a limiting factor in the

						quality of nursing documentation
4.	Joseph Thomas	2009	Medical records and issues in negligence.	It is critical for treating clinicians to accurately document patient treatment. It's the only way doctors can show that the procedure was done correctly.	To learn about the necessity of accurate patient record documentation.	Medical records are critical for scientific evaluation of the organization's patient profile, as well as for reviewing treatment results and planning treatment regimens. Aside from that, it's a critical tool in cases of claimed medical malpractice.
5.	Carol Hall Ellenbecker; Linda Samia; Margaret J. Cushman; Kristine Alste	2008	Patient Safety and Quality in Home Health Care	This article talks about patient safety and quality in a home healthcare setting and its importance. It also talks about how by	To present a clear picture of what is quality management in terms of	Finally, one cannot discuss home healthcare without

				making small but continuous changes towards it can benefit the organization in the long run.	home healthcare sector. Its building blocks and how we can move forward in the direction of achieving good quality management.	mentioning quality managemen t. Home health care clinicians try to provide high-quality, safe care in other contexts. As a result, there is a need for more study into effective ways in home health care settings.

Chapter 3. METHODOLOGY

This is a Record based retrospective study. The study setting is One Life Home Healthcare, Chennai. Files that were studied are active as well as closed files. It is of the patients who are taking or have taken treatment from the organization. Duration of this study was 3 months (from April 2022 to June 2022)**.** A Sample Size of 50 medically managed patient files were studied and all these 50 files are active and closed files. Out of which 25 files are for the month of April 2022 and 25 files are for the month of May 2022. Study population is patients who availed or are availing services from organization. Inclusion criteria is patients who availed or are availing services from the company within last three months of this study. Exclusion criteria includes people who have not availed services from the organization in last three months. Data Collection Technique is Convenience Sampling Technique. Type of Data Collected is Quantitative, primary data collected by checking files of patients taking home healthcare services from the organization. Data is collected using standardized audit tool for active and closed files that were provided by organization in form of Google Sheet. In this report, there are two variables that are taken. First is compliance and as the name suggests, it means if the parameters taken are meeting with the requirements and another one is non-compliance where if the parameters do not satisfy the requirements, it is referred as non-compliance.

Chapter 4. Results

In this study, a total of 50 active as well as closed files were checked for compliance and non-compliance. Out of these 50 files, 25 files were for the month of April 2022 and 25 files were for the month of May 2022. After checking all 50 files, collected data was compiled in MS EXCEL and with the help of graph, the data collected at One Life Home Healthcare during the month of April and May 2022 is shown below-

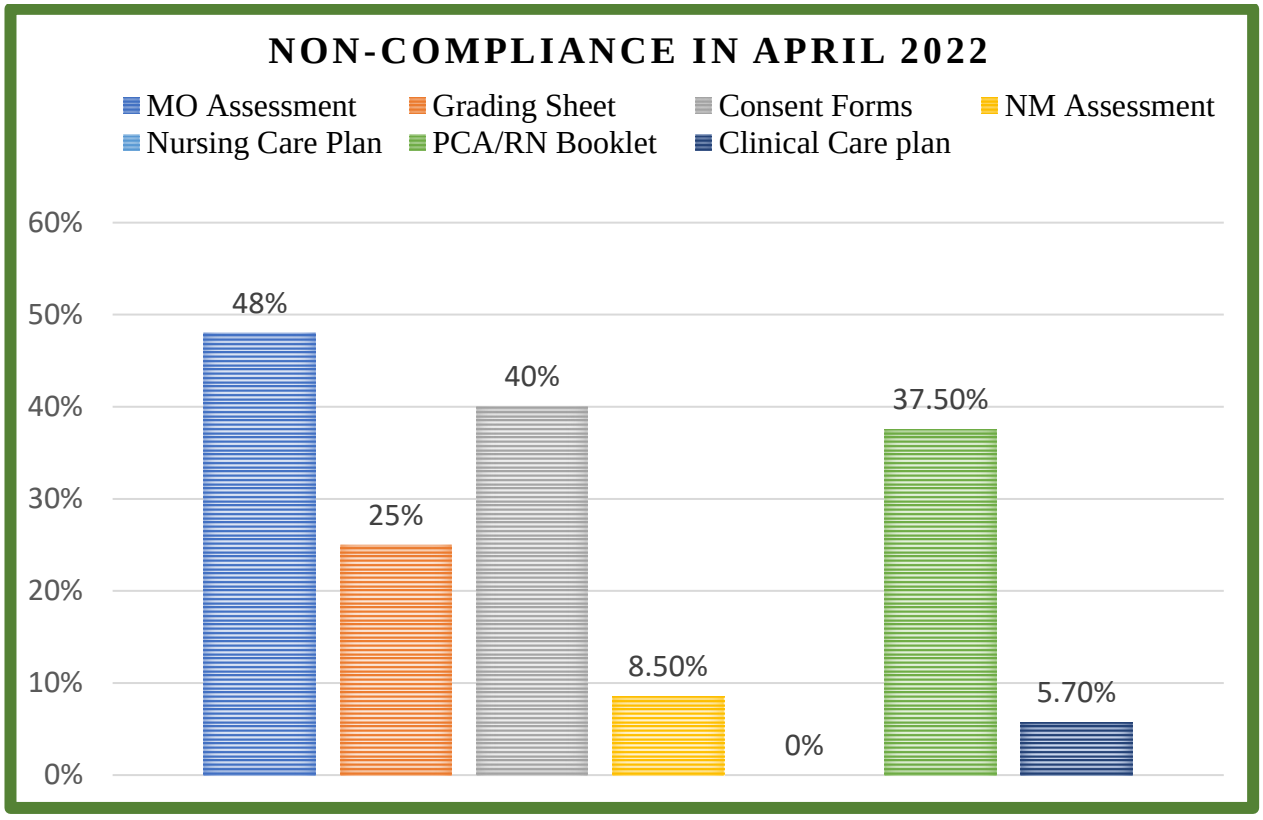

Figure 4.1 Graphical representation of non-compliance in the month of April 2022

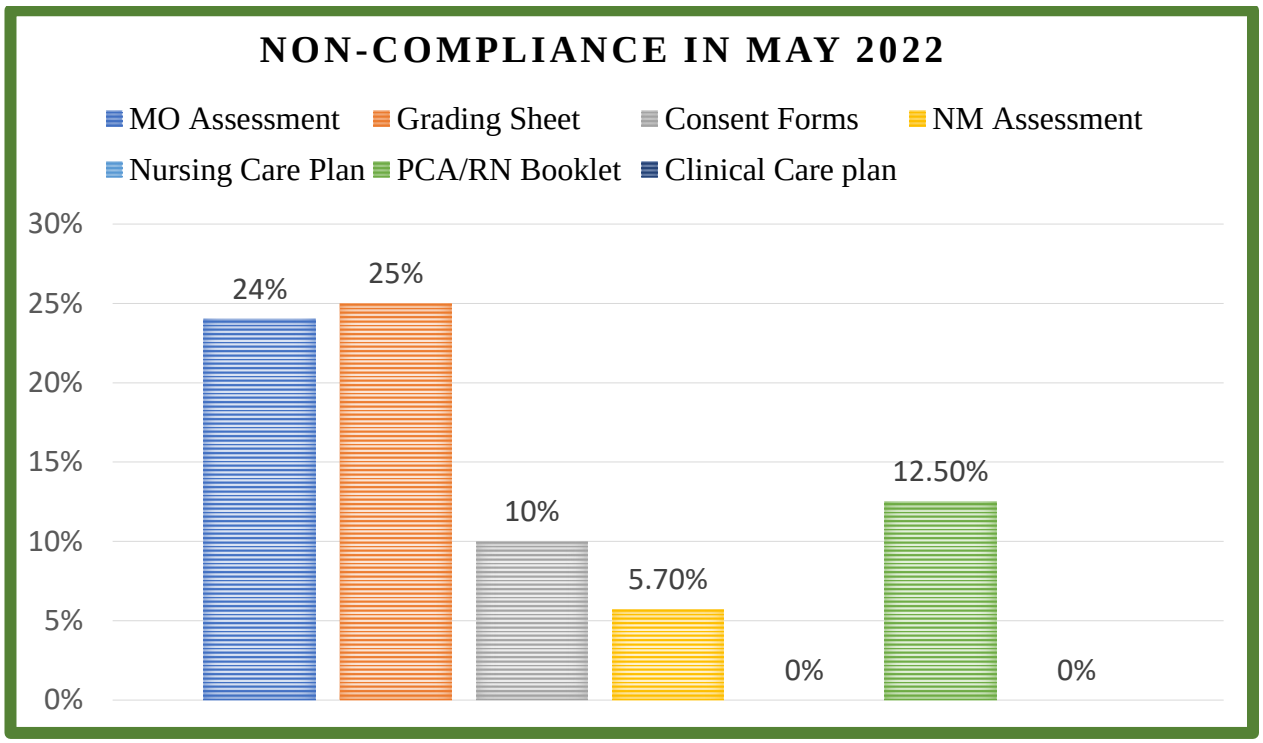

Figure 4.2 Graphical representation of non-compliance in the month of May 2022

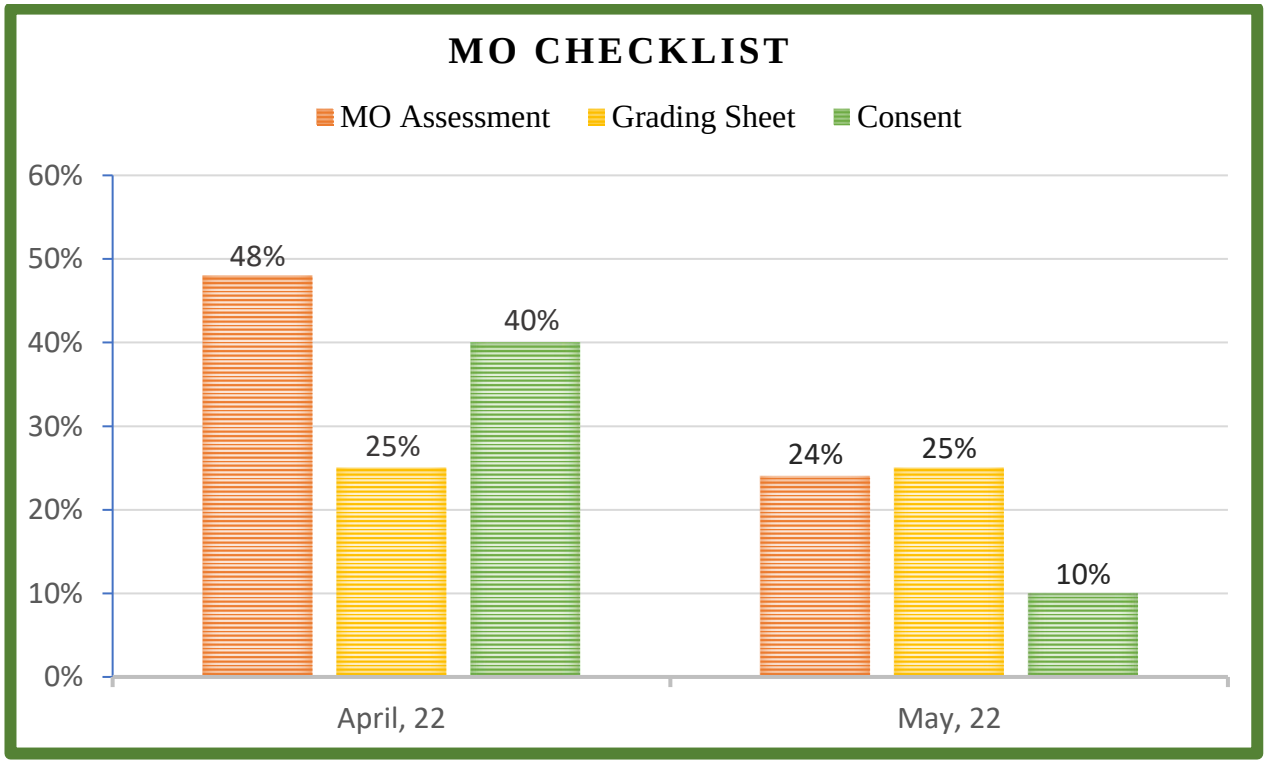

Figure 4.3 Graphical representation of non-compliance in MO checklist for the month of April and May 2022

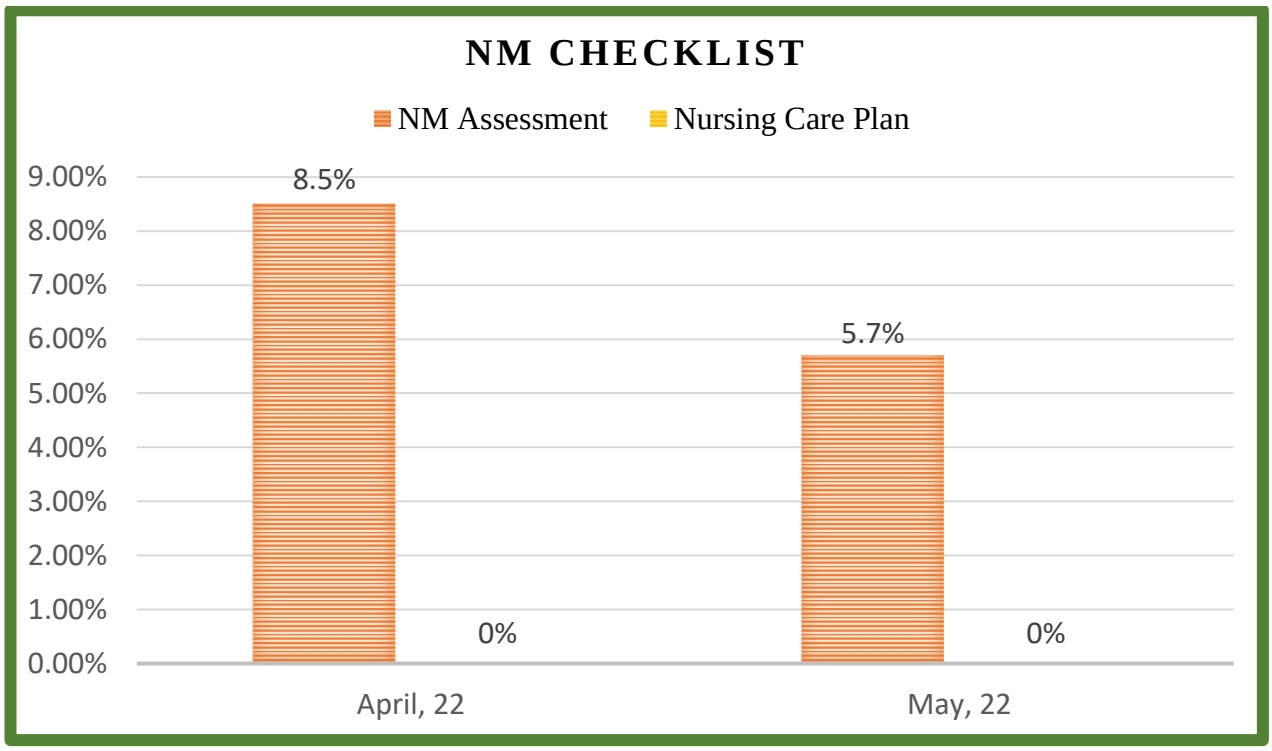

Figure 4.4 Graphical representation of non-compliance in NM checklist for the month of April and May 2022

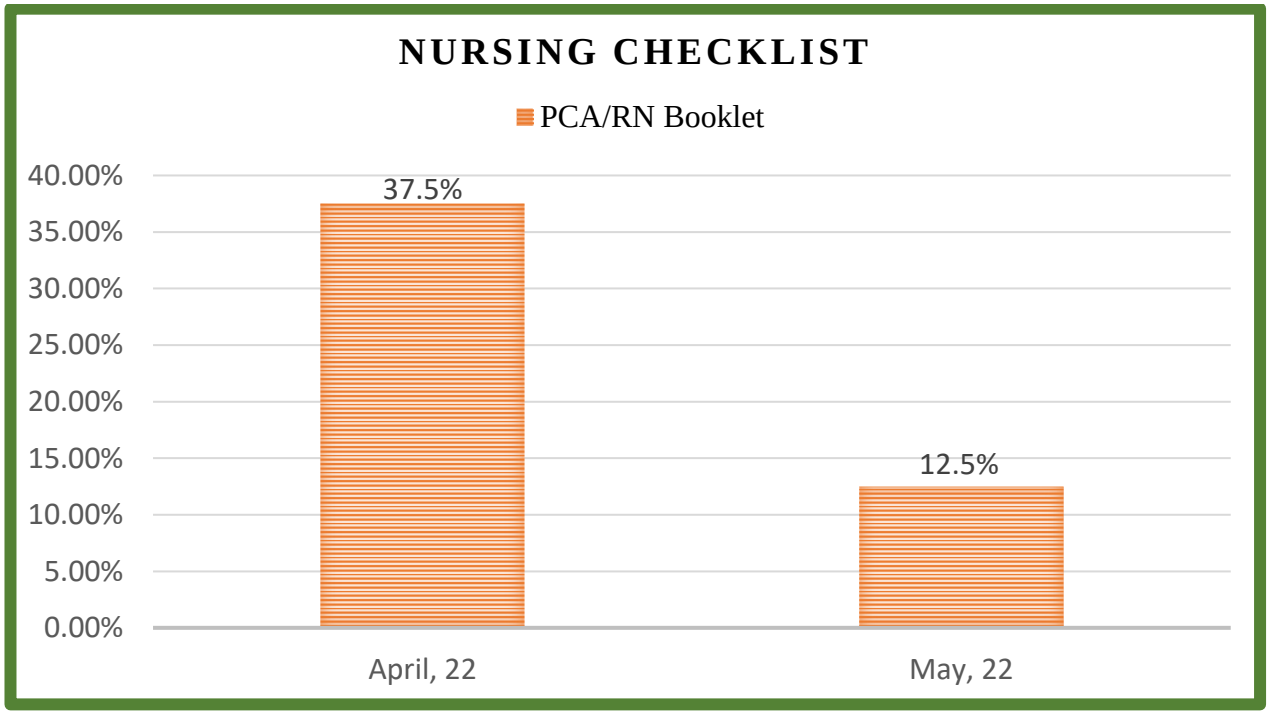

Figure 4.5 Graphical representation of non-compliance in Nursing booklet for the month of April and May 2022

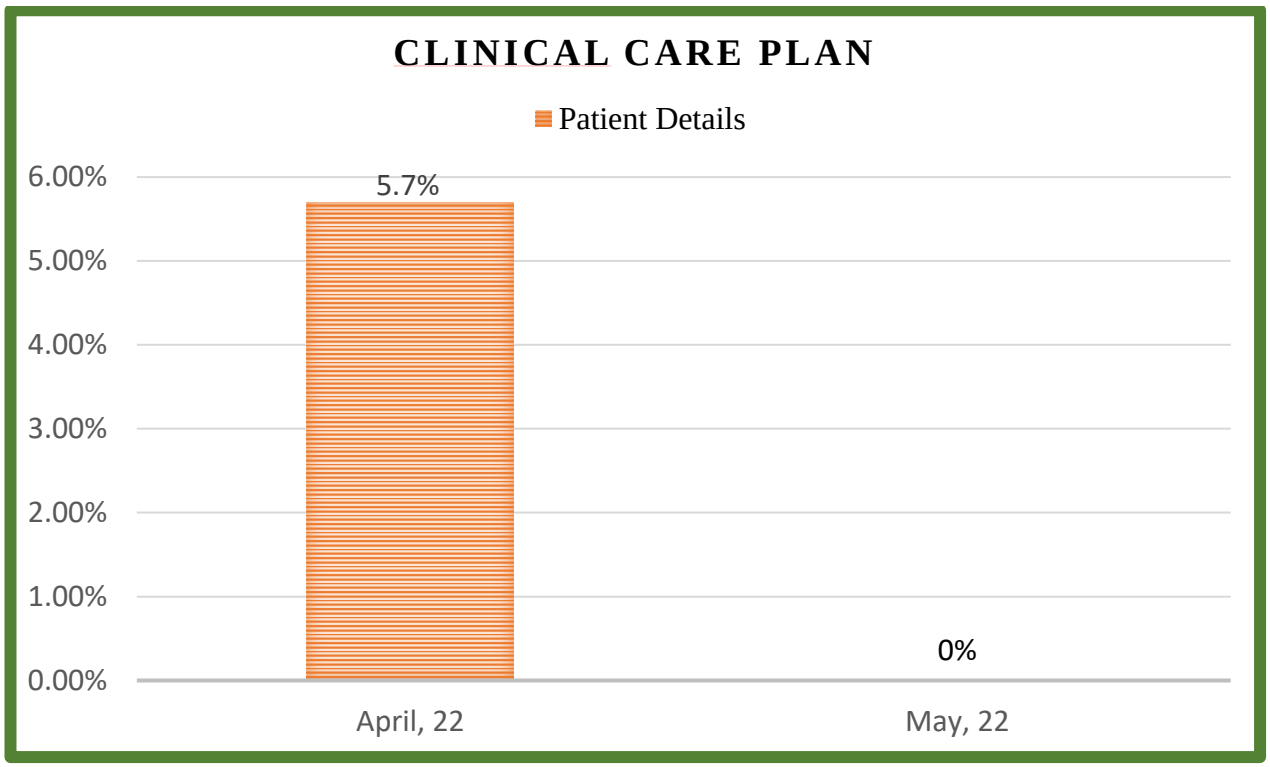

Figure 4.6 Graphical representation of non-compliance in CCP checklist for the month of April and May 2022

Chapter 5. Discussion

While comparing the collected data with the standard parameters, following things that were observed were that in the month of April, 48% MO assessment sheets were improperly documented but this percentage improved to 24% in the month of May. In the month of April, 25% Grading sheets were improperly documented and this percentage remained same i.e., to 25% in the month of May as well. In the month of April, 40% Consent forms sheets were improperly documented but this percentage improved to 10% in the month of May. In the month of April, 37.5% Nursing booklets were improperly documented but this percentage improved to 12.5% in the month of May. In the month of April, 8.5% NM assessment sheets were improperly documented but this percentage improved to 5.7% in the month of May. In the month of April, 5.7% Clinical care plan sheets were improperly documented but this percentage improved to 0% in the month of May. In the month of April as well as May, there was no non-compliance in Nursing care plan.

Apart from these, patient or attendants' signatures were not properly documented in consent forms, medicine given to patients were not documented in capital letters, staffs' signature and employee id were not documented properly in nursing booklet, patients' diet chart and positioning chart were improperly documented, in nursing booklet and MO assessment sheet, in parameters that were not applicable, NA was not documented and MOs' signature was not evident on consent form and MO assessment sheet.

5.1 Interpretation

In Fig. 4.1, out of 25 active and closed files studied in the month of April 2022, given graph shows the average compliance rate for various parameters. In the month of April, MO assessment has 48% compliance, grading sheet has 25%, consent forms have 40%, NM assessment has 8.5%, nursing care plan has 0%, nursing staff booklet has 37.5% and clinical care plan has 5.7% compliance. In Fig. 4.2, out of 25 active and closed files studied in the month of May 2022, given graph shows the average compliance rate for various parameters. In the month of May, MO assessment has 24% compliance, grading sheet has 25%, consent forms have 10%, NM assessment has 5.7%, nursing care plan has 0%, nursing staff booklet has 12.5% and clinical care plan has 0% compliance. Figure 4.3 is a graphical representation of non-compliance in MO checklist for the month of April and May 2022.Figure 4.4 is a graphical representation of non-compliance in NM checklist for the month of April and May 2022. Figure 4.5 is a graphical representation of non-compliance in nursing booklet for the month of April and May 2022 and Figure 4.6 is a graphical representation of non-compliance in CCP checklist for the month of April and May 2022.

5.2 Limitation

As per organization's policy, for one patient, one nursing booklet can only be used for 7 days and after that a fresh booklet is used in continuation and most of the patients taking service from the company are geriatric, long term patients so one patient has multiple booklets a small sample size of 50 was taken.

Chapter 6. Conclusion

As a result, keeping a patient's medical record is not only a treatment-related need, but it may also be a game-changer in medico-legal matters, helping to save innocent lives and punishing those who provide incorrect care. Complying with licence and accreditation criteria is also critical.

It is evidence of all treatments given to a patient in that facility. It not only aids other medical professionals in comprehending the patient's treatment, but also in planning the patient's future care.

This research focuses on One Life Home HealthCare's' medical records documentation system and the obtained data clearly reveals that the documentation standard in organization is satisfactory and is constantly improving. There are certain parameters including consent form documentation, which should have 0% compliance in order to avoid any license or medico-legal emergencies. These holes should be fixed right away to maintain a high level.

6.1 Recommendations

After studying the MRD data for the month of April 2022 and May 2022 it was observed that the gap in the documentation is filling significantly and there are a few recommendations that might reduce the compliance in medical record documentation. Regular audits should be undertaken for both active and closed files, but particularly for active files, because if errors in current files are eliminated, there will be minimum to no compliances in closed files. Time to time training and orientation of doctors and nurses, paying close attention to completion of all consent forms and close monitoring of all of the files for compliance and completeness should be taken into account. Nurse managers should check for completeness when visiting patients' homes to check on patients, and to collect booklets. Any incompleteness should be reported to nursing staff to avoid future errors.

Proper training of nurses should be done to educate them in order to record all medications in the medicine chart and to obtain patient and/or attendant signatures as needed and to reduce the likelihood of certain files being incomplete, a two-leveled check should be performed on them.

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