A presentation on

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

By-

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Introduction to Medical Records Department in Home Healthcare

- 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 are one of the most vital components in modern health sector. It is a patient's detailed information documents that are documented and maintained during a patient's visit or stay in any healthcare organization.
- Maintaining every patient's medical record is important as it is that only proof one can rely on to know about the treatment that has been given to the patient. Apart from that, it also plays an important role in community health studies.

Research Question

- How properly do the Home Healthcare Organizations follow QAI standards in their MRDs ?
- On comparing three month's active and closed file audit data of One Life Home Healthcare, Chennai, what was our observation ?

Rationale

This project is on “Assessment of Medical Records Documentation Compliance in a Private Home Healthcare Service Provider Company in Chennai, India.”

- It 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.

Main reasons of doing this project were: -

- 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.
- To help the organization in identifying the deficiencies in order to follow QAI protocols.
- With increasing number of medico-legal cases against healthcare professionals in both hospital as well, proper documentation of medical records plays the most important role to avoid any future legal allegations.
- The gap is analyzed to identify the steps to be taken to fill these gaps. Time-to-time training for hospital 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.

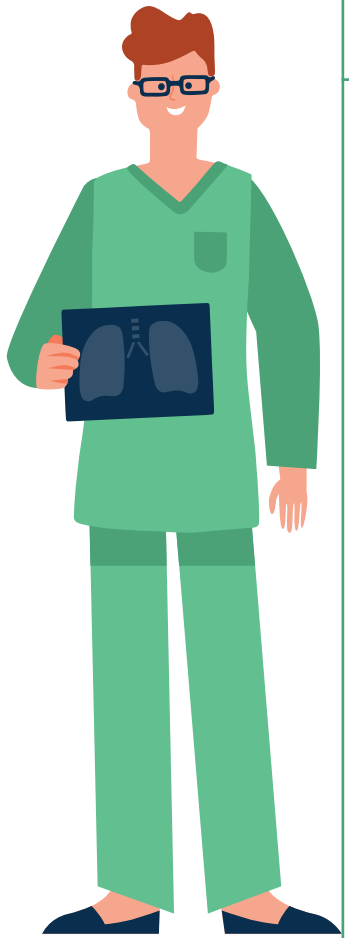
Objective

- To study the environment of One Life Home Healthcare, Chennai.
- To acknowledge the parameters used at One Life Home Healthcare's MRD for documentation.
- To identify the gaps in medical records documentation and
- To suggest few measures that might fill the gap.

Methodology

- **Study Setting-** One Life Home Healthcare, Chennai.
- **Study Design-** Record Based Retrospective Study.
    - File type is Active and closed files. It is of the patients who availed or are availing services from organization.
- **Study Duration-** 3 months (from April 2022 to June 2022)
- **Sample Size-** 50 medically managed patient files. 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 of May 2022.
- **Data Collection Technique-** Convenience sampling technique.
- **Type of Data Collected-** Type of Data Collected is Quantitative, primary data collected by checking files of patients taking home healthcare services from the organization.
- **Method of Data Collection-** Standardized audit tool for active and closed files that were provided by organization in form of Google Sheet.
- **Variables and their Meanings-** In this report, there are two variables that are taken-
    - Compliance- As the name suggests, it means if the parameters taken are meeting with the requirements.
    - Non-compliance- If the parameters does not satisfy the requirements, it is referred as Non-compliance.

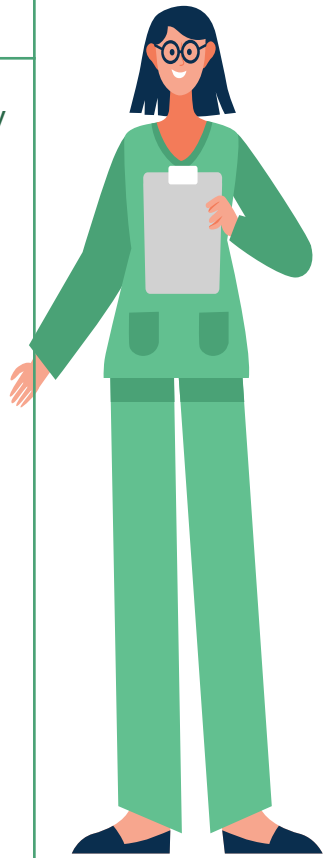
Literature Review



S. No.	Author	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.	To improve nurses' documentation abilities 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 ensure appropriate payments for the benefit, and to improve efforts to detect fraud and abuse.	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.

Literature Review

S. No.	Author	Year	Title	Study Description	Purpose	Conclusion
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.



Literature Review

S. No.	Author	Year	Title	Study Description	Purpose	Conclusion
3.	Edith R Gjevjan, Ragnhild Helleso	2009	To study how community nurses addressed patient care in the EPR and the comprehen siveness of their documenta tion.	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

Literature Review

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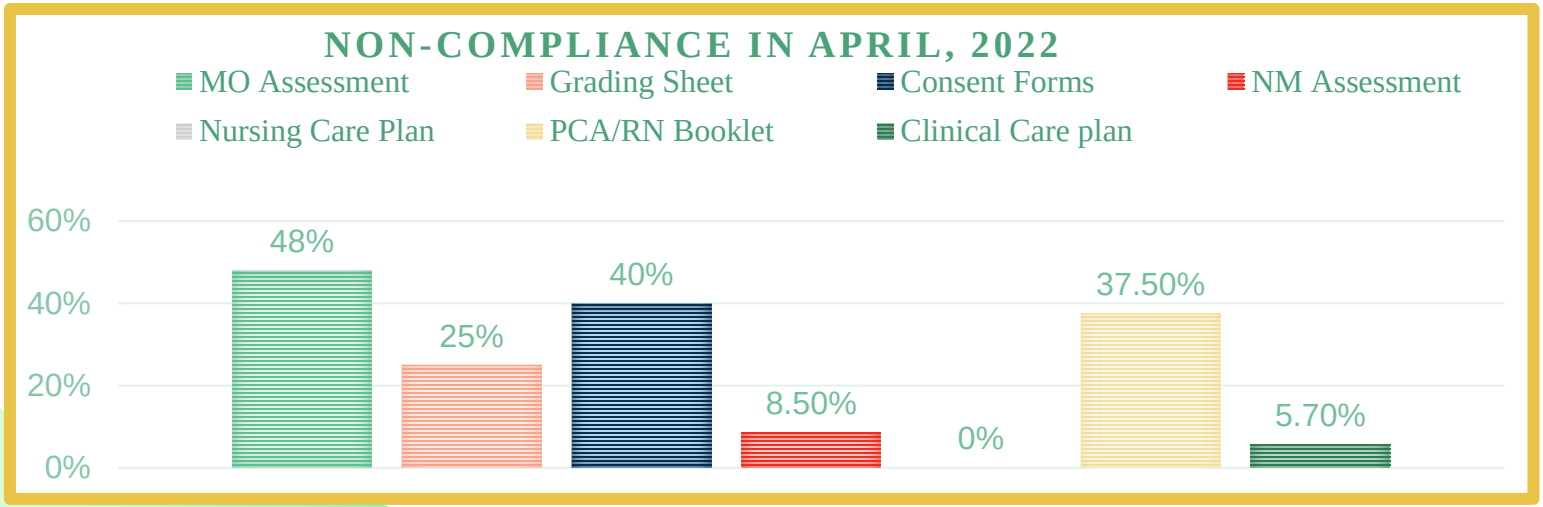
4.	Joseph Thomas	2009	Medical records and issues in negligence.	It is critical for treating clinicians to accurately document patient treatment. It's the only way doctors can show that the procedure was done correctly.	To learn about the necessity of accurate patient record documentation.	Medical records 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.

Literature Review

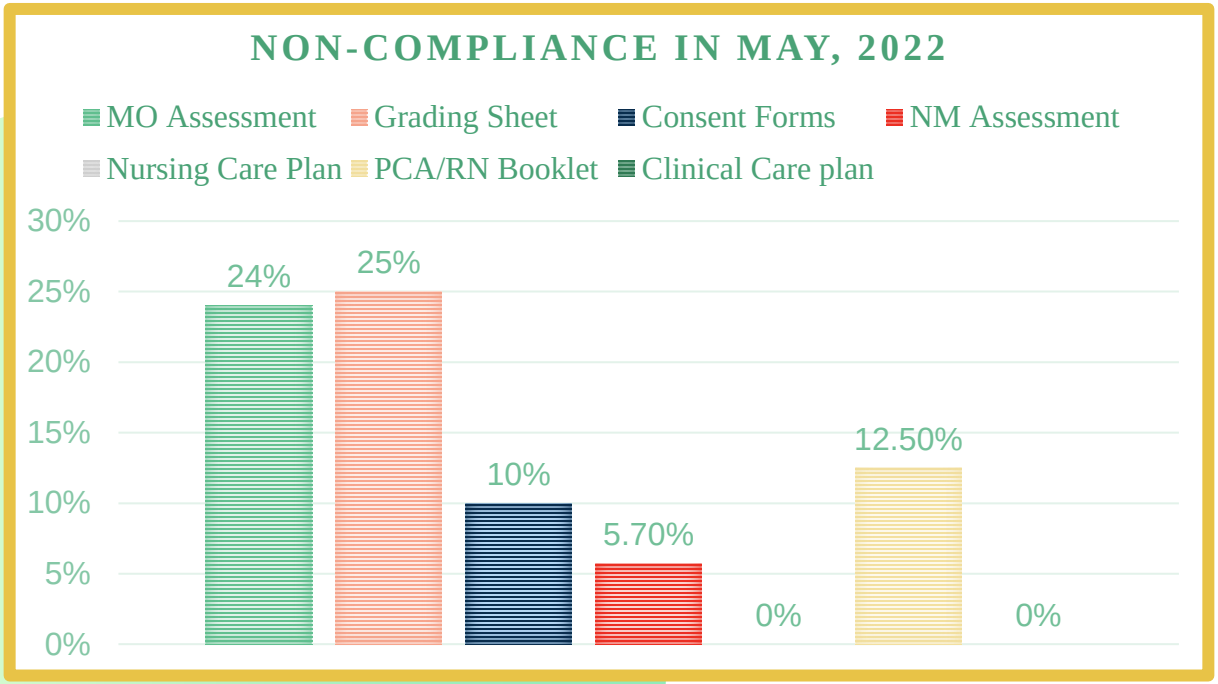
S. No.	Author	Year	Title	Study Description	Purpose	Conclusion
5.	Carol Hall Ellenbecker; Linda Samia; Margaret J. Cushman; Kristine Alste	2008	Patient Safety and Quality in Home Health Care.	This article talks about patient safety and quality in a home healthcare setting and its importance. It also talks about how by making small but continuous changes towards it can benefit the organization in the long run.	To present a clear picture of what is quality management in terms of home healthcare sector. Its building blocks and how we can move forward in the direction of achieving good quality management.	Finally, one cannot discuss home healthcare without mentioning quality management. 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.

Data Analysis and Interpretation

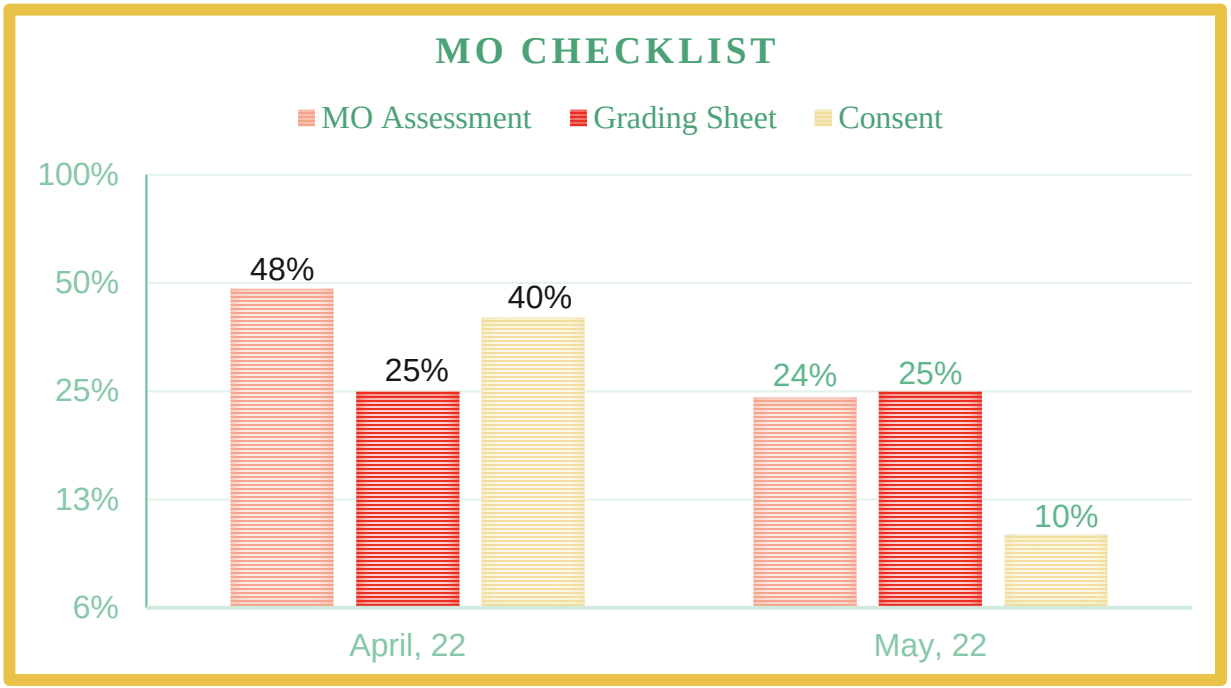
In this study, a total of 50 active as well as closed files were checked for compliance and non-compliance. Out of these 50 files, 25 files were for the month of April 2022 and 25 files were for the month of May, 2022. After checking all 50 files, collected data was compiled in MS EXCEL and with the help of graph, the data collected at One Life Home Healthcare during the month of April and May, 2021 is shown below-



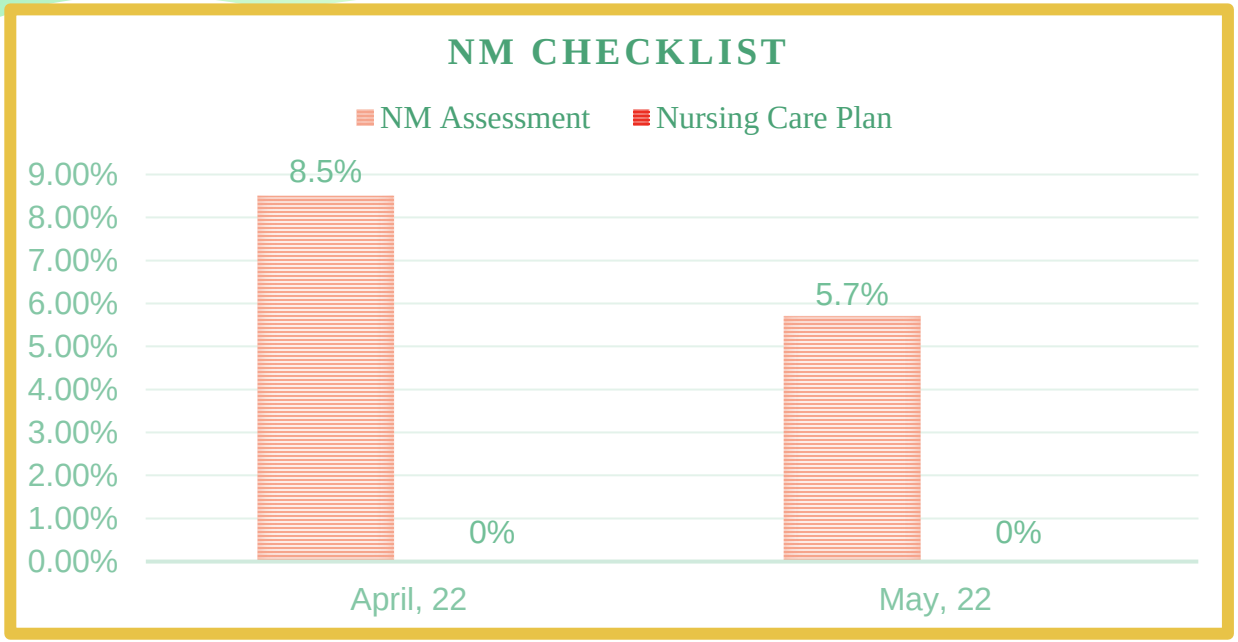
Interpretation- Out of 25 active and closed files studied in the month of April, 2022, given graph shows the average compliance rate for various parameters. In the month of April, MO assessment has 48% compliance, grading sheet has 25%, consent forms have 40%, NM assessment has 8.5%, nursing care plan has 0%, nursing staff booklet has 37.5% and clinical care plan has 5.7% compliance



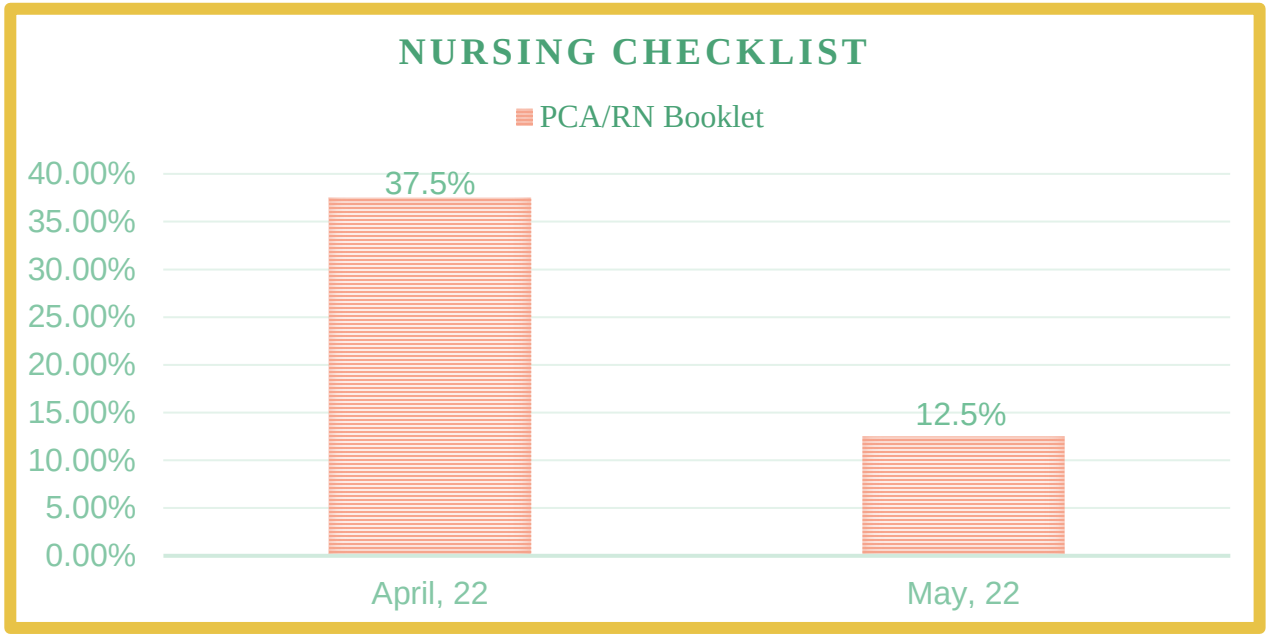
Interpretation - Out of 25 active and closed files studied in the month of May, 2022, given graph shows the average compliance rate for various parameters. In the month of May, MO assessment has 24% compliance, grading sheet has 25%, consent forms have 10%, NM assessment has 5.7%, nursing care plan has 0%, nursing staff booklet has 12.5% and clinical care plan has 0% compliance.



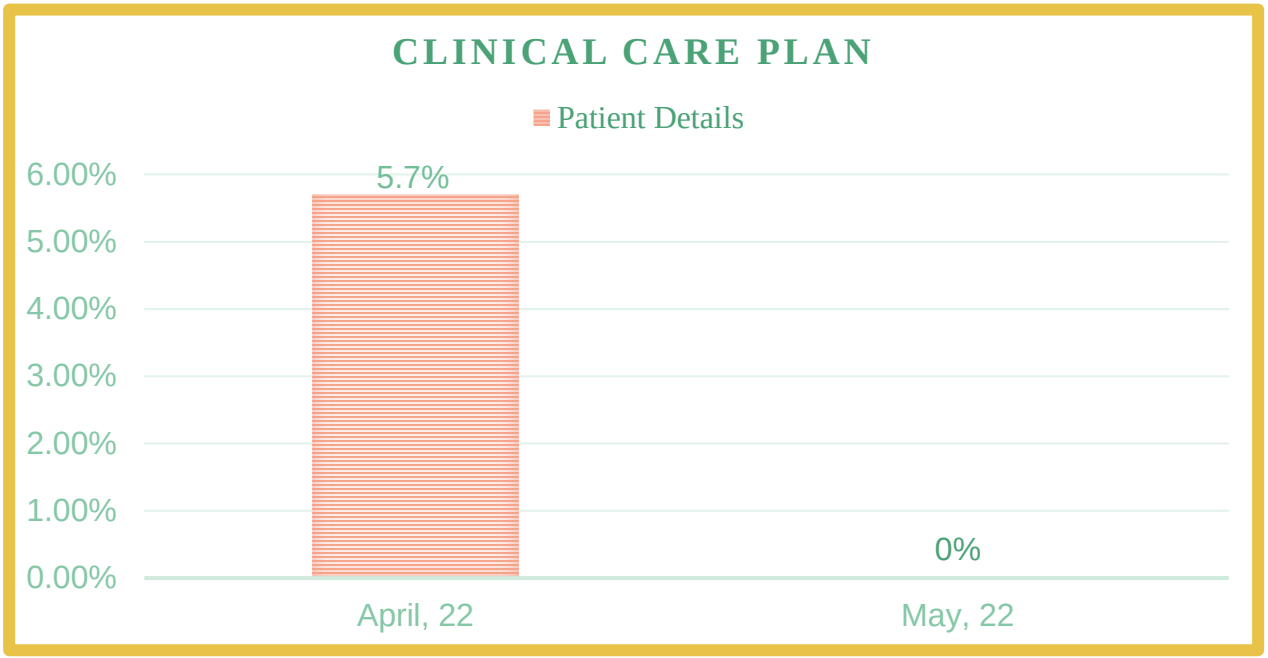
Interpretation – On comparing the data for the month of April and May In MO Checklist, MO assessment had 48%, Grading Sheet had 25%, Consent Forms had 40% compliance in April. In May, MO Assessment had 24%, Grading sheet had 25% and Consent Forms had 10% compliance.



Interpretation- On comparing the data for the month of April and May In NM Checklist, NM assessment had 8.5% and Nursing Care Plan had 0% compliance. In May, NM Assessment had 5.7% and Nursing Care Plan had 0% compliance.



Interpretation- On comparing the data for the month of April and May In Nursing Checklist, PCA/RN Booklet had 37.5% compliance in April. In May, PCA/RN Booklet had 12.5% compliance.



Interpretation- On comparing the data for the month of April and May In Clinical Care Plan, Patient's details had 5.7% compliance in April. In May, Patient's details had 0% compliance.

Observations

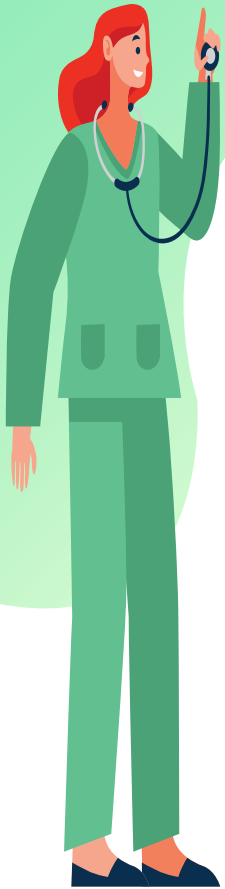
While comparing the collected data with the standard parameters, following things were observed

- 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.

SUGGESTIONS



- Regular audits should be conducted for both active and closed files but specially for active files because if we eliminate the errors from active files itself, there wont be any discrepancies 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
- A 2-levelled checking of these files should be done so as to minimize the chances of incompleteness of these files.

Conclusion

To conclude, 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.

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