Summer Internship Project Presentation

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STUDY ON COMPLIANCE OF ACTIVE MEDICAL RECORDS

Introduction

- A **medical record** can be defined as a set of documents which contains clinical , administrative ,treatment and management related information about a patient in a sequential manner to justify the diagnosis , treatment and the end results .
- **Medical record audit** is a systematic assessment of performance within a healthcare organization .
- The **main purpose** of the audit is to identify the medical practices that are inconsistent or which needs improvement.

Objectives of study

- To assess whether the documentation is being done as per the NABH guidelines of the hospital .
- To suggest measures for the improvement in accordance to the NABH guidelines.

Rationale

- Medical record is necessary to find out that hospitals are working effectively and with efficiency. They follow the NABH guidelines. This study reveals the numerous significance and challenges of the medical record generally. This study identify the weakness or the findings that requires improvement and which parameters are required to be up to the point.
- The main aim of study is to find out the compliances of quality indicators as per NABH guidelines .

Research Methodology

- Study site :- Bhagwan Mahaveer Cancer Hospital and Research Centre ,Jaipur
- Study design :- Observational and descriptive study .
- Sample size :- 300 active files were audited
- Study duration :- 1 month (17.05.2021to 17.06.2021)
- Data collection technique :- Convenience sampling with no repeat entries.
- Type of data collected :- The primary collection of data by auditing the active files at nursing stations or from their respective wards .
- Method of data collection :- Standardized audit tool provided by the organization.
- Variables used :- Compliances and non – compliances .

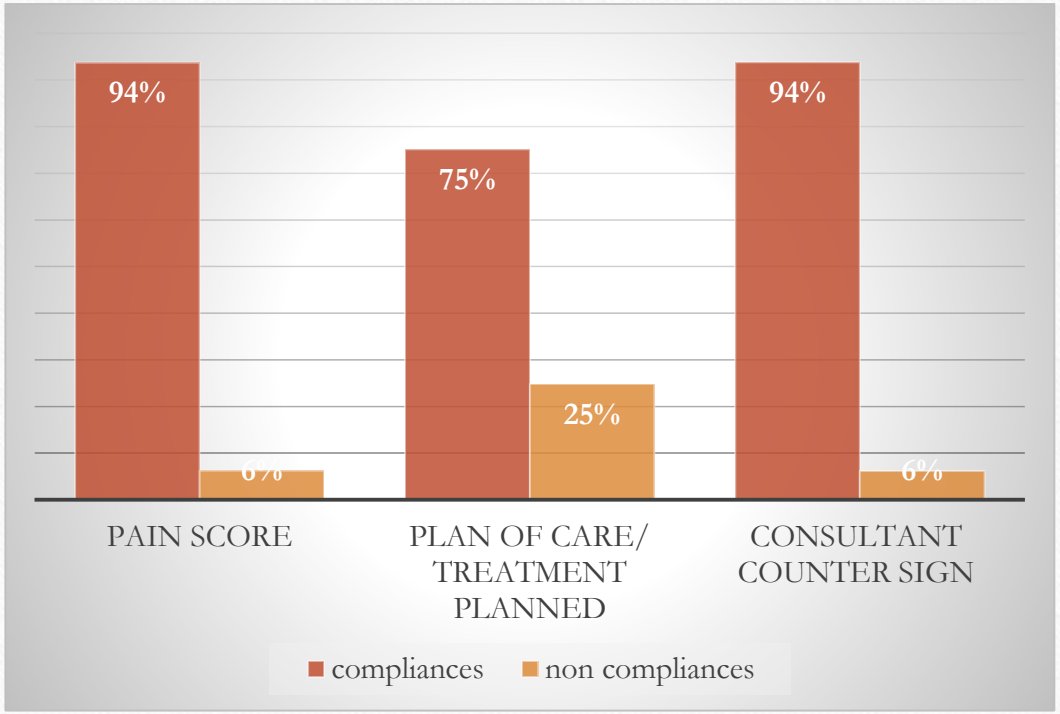
Literature review

Author	Year	Title	Study description	Purpose	Conclusion
Joseph Thomas	2009	Medical records and issues in negligiance	It is very important for healthier document patient's medical records .It is the only way for medical professionals and hospitals to prove that treatment procedure were carried out in proper way	To evaluate the patient profile of the organization ,helping them in analyzing the results and to emphasize its importance in the issues of alleged medical negligence.	Patient's medical record documentation must be done carefully and in organized way because it plays role in scientific evaluation of patient profile of any organization. It not only helps in analyzing the treatment plan results but also to plan treatment protocols . It plays the most important role in alleged medical negligence cases .

Author	Year	Title	Study description	Purpose	Conclusion
G. Johnston , I.K Crombie , HT Daries , EM Alder , A . Milleard	2000	Barriers and facilitating factors for effective clinical audit	Audit report from 93 different pulications were reviewed to study the benefits and barriers of clinical audit	To review the advantages disadvantages and limitations of clinical audit .	Clinical audits not only improve the quality of medical record documentation but this study showed that it also improved communication between collegues . If done in a strategic manner , clinical audits will improve the quality of healthcare delivery .

Findings and data analysis

OPD Assessment



OPD assessment	Compliances	Non compliances
Pain score	94%	6%
plan of care/ treatment planned	75%	25%
Consultant counter sign	94%	6%

Interpretation :- As per graph, it was seen the significant non compliance in plan of care /treatment planned , as this is the important parameter in medical record , as it is related to patient care and treatment given by doctors .

IPD Assessment

IPD assessment	Compliances	Non compliances
Timeliness (initial assessment within 60 minutes)	85%	15%
Form Completeness	81%	19%
Pain score	80%	20%
Plan of care/ treatment planned	87%	13%
MO/Registrars sign, date, time	94%	6%
Consultant counter sign	87%	13%

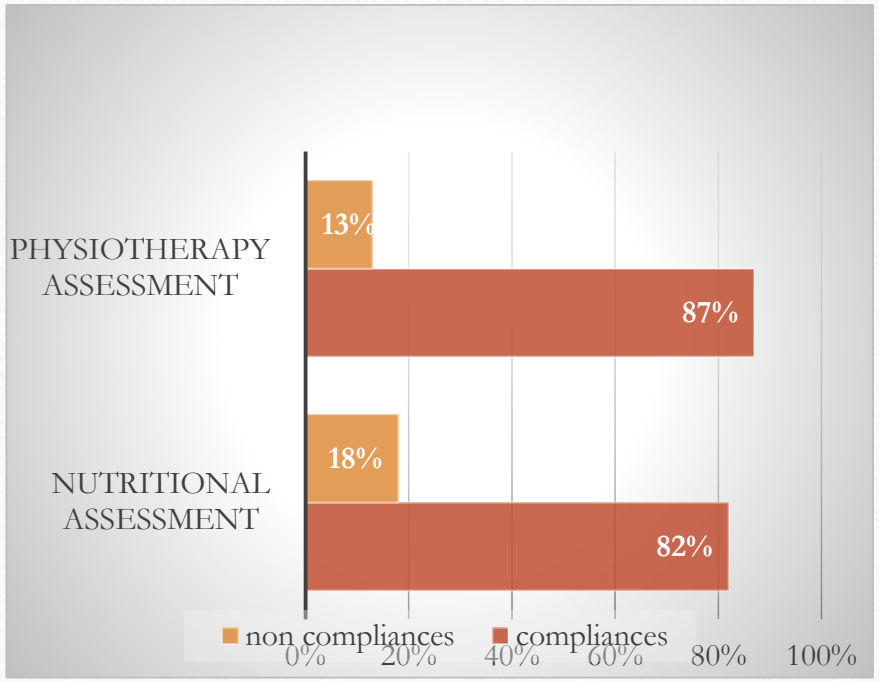
Interpretation :- As per graph , it was seen that significant non compliances in IPD forms.

Nursing admission assessment

Nursing admission assessment	Compliances	Non compliances
Timeliness (initial assessment within 30 mins)	95%	5%
Form Completeness	99%	1%
Fall assessment	99%	1%
Vulnerable Scoring	99%	1%
Pain assessment	96%	4%
plan of care/treatment planned	98%	2%

Interpretation :- As per graph and table it was seen the nursing admission assessment compliances were satisfactory .

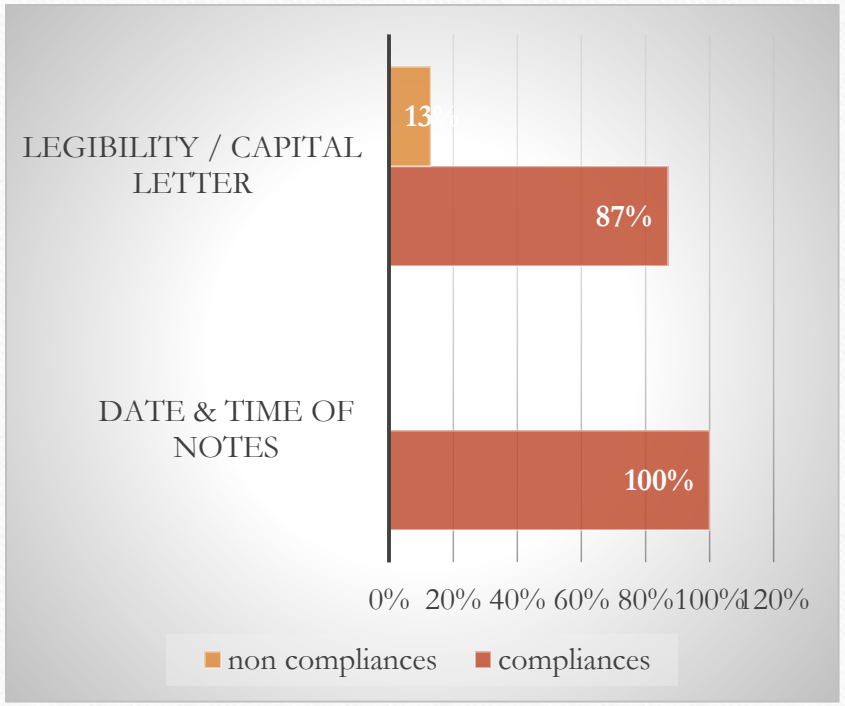
Other assessments



Other assessment	Compliances	Non compliances
Nutritional Assessment	82%	18%
Physiotherapy Assessment	87%	13%

Interpretation :- As per the graph and table it was seen that compliances in nutritional assessment and physiotherapy assessment was low .

Progress notes



Progress notes	Compliances	Non compliances
Date & Time of notes	100%	0%
Legibility / Capital Letter	87%	13%

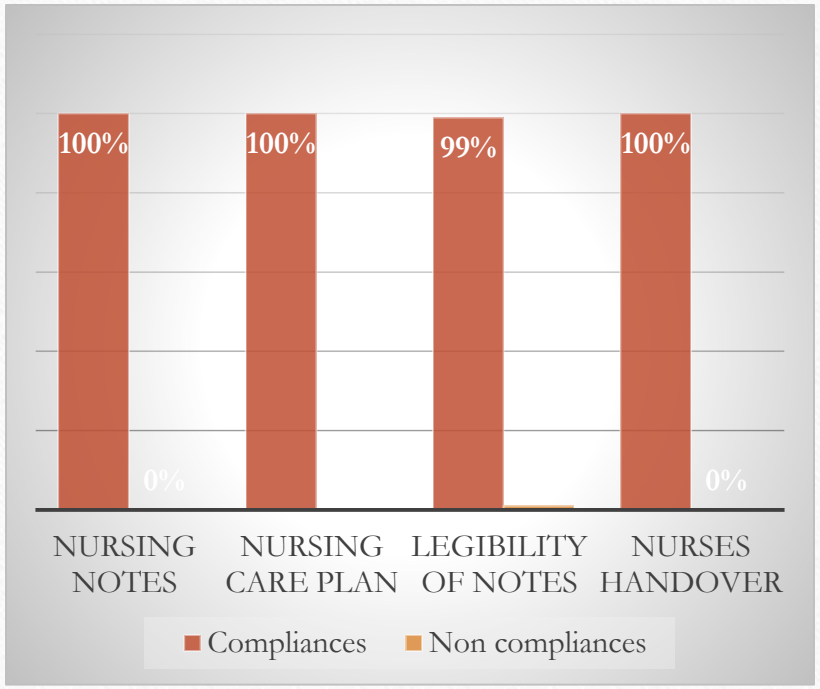
Interpretation :- As per graph and table it was seen the non compliance in legibility/capital letter was 13 % .

Drug order sheet

Drug order sheet	Compliances	Non compliances
Allergies documented	97%	3%
Written in capital letter	98%	2%
Clear Dose	99%	1%
Clear Route	99%	1%
Clear Frequency	99%	1%
Verification	93%	7%
Resident Signature	90%	10%
Actual time of administration	99%	1%
Nurse sign	99%	1%

Interpretation :- As per graph and table it was seen parameters in drug order sheet were mentioned properly .

Nursing Part



Nursing Part	Compliances	Non compliances
Nursing Notes	100%	0%
Nursing Care plan	100%	0%
legibility of notes	99%	1%
Nurses Handover	100%	0%

Interpretation :- As per the graph and table compliance in nursing part was perfect .

Conclusion

- Maintaining a complete medical record is not only important to comply with accredition and licensing requirement , but also as a proof to establish that the adequate care that a patient received in the organization .
- Medical record department has become an essential and important department of each and every hospital . Documents develop by the hospital are widely used to , achieve regulatory and standardized in the recording and presentation of the information .
- This report highlights the area of medical records of hospital that need more concern and attention . Overall study shows that the documentation standards in the hospital is satisfactory .
- To keep the standard and to improve them , the non compliances stated should be managed .

Suggestions

- Sensitizing the clinical staff regarding the importance of medical records and proper documentation of each form .
- Training should be given to the doctors regarding the proper documentation of the treatment record and allergy documentation and sensitizing them regarding its importance so that in future medication error can be avoided .
- Educating and training to nursing staff on NABH guidelines for documentation in medical records .
- Monthly audit of document procedure .
- Rewarding the best performing department /unit for documentation .

Thank you