A PRESENTATION ON

A STUDY ON FIT-GAP ANALYSIS OF MEDICAL RECORDS DOCUMENTATION AND ITS IMPORTANCE IN QUALITY MANAGEMENT

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Introduction to Medical Records Department

- 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.
- A patient's medical record generally contains patient's face sheet having her/his age, gender, address etc., patient and attendant's ID proofs., medical, paramedical, and clinical documents along with investigation reports etc.
- 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 hospitals follow NABH standards in their MRDs ?
- On comparing two month's closed file audit data of Orchid Medical Centre, Ranchi, what was our observation ?

RATIONALE

This project is on "MRD and Its Importance in Quality Management."

- It mainly focuses on how medical records are documented in the hospital 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 the various clinical departments of any healthcare organization for checking not only the completeness of files but also to check for quality indicators for improvement as well.
- With increasing number of medical negligence cases against healthcare professionals and hospitals, proper documentation of medical records plays the most important role to avoid any future legal allegations.

OBJECTIVES

- To study the environment of Orchid Medical Centre, Ranchi.
- To acknowledge the parameters used at Orchid Medical Centre's MRD for documentation.
- To identify the gaps in medical records documentation and
- To suggest few measures that might fill the gap.

RESEARCH METHODOLOGY

- ✓ **Study Setting-** Orchid Medical Centre, Ranchi.
- ✓ **Study Design-** Record Based Retrospective Study.
    - ✓ File type is Passive or closed file. It is of the patients who have taken treatment from the organization and have already been discharged or died.
- ✓ **Study Duration-** 2 months.
- ✓ **Sample Size-** 360 medically managed patient files. All these 360 files are passive/closed files. Out of which 180 files are for the month of May 2021 and 180 files are of June 2021.
- ✓ **Data Collection Technique-** Convenience sampling with no repeat entries.
- ✓ **Type of Data Collected-** Primary data collected by checking files of discharged or dead patients at MRD.
- ✓ **Method of Data Collection-** Standardized audit tool for passive/closed. (In-patient) files were provided by the hospital itself.
- ✓ **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.	Gunjan Patel	2009	Total quality management in healthcare	Quality management was introduced during Crimean war. It proved to improve the death rate from 43% to 10%. In this article, author also mentions the various principles and components of quality management in healthcare sector and how to achieve it.	To show the importance of quality management in healthcare. And, also to understand the principle components and steps to achieve and maintain the quality of various services provided in healthcare	To conclude, quality management plays a vital role in the healthcare sector. It ensures that the services that are provided to the patients in a healthcare system is safe and is a quality service. To ensure an indented quality management, one must ought to be a customer focused organization, keeping in mind the needs of their customers and constantly working towards achieving and in-fact overachieving it. The organization must lead and involve all the people in it to move towards their goal of customer satisfaction and towards putting constant effort to be better than yesterday.

LITERATURE REVIEW

S. No.	Author	Year	Title	Study Description	Purpose	Conclusion
2.	Joseph Thomas	2009	Medical records and issues in negligence	For treating doctors, properly document patient management is very important. It is the only way for doctors to prove that the treatment was carried out properly	To study about proper documentation of patient records and its importance.	For scientific evaluation of the organization's patient profile, to help them in analyzing the treatment results and to plan treatment protocols, medical records are very important. Other than that, it is a very important tool in the issues of alleged medical negligence.

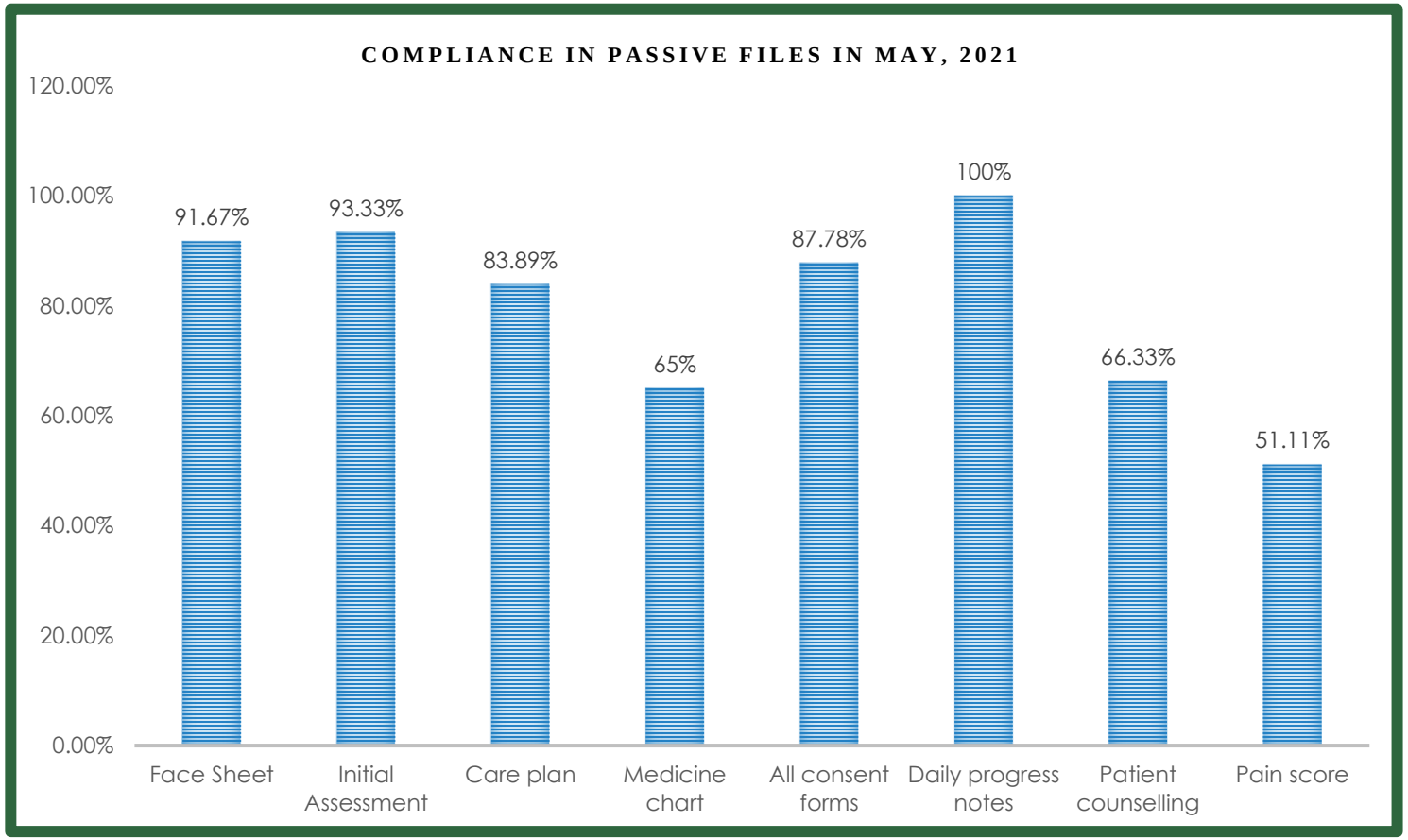
LITERATURE REVIEW

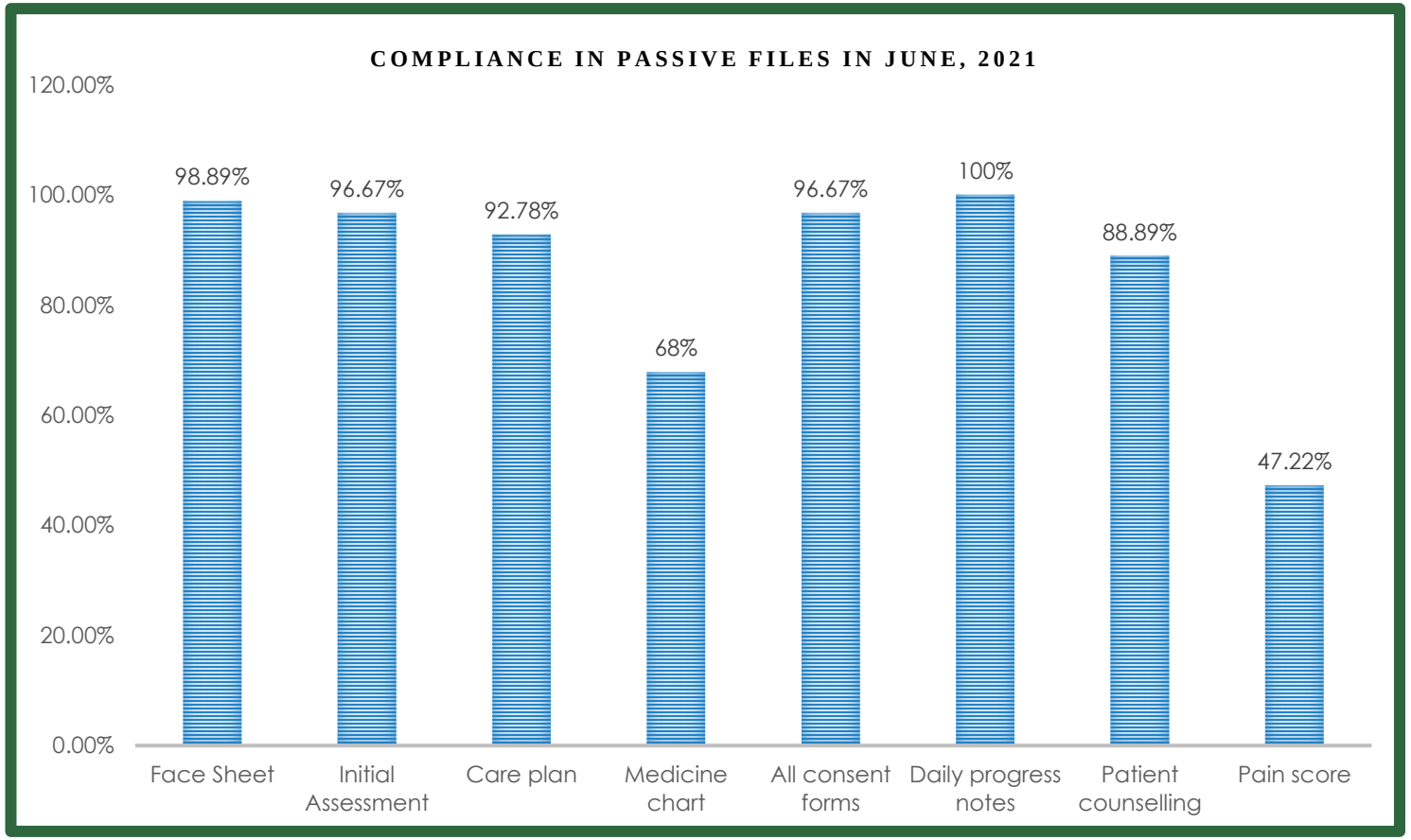
S. No.	Author	Year	Title	Study Description	Purpose	Conclusion
3.	Ashok Deorari & Nigel Livesley	2018	Delivering quality healthcare in India-Beginning of improvement journey.	Quality management ensures that the services provided to the patients are up to mark which ensures smooth functioning of the system in the long run. It has two parts-Quality assurance and Quality improvement.	To study about the building blocks of quality management and how managers can implement it in real life hospital scenarios	To conclude, quality improvement at ground level is the key to proper functioning of the healthcare system. Leading a team of people from all levels of the healthcare system to remove obstacles for improvement in targeted area on a day-to-day basis is a challenge. Every member of the team must have the knowledge of the key processes that are involved in the system. The purpose of quality improvement is to fill the gap between the prevalent and the desirable. It can only be achieved by providing proper training and conducting regular audits regarding the same. Reaching the goal of providing indented quality service in lowest cost possible is difficult but it can be achieved by taking one step at a time on a day-to-day basis.

LITERATURE REVIEW

S. No.	Author	Year	Title	Study Description	Purpose	Conclusion
4.	K Srinivasulu, V Tejaswini Namburi, AB Sai Samhitha	2016	A study on documentation of medical records.	Documentation is an essential part in healthcare sector, it should be documented timely, accurately and completely. This study was done on 100 case sheets.	To show the importance of proper documentation of medical records of patients and the drawbacks of a poorly documented medical record.	Proper documentation, organization and maintenance is not only the duty of every working doctor but of all the staffs of a healthcare organization including MRD of every hospital as ill-documentation can not only put someone behind the bars, but proper documentation can save a person from it as well.

DATA ANALYSIS AND INTERPRETATION




COMPLIANCE IN PASSIVE FILES IN JUNE, 2021
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
98.89%
96.67%
92.78%
68%
96.67%
100%
88.89%
47.22%
Face Sheet
Initial Assessment
Care plan
Medicine chart
All consent forms
Daily progress notes
Patient counselling
Pain score

OBSERVATIONS

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

→ In the month of May, only 65% patient's medicine chart was properly documented, and this percentage slightly improved to 68% in the month of June.

→ In the month of May, only 66.33% patient's counselling sheet was properly documented but this percentage improved to 88.89% in the month of June.

→ In the month of May, only 51.11% patient's pain score was properly documented but this percentage decreased to 47.22% in the month of June.

SUGGESTIONS

- → Regular audits should be conducted for both active and closed files but specially for active files.
- → Time to time training and orientation of doctors and nurses should be conducted.
- → MRD should closely check all the files for completion and those files which have deficiencies should be immediately send to the concerned department for completion.
- → Management should make policies regarding the same.

CONCLUSION

"As rightly said by someone, what's not on the paper is not there at all."

- ✓ So, maintaining a medical record of patients is not only a treatment related need but it also proves to be a game-changer in medico-legal cases, in saving innocent lives as well as to punish the culprit for providing wrong treatment etc.
- ✓ It not only helps other medical professional to understand the treatment patient has undergone but also helps them in planning the further treatment plan.

REFERENCES

1. Gunjan Patel's analysis on total quality management in healthcare, 2009
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3. Ashok Deorari & Nigel Livesley's analysis on delivering quality healthcare in India- Beginning of improvement journey, 2018.
4. Joseph Thomas's analysis on medical records and issues in negligence, 2009.
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6. K. srinivasulu, V. Tejaswini Namburi,AB Sai Samhitha's study on documentation of medical records, 2016
7. https://orchidmedcentre.com/


THANK YOU :)