SUMMER INTERNSHIP RESEARCH PROJECT

- ***Process Mapping of MRD and Compliance of Consents Obtained and Medical Record Documentation.***
- ***Gap Analysis Of Records Against The Set Standard Operating Procedure By NABH Operating Protocol***

Presented by – Dr. Aayushi Sharma
MBA (HM- 2020-2022)
Roll No.- 1050
Submitted to – Dr. Daya Krishan Mangal

Presentation Breakdown:

1. Objective
2. Research Methodology
3. Process Flow For MRD
4. Storage And Stacking Of Files In The Department
5. Consents Used In Fortis Healthcare Facility And Other Medical Records
6. General Admission Consent
7. Procedural Consents
8. Blood Transfusion Consent
9. High Risk Procedures And Treatment Consent
10. Anaesthesia Consent
11. Other Consents
12. Doctor's Admission Assessment
13. Doctor's Daily Progress Notes
14. Nursing Admission Assessment
15. Nutritional Assessment And Screening Form
16. Dietician's Notes And Diet Chart
17. Safe Surgical Checklist
18. Discharge /Death Summary
19. Observations And Recommendations
20. Conclusion
21. Recommendations

Fortis HOSPITAL

OBJECTIVE

- To analyse the gaps and discrepancies in medical records with reference to checklist prepared according to NABH standards.
- To measure the overall compliance.
- To recommend effective methods for closure of gaps.

RESEARCH

MODE OF COLLECTION OF DATA

- Primary Data Collection Technique: Observation & semi-structured interview
- Secondary data Collection: Files from the MRD

SAMPLING

- Study Design- Quantitative data is collected through simple random sampling method.
- Sample Size- 300 in-patient files
- Study Duration Month- Months of April, May and June of 2021(100 files for each month).
- Study Area- Fortis Healthcare, Shalimar Bagh, New Delhi, India.

SAMPLING INSTRUMENT

Pre-structural checklist - An audit tool was prepared with a structured checklist and analysed in MS Excel.

TYPES OF FILES

The files are separated in two ways -

- Active Files: The files of the patients that not discharged yet, hence their files are in the ward are called Active files. To study such files, a prospective study was done. Patients admitted in the month of June.
- Closed Files: The files received in the MRD after the discharge of the patient. For these files, a retrospective study was done. For medical records from April and May.

VARIABLES AND THEIR MEANINGS

In this report three variables are taken – Compliance (marked as 10), Partial Compliance (marked as 5) and Non-Compliance (marked as 0). ‘Compliance’ as a term denotes whether the parameter is being met with the standard. Before we discuss the documents audited, we need to understand about consents.

PROCESS FLOW FOR MRD:

STORAGE AND STACKING OF FILES IN THE DEPARTMENT:

The arrangement of files is done in following ways:

1. Year wise
2. UHID wise.
3. On the basis of their type:

- Regular files
- DAMA files
- MLC flies
- OT recovery files
- Chemotherapy files
- Dialysis files

FORMS AND RECORDS STORED IN THIS DEPARTMENT:

- Consent forms
- OT papers
- A&E Papers
- Certificates issued from the department:
- Patient fitness certificate
- Fit to fly certificate
- Leave certificate

CONSENTS USED IN FORTIS HEALTHCARE FACILITY (FHSB):

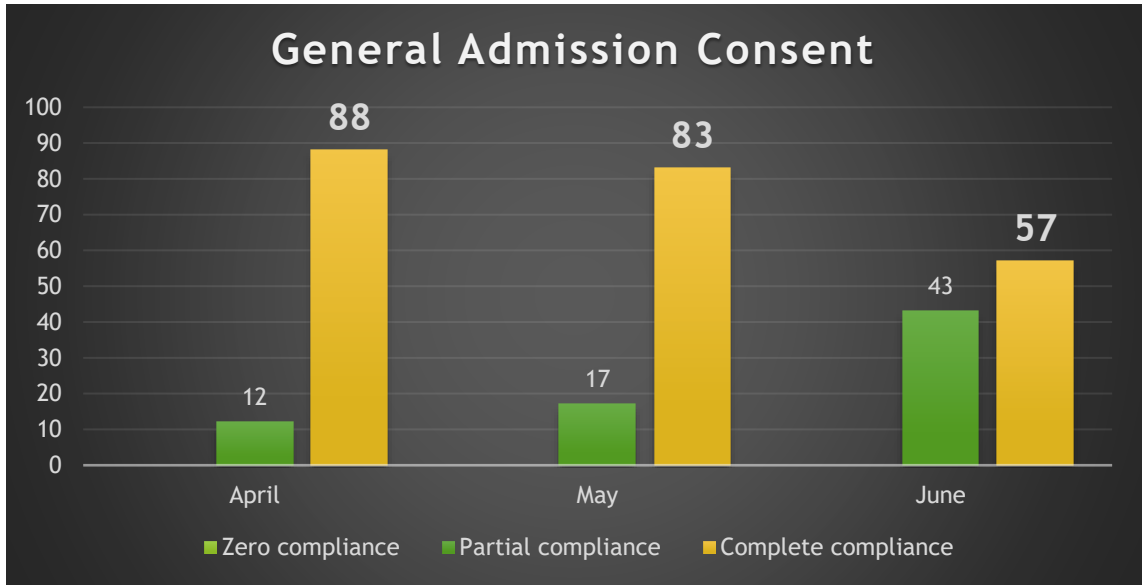
- General Admission consent.
- Covid-19 Consent
- Procedure consent
- Blood Component consent
- HIV Testing consent
- High Risk Medication consent
- Anaesthesia consent
- Conscious Sedation
- Consent of Surgery
- Haemodialysis Consent.

OTHER MEDICAL RECORDS AUDITED:

- Doctor’s admission assessment
- Doctor' daily progress notes
- Nursing admission assessment
- Daily nursing flow sheet and Nursing Care Plan
- Nutritional assessment and screening form

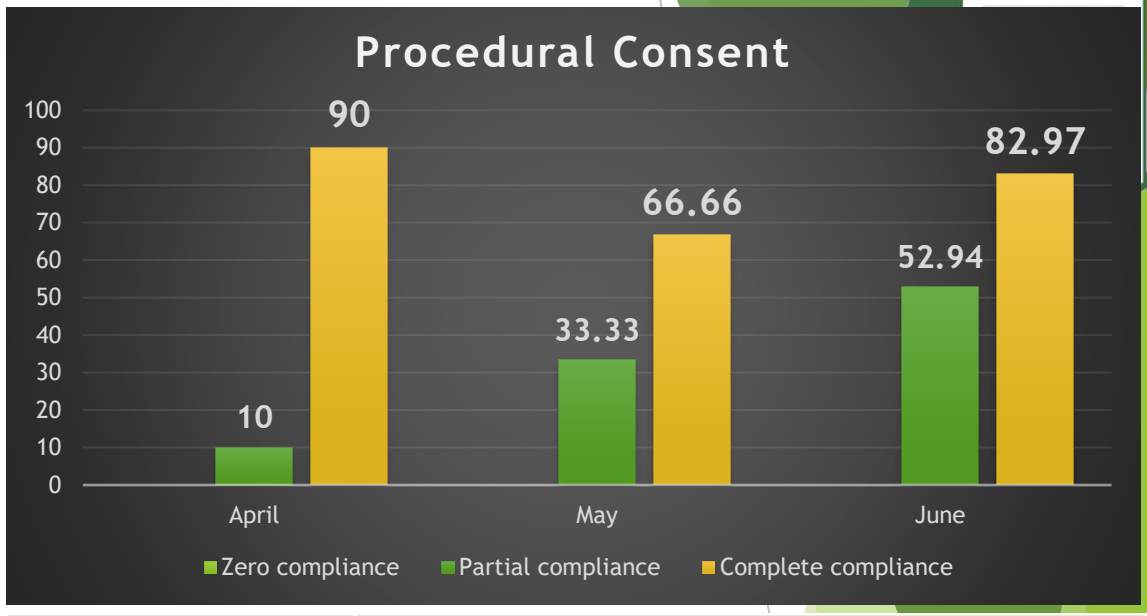
- Surgical Safety checklist
- Discharge/death summary (applicable in only discharged/death patients)

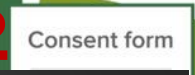
General Admission Consent



PARAMETERS NOT MET	• Date and time missing in admission consent • In case of surrogate signature, reason has not been mentioned. • Patient gave a Hindi signature in an English language consent.
CAPA	• Escalated PCS head • Staff briefed for mentioning of date and time
Current Status	Ongoing

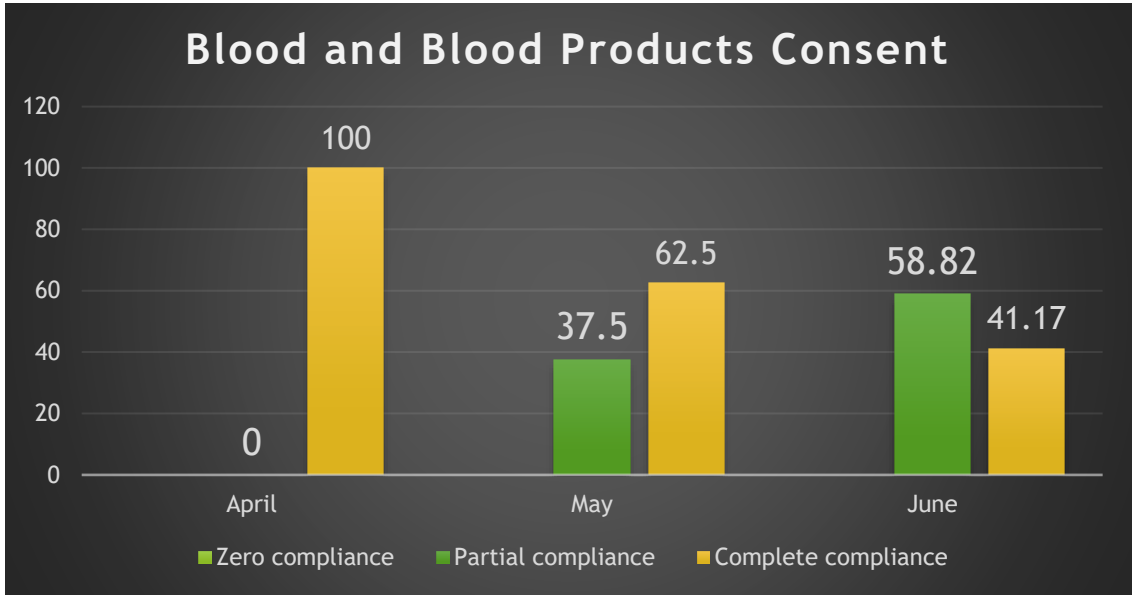
Procedural Consents





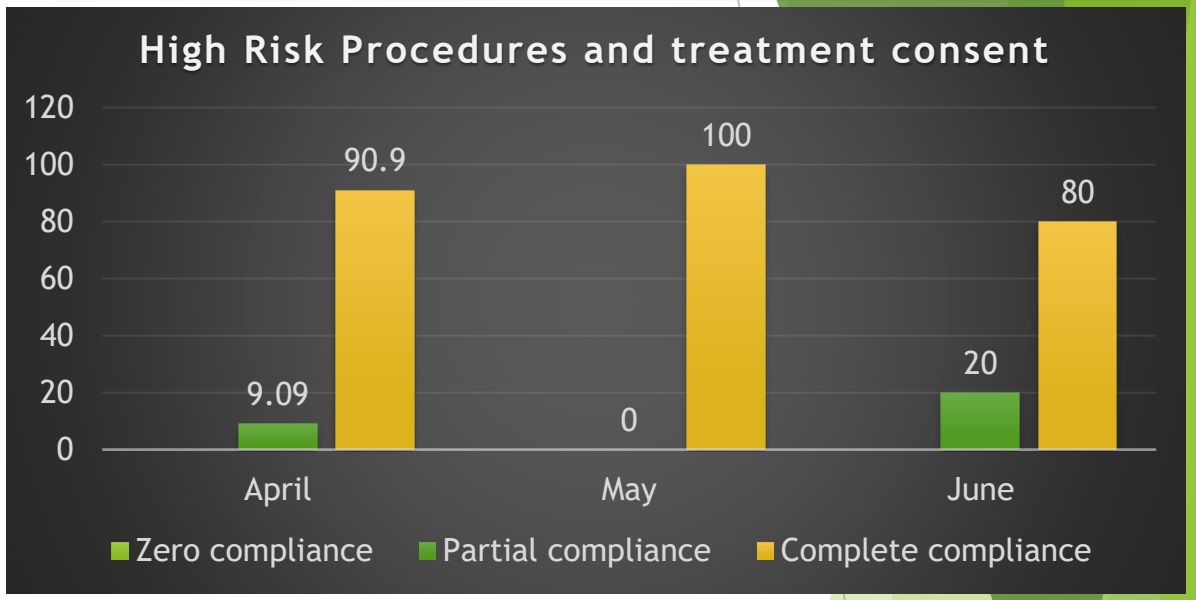
PARAMETERS NOT MET	• Time missing • Witness Signature missing
CAPA	• Escalated to concerned departmental personnel.
Most Frequently In	Consent for LSCS, Hysterectomy, PTCA, MRI, CAG

Blood Transfusion Consent



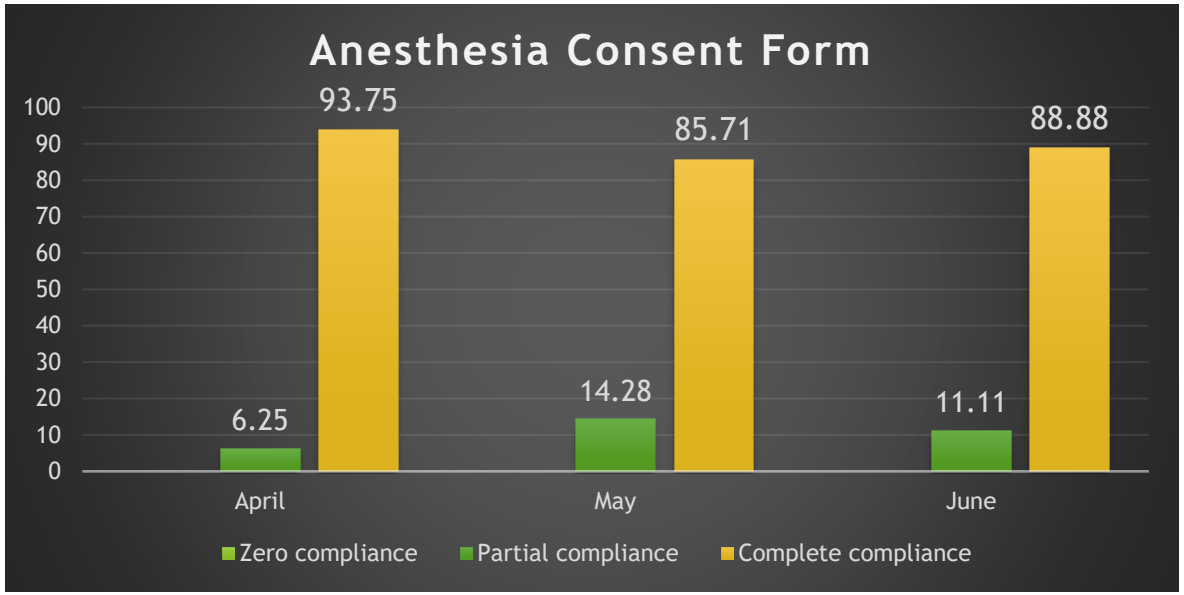
PARAMETERS NOT MET	• Date and time missing • Witness Signature missing
Current Status	Ongoing

High Risk Procedures and treatment consent



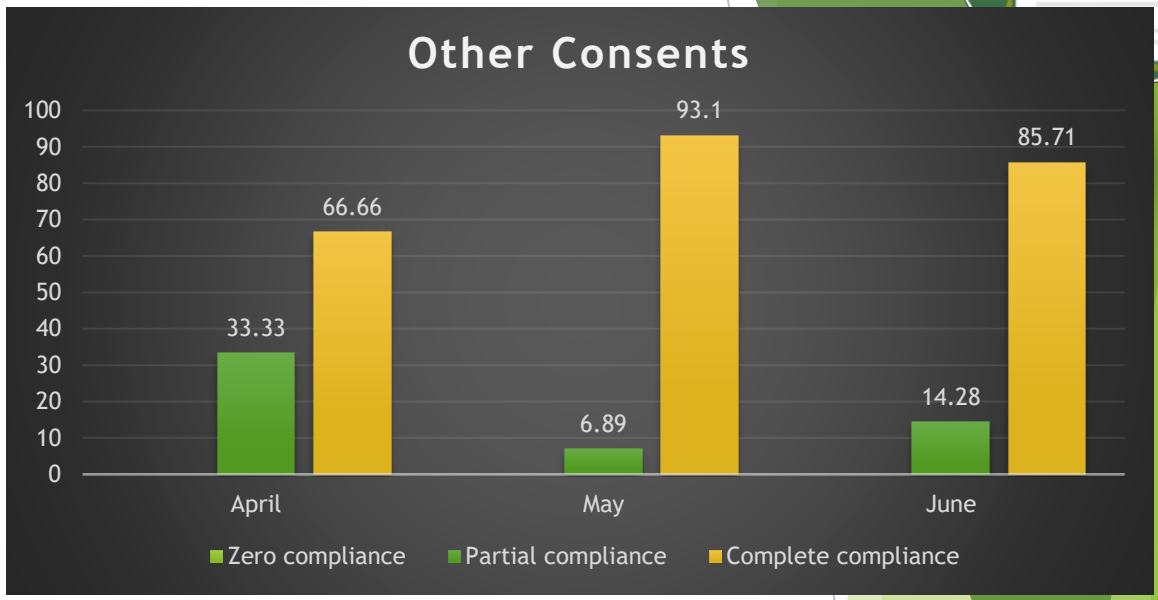
PARAMETERS NOT MET	• Date and time missing • Witness Signature missing.
Most Frequently In	Orthopaedics, Neurology, Urology Cases
Corrective Action And Preventive Measures	Sensitization of departmental medical professionals about the significance of filling of forms.

Anaesthesia Consent



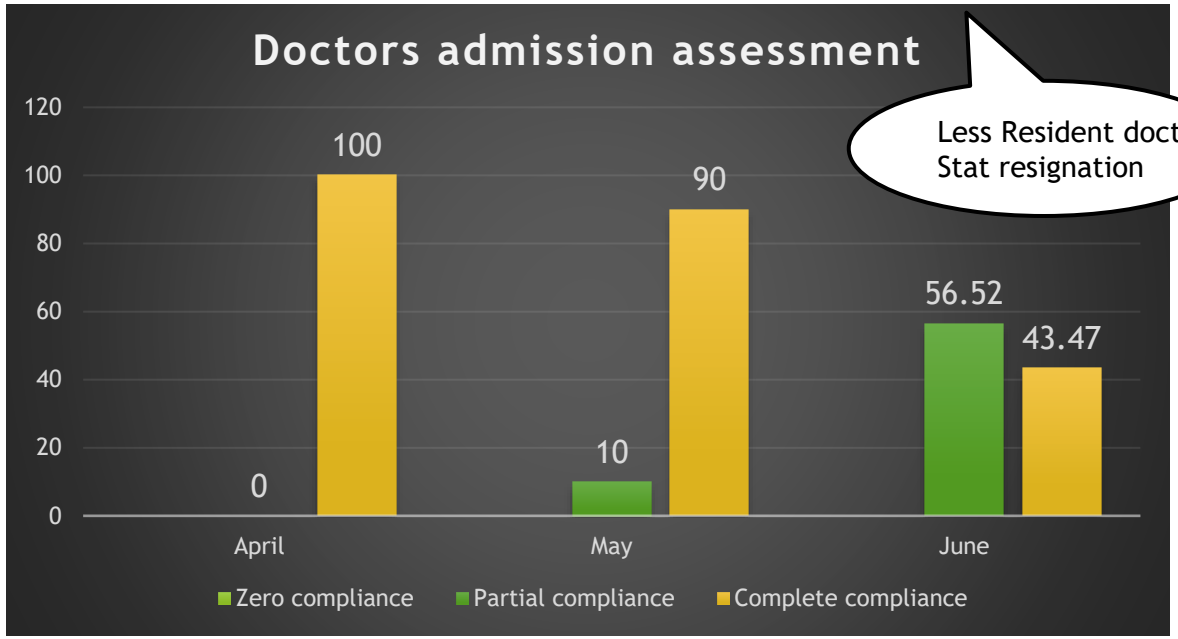
PARAMETERS NOT MET	• Date and time missing • Witness Signature missing.
CAPA	• Escalation to OT manager
Current Status	Improvement in documentation

Other Consents



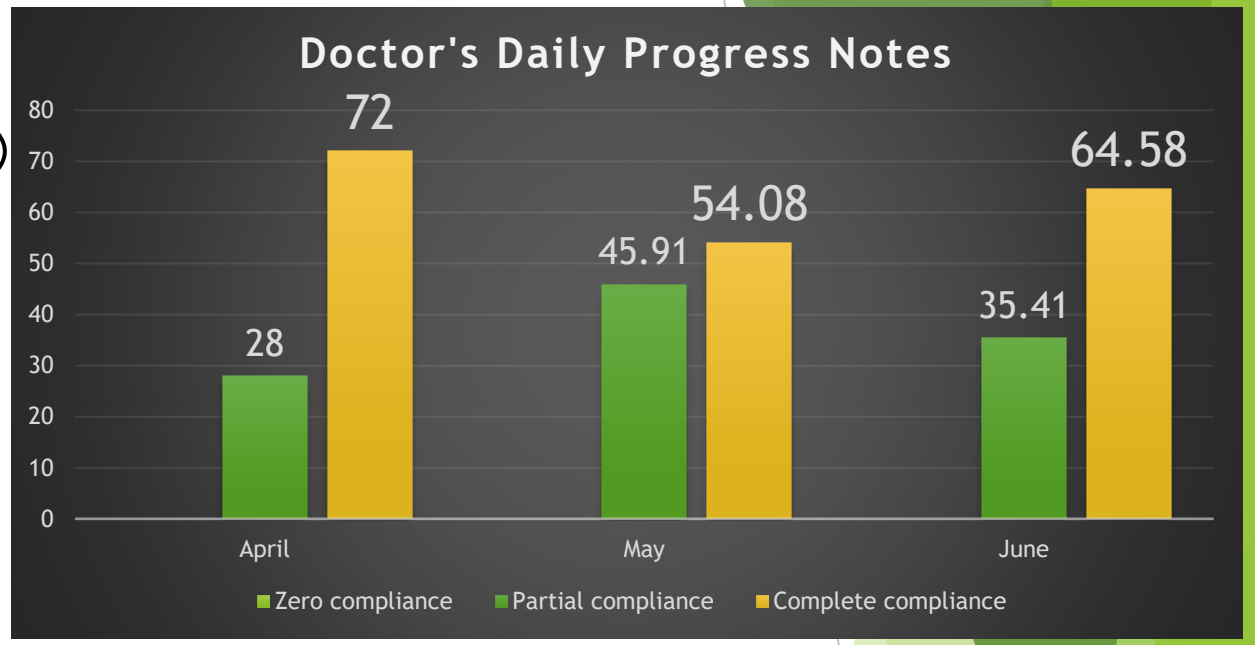
PARAMETERS NOT MET	• Date and time missing • Witness Signature missing.
MOST FREQUENTLY FOUND IN	1. CAG 2. PTCA 3. Investigational therapies for COVID-19 patients 4. NICU 5. Cystoscopy
Current Status	Ongoing

Doctor’s admission



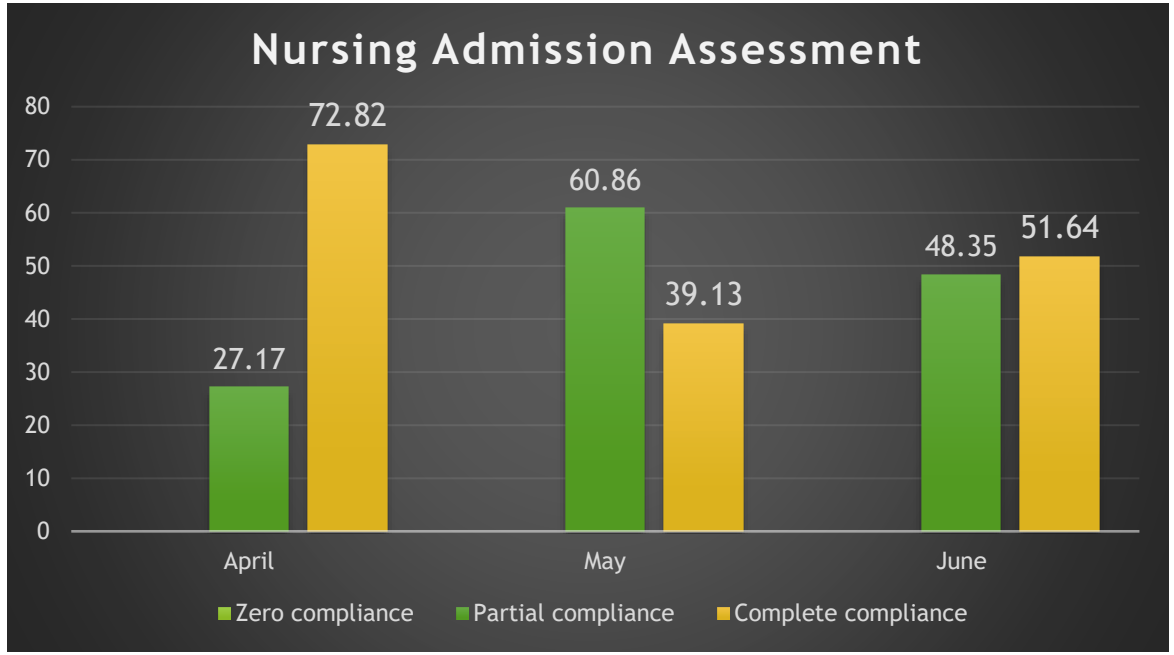
PARAMETERS NOT MET:	• Signature of doctor missing. • Countersign of consultant missing. • Date, time missing.
Zero compliance	• Blank sheets for patients more than 24 hrs. of admission.
CAPA	• Escalated AMS and DMS • Daily completion of records, discussion in morning meeting

Doctor’s daily progress notes



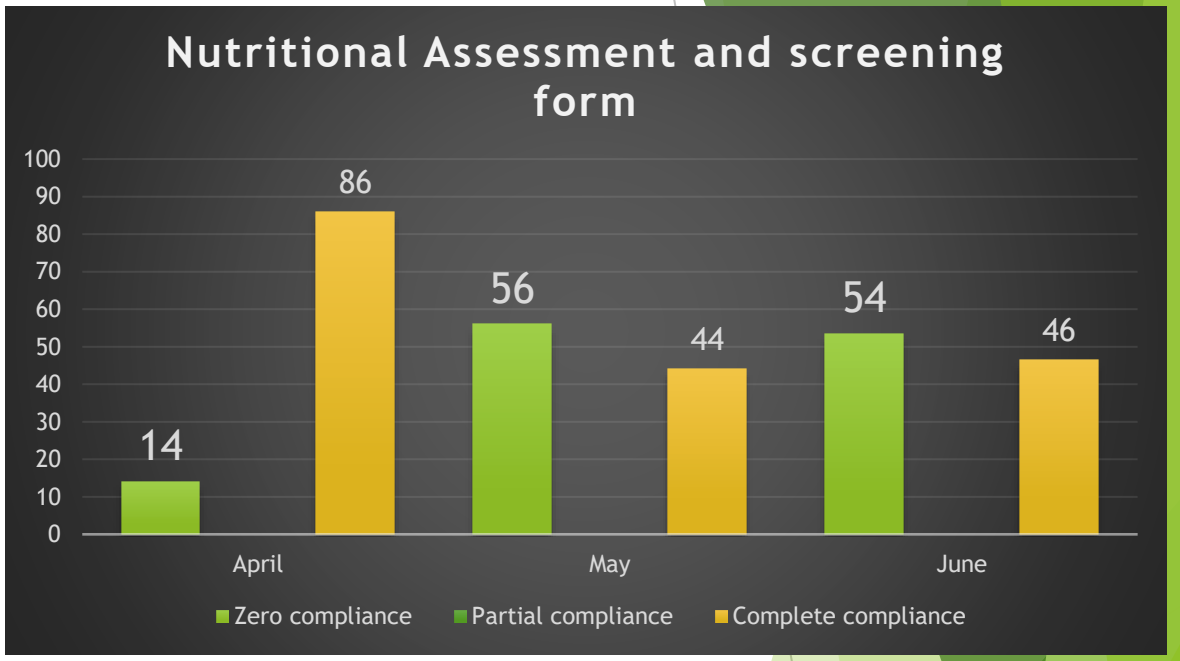
PARAMETERS NOT MET	• Time missing, only shift mentioned • Author name is not mentioned.
CAPA	• Escalated AMS and DMS
Specialities observed	Covid team Pulmonology Internal Medicine Neurology Nephrology Medical Oncology CTVS

Nursing admission assessment



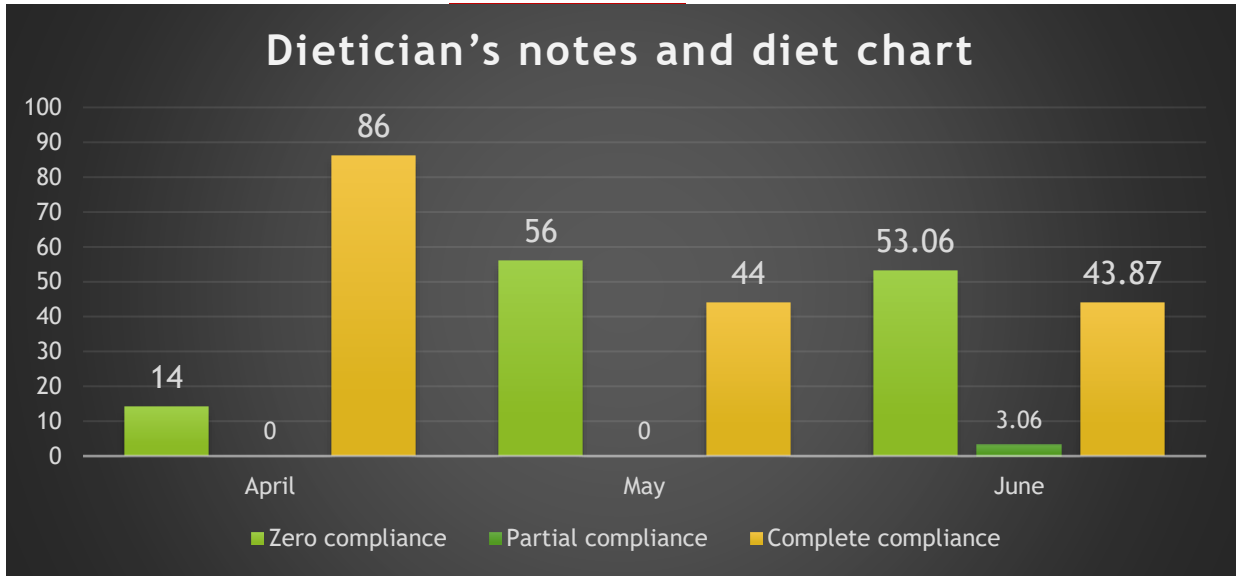
PARAMETERS NOT MET	• Attendant signature on Fall prevention acknowledgment missing (Score High Risk) • Date, time and TL signature missing
CAPA	• While auditing sensitization of nurses and sharing same with TL's of respective floors

Nutritional assessment & screening form



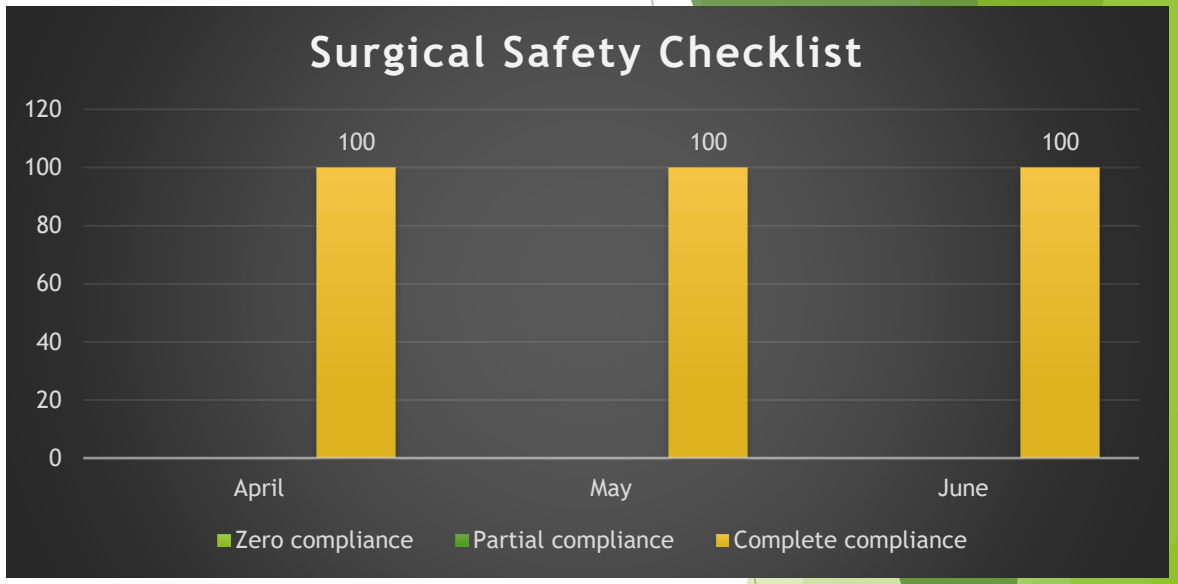
PARAMETERS NOT MET	• Blank for admissions more than 24hrs • Signatures of the dietician
CAPA	• Escalation of same to head dietician • Dieticians on floor sensitized on same while auditing on floor

Dietician’s notes and diet chart



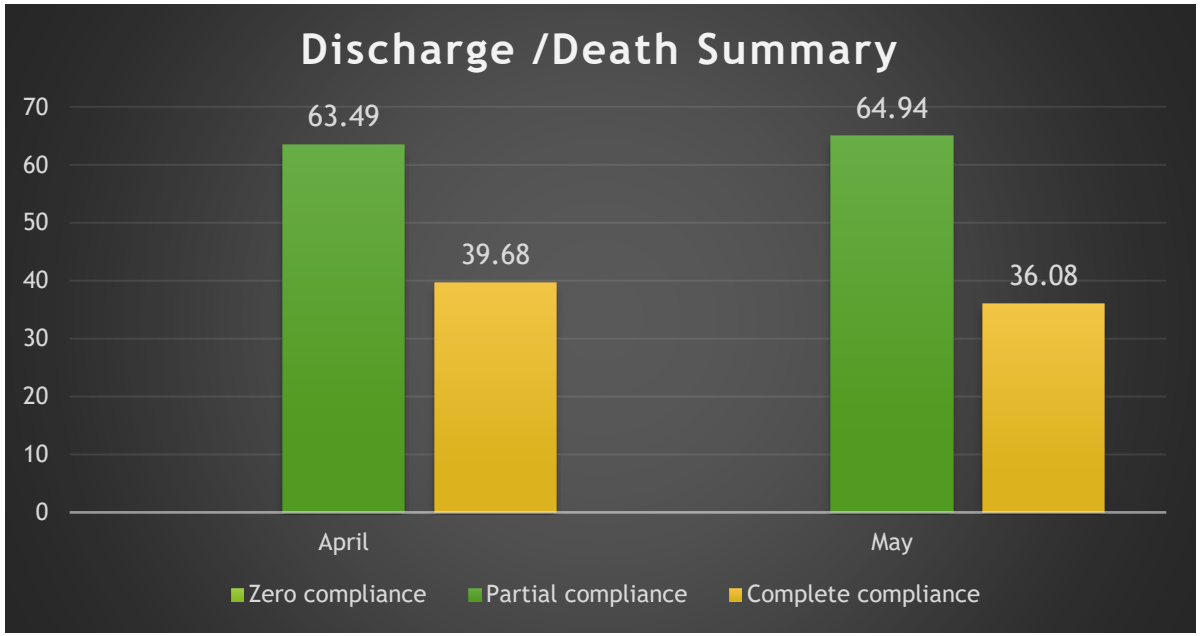
PARAMETERS NOT MET	• Not filled for all dates. • Notes for some days not present
Zero Compliance	• Assessment not present.
CAPA	• Escalation of same to head dietician • Dieticians on floor sensitized on same while auditing on floor
Current Status	On going

Safe Surgical Checklist



Complete compliance for consecutive months

Discharge /Death Summary



PARAMETERS NOT MET	• Instead of doctor's signature, Medical officer's signature is present. • Consulting doctor's signature is missing
Current Status	Improvement in documentation in current month.

OBSERVATIONS AND RECOMMENDATIONS FOR THE MEDICAL RECORD DEPARTMENT

1) The rooms that are allotted for MRD is insufficient.

2) The retention period of files can be reduced, so the space can be kept more organised.

3) The files are extremely bulky and heavy. It also means a lot of stationery is used.

4) Requirement for Electronic Medical Record system.

5) Requirement of more staff and GDA in the MRD.

6) Need of security i.e. electronic door operator at the door of the department.

7) An access to the HIS where in the MRD person can print the reports directly should be done.

8) Pages like doctor's progress notes are overused in a file.

9) Air conditioner and suction vents are not in proper condition in the MRD.

10) The doctors and the nurses should be given a proper orientation about the importance of complete documentation, so as to avoid sub-standard quality.

CONCLUSION

This study was conducted to understand whether the medical record is documented in a proper manner or not. In FHSB, in most documents there is high percentage of compliance but areas of concern are the name and signature of the doctor along with date and time in all the documentation.

MRD maintains records to ensure quality, continuity, assessment and evidence of care. Complete treatment sheets, timely signature of doctors and consultants, proper consent forms documentation could improve treatment analysis and retrieval of documents when needed.

The department was overall good but needed improvement in terms of storage space and stacking of records.

Use of electronic medical records would present with a lot of advantages such as saving of time, greater efficiency, reduced work, scanning costs and man-power.

RECOMMENDATIONS

1. A single consent form can be made - wherein the doctors can be given a provision to write the procedures needed and mark the related risks.
2. Educate the patient about the consent forms.
3. Orientation of all medical professionals
4. Regular training sessions should take place for the staff
5. Introduction of Electronic Medical Record in the hospital. If not a complete EMR, then even a Partial EMR can be introduced.
6. Multiple entries of same data should be reduced.
7. If some portion is not applicable for a particular patient, then that part should be stroked off or marked as Not Applicable
8. Root cause analysis should be done to trace the deficiency for incompletely filled records.
9. Monthly presentations can be done to bring about improvement in medical records.
10. Regular assessments can be made through audit for randomly chosen files to ensure high standards.
11. The consent should be available in all the other languages spoken/written in India.
12. Hospital-wide standardization of the Discharge summary can be beneficial.
13. Colour coding of the files should be done for easy handling of the files at MRD.
14. Rewarding the best performing Department Unit could prove effective in bringing the required changes.

THANK YOU