A STUDY ON MEDICAL DOCUMENTATION COMPLIANCE IN INPATIEN

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INTRODUCTION

Max Super Speciality Hospital, Saket (a Unit of Devki Devi foundation) is one of the premier names in the healthcare world. A 500+ bedded facility offers treatment across all medical disciplines of Cardiac, Oncology (Medical, Surgical and Radiotherapy), Neurosciences, Obstetrics and Gynaecology, Metabolic and Bariatric Surgery, Bone Marrow Transplant, Urology, Nephrology, Kidney Transplant,
Aesthetics and Reconstructive Surgery, and other ancillary services.

SIGNIFICANCE OF MEDICAL COMPLIANCE

The purpose of complete and accurate patient record documentation is to foster quality and continuity of care. It creates a means of communication between providers and members about health status, preventive health services, treatment, planning, and delivery of care.

OBJECTIVES

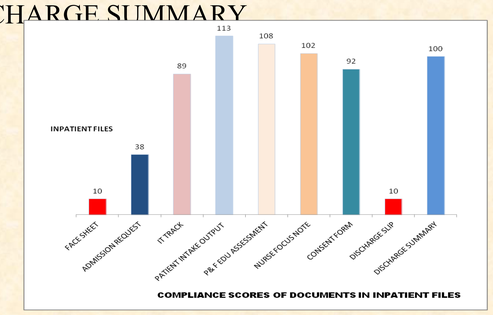
To determine guidelines for the contents, maintenance, and confidentiality of patient Medical Records.
To define the requirements for the documentation and management of patient records._
To ensure that high standards for documentation and management of patient records are maintained consistent with common law, legislative, ethical and current best practice requirements.

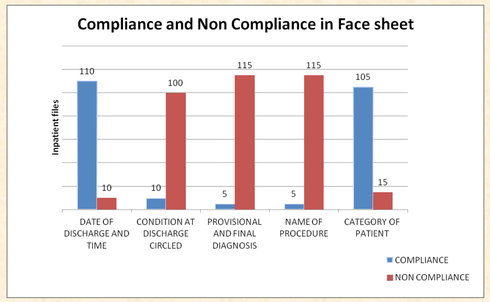
RESEARCH METHODOLOGY

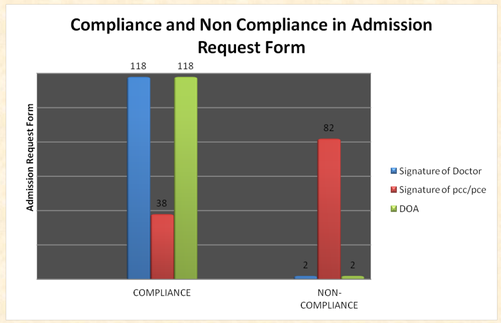
Type of study – Prospective Cross sectional study
Study Area- West Block, Max Super speciality Hospital
Duration of study- 3 weeks
Sample size- 120 patients
Sampling Technique– Purposive Sampling
Sampling Tool- Checklist for compliance in inpatient file

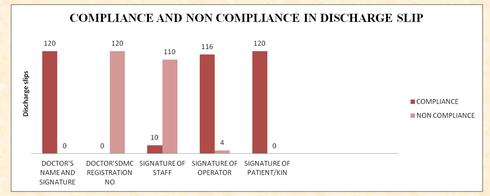
DATA ANALYSIS

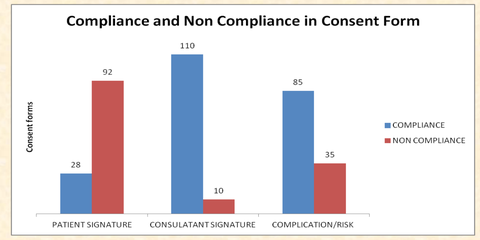
In this study inpatient files are checked for compliance based on following parameters .
FACE SHEET
ADMISSION REQUEST FORM
INVESTIGATION TRACK
NURSING FOCUS NOTE
PATIENT INTAKE OUTPUT CHART
CONSENT FORMS
PATIENT AND FAMILY EDUCATION ASSESSMENT
DISCHARGE SLIP
DISCHARGE SUMMARY











INTERPRETATION

Out of 120 files major discrepancies are observed in face sheet , discharge slip , admission request form . The
reasons for this non compliance was absence of signature of authorised personnel in the form and incorrectly or partially filled columns or entries.

RECOMMENDATIONS

Use electronic medical record for all the major discrepancies observed.
The benefits that an EMR is expected to bring in are:
Paperless medical history , Reduced healthcare costs Empowering the stakeholders to be able to deliver right treatment at the right time , Promote the practice of evidence-based medicine , Accelerate research and building effective medical practices , Usher in ease in maintaining health information of patients , With proper backup policies increase lifespan of health records of individuals that is from conception to cremation , safety with access, audit and authorization control mechanisms , Faster search and updates.
Authorised personnel must be instructed to fill the details properly and clearly and ensure their signatures are present in the forms.
To manage lost reports while moving interdepartmentally one person from nursing must be given responsibility to take the reports from the GDA and maintain a record of documents carried by GDA daily. This will make the process hustle free and prevent the loss of important documents.
Pending Report status formats must be standardized so as to bring uniformity.

Use electronic medical record for all the major