Audit of Medical Documentation of Patients Admitted in Sterling Hospital.

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INTRODUCTION

"Medical audit is systematic review and evaluation of records and other data to deter mine the quality of the services "

Medical audit and clinical audit are often used interchangeably, but clinical audit might be considered to cover all aspects of clinical care. It compliments and may partly overlap financial audit, utilization review, and management of resources; its focus is on the process and results of medical care rather than the use of resources. Medical audit is more systematic, quantified, and formal than traditional clinical ward rounds, meetings, and case presentations but shares with these the objectives of better patient care and education.

"Documentation of patient care is frequently the Achilles heel of Clinical services." Proper documentation of clinical record is of paramount importance.

The aim of the current study is to evaluate the quality of medical notes writing in a medial unit of a tertiary care hospital. This would help in identifying the deficiencies and shortfalls in medical records documentation.

OBJECTIVES

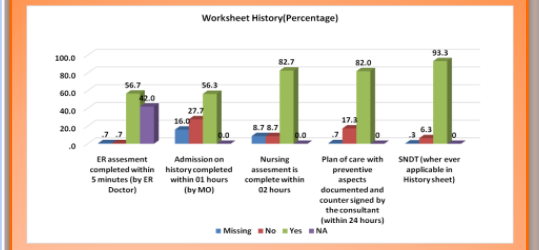
- To evaluate the quality of medical record documented in patients file.
- To identify the deficiencies and shortfalls in medical record documentation.

RESEARCH METODOLOGY

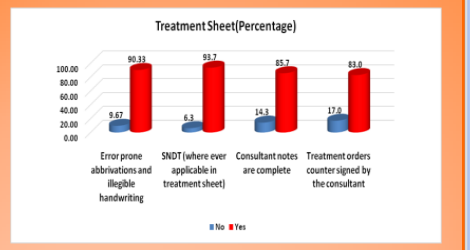
- **Study Design:** Descriptive study.
- **Setting:** Sterling Hospital, Ahmadabad.
- **Duration of Study:** 2 months (1st April to 31st May 2016)
- **Sample Size :** 300
- **Sampling Technique :** Simple Random Sampling

This is a descriptive study (audit) hence the frequency and percentages were determined.

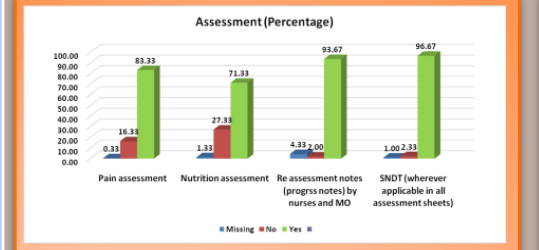
OBSERVATIONS



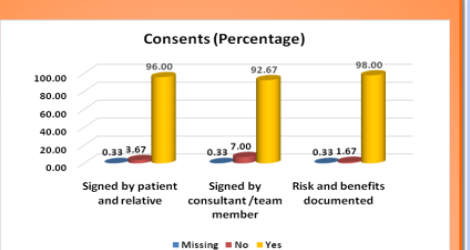
	ER assesment completed within 5 minutes (by ER Doctor)	Admission on history completed within 01 hours (by MO)	Nursing assesment is complete within 02 hours	counter signed by the consultant (within 24 hours)	SNDT (wher ever applicable in History sheet)
Missing	2	48	26	2	1
No	2	83	26	52	19
Yes	170	169	248	246	280
NA	126	0	0	0	0



	Error prone abbrivations and illegible handwriting	SNDT (where ever applicable in treatment sheet)	Consultant notes are complete	Treatment orders counter signed by the consultant
No	29	19	43	51
Yes	271	281	257	249



	Pain assessment	Nutrition assessment	Re assessment notes (progrss notes) by nurses and MO	SNDT (wherever applicable in all assessment sheets)
Missing	1	4	13	3
No	49	82	6	7
Yes	250	214	281	290



	Signed by patient and relative	Signed by consultant /team member	Risk and benefits documented
Missing	1	1	1
No	11	21	5
Yes	288	278	294

RESULT

Overall,15.7% (n=47) files were recorded in efficient manner, whereas rest were revealed with deficiencies in medical record documentation.

CONCLUSION

Documentation of important clinical information is poor even in the charts of patients in tertiary care hospital. Since the quality of record does not only affect the individual patient, but also the qualities of medical care in general. All clinical departments and hospitals should carry out detailed studies into the contents of their medical notes.

LIMITATIONS

- Small sample size.
- Less study duration
- Single handed study

RECOMMENDATIONS

There should be regular check of the records by the floor co coordinator at the floors to see if the clinical details are filled or not. Clinician should be made reminded again and again about the importance of maintaining the records and especially the areas where they tend to skip regularly. Regular training of clinicians to emphasize the importance of medical record documentation.