OPEN FILE REVIEW OF INPATIENT MEDICAL RECORD DOCUMENTATION IN MULTI SPECALITY TERTIARY CARE HOSPITAL

Dissertation submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of
the degree of
Master of Business Administration (MBA)
in Hospital and Health Management

by
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(IIHMR-U/01/2021-23/1403)

Under the Supervision and Guidance of

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(Associate Professor)
2023

OPEN FILE REVIEW OF INPATIENT MEDICAL RECORD DOCUMENTATION IN MULTI SPECALITY TERTIARY CARE HOSPITAL

DECLARATION

I hereby declare that this dissertation **"Open File Review of Inpatient Medical Record Documentation in Multi-Specialty Tertiary Care Hospital"** is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Shreyash Mhatre
HM26-1403

CERTIFICATE

This is to certify that dissertation titled Open File Review of inpatient medical record documentation in multi-specialty tertiary care hospital is a record of theresearch work undertaken by Shreyash Mhatre in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide	**School Dean**
Dr. Deepti Sharma	**Dr. Col Mahendra Kumar**
IIHMR University, Jaipur	**IIHMR University, Jaipur**
Date:	**Date:**

ACKNOWLEDGEMENT

"Appreciation is a wonderful thing: it makes what is excellent in others belong tous as well."

-Voltaire

On the very outset of this report, I would like to extend my sincere and heartfelt gratitude towards all the respected personages who have helped me in this endeavor. Without their active guidance, help, cooperation, and encouragement, I would not have made headway in the report. It is a privilege to have a wonderful internship in one of the renowned Cooperate Hospital. The internship opportunity I had with **Hinduja Hospital** was a great chance for learning and professional development. I'm appreciative for this chance and for getting an opportunity to meet such countless brilliant individuals and experts who directed me through this internship.

I would also like to take this opportunity to express my deepest gratitude and special thanks to the Executive-Quality, **Zincy Aranjikkal ,** who despite being extraordinary busy with his duties, took time to hear, guide and keep me on the correct path and allowing me to carry my internship at their esteemed organization and guidingthroughout the internship.

It is my radiant sentiment to place on record my best regards, deepest sense of gratitude to **Dr. Preeti Goraksha (Assistant Director Quality & Clinical Administration)** for their careful and precious guidance which was extremely valuable for my study both theoretically and practically.

I would like to express sincere thanks to **Dr. P.R. Sodani** (President, IIHMR university, Jaipur) for giving me a chance to do this internship. Now, I would like to express my gratitude towards my mentor at IIHMR University, **Dr.Deepti Sharma** for his extraordinary cooperation, invaluable guidance, and supervision.

This report is the result of his painstaking and generous attitude.

I would also like to express a deep sense of gratitude to the Placement Cell of my esteemed university for guiding me throughout the internship process and for providing time to time internship guidelines.

I perceive this opportunity as a big milestone in my career development. I will strive touse gained skills and knowledge in the best possible way, and will continue to work onthe improvements, to attain desired career objectives.

ABSTRACT

Introduction and objectives:

The medical record must contain accurate and complete documentation to guarantee patient safety a quality of care. Errors in diagnosis, treatment, and follow-up care can be caused by incomplete or inaccurate documentation. The purpose of the study was to assess whether the existing documentation procedure is in compliance with the policy established with the hospital, to evaluate the medical records on the basis of predetermined quality indicators and, to assess the compliance of various types of medical records.

Methodology:

Over the course of three months, a retrospective descriptive chart review of randomly chosen inpatient medical records was carried out for this study. The completeness and accuracy of the documentation in various areas, such as patient demographics, medical history, physical examination, diagnostic tests, medication orders, and discharge summaries, were evaluated using a standardized data collection tool.

Results:

A total of 150 medical records were reviewed. It was determined that the documentation in general was of high quality. Nonetheless, there were a few regions for development, including documentation of sensitivities and unfriendly medication responses, medicine, compromises, and reference notes.

Conclusion:

The hospital's documentation of inpatient medical records was found to be of good quality, but there is still room for improvement in some areas. In order to guarantee the safety and quality of patient care, this study emphasizes the significance of regularly reviewing and enhancing documentation practices.

Keywords: medical records, medication order, reference notes, diagnostic

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LIST OF ABBREVIATION

NABH	National Accreditation Board for Hospitals and Healthcare Providers
ACC	Access Assessment and Continuity of Care
TPA	Third Party Administrator
ISQua	"International Society for Quality in Healthcare"
HMIS	Health Management Information System
KPI	Key Performance Indicator
DMO	Duty medical officer
OT	Operation Theatre
CNS	Central Nervous System
CVS/RS	Cardiovascular System/ Respiratory System
MRD	Medical Records Department
IP	In-Patient
ENT	Ear, Nose and Throat
ICU	Intensive Care Unit
MAR	Medication Administration Record
AD	Administrative Department

CHAPTER 1:

INTRODUCTION

INTRODUCTION

The most essential source of information on a patient's course of treatment in a hospital or healthcare facility is said to be their medical records, also known as health records, medical charts, or any combination of these terms. They are sometimes referred to at the methodically recorded patient history documentation of sickness, treatment, and care throughout a specific time period while under the care of a specific healthcare professional. Clinical observations, drug administrations, doctor's orders, investigations, treatment plans, health assessments, billings, consent forms, and other significant data deemed crucial to the patient's tenure under a healthcare provider are just a few of the "notes" that are documented in a medical record. Medical records have a range of functions since they serve as a recorded history of a patient's period of care.

While medical records assist doctors in giving each patient individualized, high-quality care, they also support hospitals by giving them access to crucial data for research, performance evaluation of the services provided, and policy formulation in the future. It helps to reduce medical errors when a patient is being treated in a hospital or healthcare facility and is crucial evidence in medico-legal situations. Given the significance of medical records for both patients and healthcare professionals, it is crucial that the information be kept in a comprehensive, accurate, and standardized format. Healthcare professionals and other staff members who input data into medical records must do so within a certain time frame and in accordance with the necessary guidelines. A medical records division or a health centre at a hospital or healthcare. The information systems division of a facility is in charge of keeping track of the patients' medical records. They make that the records are uniform, accurate, and comprehensive and alert the clinicians if any crucial data is missing.

Additionally, several organizations have established requirements for medical records. For individuals looking to obtain licensing and accreditation from these organizations', compliance with the necessary documentation in a healthcare facility is crucial.

The documentation of the medical records must be assessed against the NABH standards because these standards are seen as the barometer for the quality of services provided by a hospital to its patients. A patient's experience in a hospital or under a healthcare professional is fundamentally impacted by their medical records. To guarantee that the medical records are organized, accurate, and standardized, it is crucial that the documentation of the medical records be evaluated against the standards established by NABH.

The documentation of the medical records must be assessed against the NABH standards because these standards are seen as the barometer for the quality of services provided by a hospital to its patients. A patient's experience in a hospital or under a healthcare professional is fundamentally impacted by their medical records. To guarantee that the medical records are organized, accurate, and standardized, it is crucial that the documentation of the medical record be evaluated against the standards established by NABH. The purpose of this study is to evaluate the documentation of medical records on the objective aspects listed by NABH in a multi-specialty tertiary care hospital in Mumbai. Additionally, it seeks to do a comparison analysis of various types of medical records to determine if medical records adhere to NABH standards, assess them using the predetermined quality indicators. With the help of this study, it is anticipated that the hospital would be helped to improve best documentation practices while upholding NABH standards, since this will directly impact the caliber of care given and assist the organization in obtaining NABH certification.

An extensive assessment of the medical records of patients who have been admitted to the hospital is part of an open file review of inpatient medical record documentation in a multispecialty hospital. This review's objectives are to assess the accuracy and comprehensiveness of the medical records' documentation and to pinpoint any areas where the hospital's record-keeping procedures should be strengthened. A variety of documentation, including admission notes, progress notes, physician orders, nursing notes, laboratory and imaging reports, medication records, discharge summaries, and other pertinent documents are routinely examined by the reviewer throughout the process. In addition to concise and clear descriptions of the patient's medical history, diagnosis, treatment plan, and progress, the reviewer will be looking for evidence of comprehensive and accurate documentation.

In a multispecialty hospital, the open file review of inpatient medical record

documentation is a crucial procedure for ensuring patient care quality, fostering regulatory compliance, and assisting ongoing improvements in the hospital's record-keeping procedures.

1.1 : Objectives

While conducting the study, the following objectives were kept in mind:

- To assess whether the existing documentation procedure is in compliance with the policy established with the hospital,
- To evaluate the medical records on the basis of predetermined quality indicators and,
- To assess the compliance of various types of medical records.

CHAPTER 2: LITERAURE REVIEWS

Although medical records constitute an integral component in a patient'slife at a hospital, little research has been conducted to evaluate its documentation process. Similarly, even though NABH is the pioneer accreditation body for hospital accreditation, very few articles have documented its compliance with the accreditation standards of NABH in India.

In the year 1991, H. Feather and N. Morgan, described the role of medical records and the concerned department in the risk management practices (2). They stated that medical records should be treated as an integral part of the patient care and holds great importance. In the situation where a medicolegal case arises, the information missing from the medical records might be as significant as the information present.

Renvoize et al in 1997 (1) described the documentation of patient care under a healthcare provider as the Achilles heel of clinical services. They also stated that improvements can be achieved by using a multidisciplinary,semi-structured medical record, but appropriate strategies need to be pairedwith the process. This would work towards overcoming the professional and cultural barriers to unified documentation.

Mishra et al. (2009), a team of researchers from Nepal, conducted a study with aim of assessing the adequacy of medical records in Bir Hospital, a medical university in Nepal. They analyzed the discharge summaries of patient for a period of 6 months in a single tertiary care unit (3). They found that in 66 percent of cases patient's condition at discharge was not mentioned, doctor's signature was illegible in 79.3 percent of cases, and 96.9 percent of were discharged without any instructions given to them.

There were several other disparities observed in the discharge summary aswell.

Lövestam et all (2013), conducted research in which they evaluated the documentation of dietic care in the Swedish Medical Records. It was a retrospective audit in which 147 dietic notes from the electronic medical records were taken and evaluated. The audit showed them that several significant components of the nutrition care were not documented properly.It outlined the fact that the Swedish dieticians need to improve the medical records documentation of the dietic records. It was also suggested by the authors that a structured documentation model might be helpful in the process (5).

It was in the year 2015 that Halasa et el. conducted a four-year retrospective study to assess the economic impact of JCI accreditation on the performance of hospitals on selected structural and outcome measures in Jordan. They found that out of the five selected measures, statistically significant effects were observed in three. When combined over 3 years, it was expressed into a total savings of US$ 593 000 in the healthcare systemof Jordan (14).

As part of a two-year retrospective study conducted in a tertiary care hospital in a metropolitan city in India, two researchers named Anshu Gupta and Chhavi Gupta examined the role of NABH core indicators in monitoring blood transfusion quality and safety. (6). In addition to reduced wastage of blood and blood components, reduced transfusion reactions, and a shorter average turnaround time, they observed significant improvements in the quality of the process.

In another study Nomura et al. (2016) Utilizing Quality of Nursing Diagnoses, Interventions, and Outcomes, analyzed the quality of nursing documentation. It was an observational study, in which the authors compared

the documentation before and after the hospital accreditation in a university hospital (8). It was observed that after the hospital accreditation, there were significant improvement in the documentation in 24 out of 29 items (82.8 percent).

Ryan et al (2017) discussed about the adherence to medical regimens and medical records accuracy in polypharmacy patients in the United States by selecting a retrospectively tested patient cohort of 821 individuals. They found that poor adherence and inaccurate/incomplete medical records giverise to incomplete knowledge about the medication therapy in these patients (4).

Prerana Singh and Sakshi John (2018), a team of researchers from Jamia Hamdard, New Delhi, conducted a study in which they analyzed the health records documentation process in a tertiary care hospital as per the National Standards of Accreditation. 200 patient files from the nursing stations, wards and critical areas were selected and assessed on the predetermined documentation review audit tool. Through their study they found that higher compliance was observed in surgical patient files as compared to themedical patient records (7). They also noted various areas of patient files where compliance was varying and used this information to communicate to the staff about the improvement measure to be undertaken in the future.

Nugraheni et al. (2019), assessed the management of medical records in Primary Care Centers in Indonesia, on the basis of the accreditation for these facilities and the legislative provisions applicable. The study revealedpartial fulfillment for the Standard Criteria 8.4.1 and 8.4.2 while there was complete overall fulfillment for the Standard Criteria 8.4.3 and 8.4.4. Theydescribed that the fulfillment of the above-mentioned criteria was greatly influence by regulations, manager’s commitment in following them, and synchronizing these regulations in the primary health centers with legislations which are recognized nationally and internationally.

The same year, Sadagheyani (2019) mentioned the issue of poor-quality medical records in Iran in their research paper and stated that physicians and surgeons emphasize the criticality of high-quality care for the patient, but do not recognize the documentation of medical records as an integral component of the patient care. In their research paper they described the study conducted to assess the role accreditation in improvement of medicalrecords documentation in Iran (9). The study was conducted in 2018 and analyzed a sample of 1500 inpatient medical records of Besat Hamadan Hospital from the year 2011 (pre-accreditation) and 2017 (post- accreditation). The authors found that there was significant improvement inall forms after the accreditation of documentation status as compared to previous arrangements. Admission and Discharge Summary forms saw highest improvement, while lowest improvement score was obtained for progress notes (pre-accreditation) and clinical form header (post- accreditation).

In 2020, A similar study was conducted by Attia et al. in which they assessed the impact of achieving accreditation standards in a hospital on thequality of electronic health records. A private 30 bedded hospital in Abha, Aseer Saudi Arabia was selected for this study and 18 percent of medical records of the discharged patients were manually chosen each month for the audit. The data collection was based on the modified medical records checklist adapted according to the JCI criteria (10). The authors observed that after the accreditation, there was significant improvement in the compliance with complete medical records documentation.

A study by Sharifi et al. (2021), highlighted how the deployment of accrediting models in hospitals changed the elements that affected the quality of medical records. Information was gathered from medical administrators and supervisors of several departments, including nursing, medical records, and accreditation of academic hospitals in Ahvaz, Southwest Iran, using a series of 28 semi-structured interview questions.

The factors facilitating and hindering factors which affected the quality of documentation were categorized into three levels, organizational, environmental, and personal. Six facilitating factors namely, organizational structure, organizational culture, management support, individual characteristics, and perceived benefits science and technology while five

hindering factors identified in this study were program structure, organizational structure, beliefs, justice,and individual characteristics (10).

Table 2.1, described below, presents a summarized version of the literature review discussed above.

Table 2.1. Summarized Version of the Review of Literature.

Author (Year)	Study Location/ Sample Size	Methodology	Salient Features	
			Objective	Results
Mishra et al. (Apr 2009)	**Location:** Nepal **Sample Size:** 130 Discharge summaries	**Study Period:** Apr 2008- Oct 2008 **Study Design:** Descriptive Cross-Sectional Study. **Study Setting:** Liver Unit Bir Hospital, Nepal. **Sampling Technique:** NA **Study Tool:** Predetermined Audit Checklist.	Aim of assessing the adequacy of medical records in Bir Hospital, a medical university in Nepal	In 66 percent of cases patient's condition at discharge was not mentioned, doctor's signature was illegible in 79.3 percent of cases, and 96.9 percent of were discharged without any instructions given to them. Several other disparities were observed in the discharge summary as well

Lövestam et al. (2013)	**Location:** Sweden **Sample Size:** 147 dietic notes	**Study Period:** 2009 **Study Design:** Retrospective Observational Audit **Study Setting:** Six hospitals and	To evaluate the documentation of dietic care in the Swedish Medical Records.	Several significant components of the nutrition care were not documented properly. Swedish dieticians needed to improve the medical records

Table 2.1. Summarized Version of the Review of Literature. Continued

		4 PCCs in central Sweden **Sampling Technique:** NA **Study Tool:** "Diet-NCP-Audit" instrument		documentation of the dietic records. They suggested that a structured documentation model might be helpful in the process.
Anshu Gupta, Chhavi Gupta (2016)	**Location:** India **Sample Size:** NA	**Study Period:** 2011-2012. **Study Design:** Retrospective study **Study Parameters:** "whole blood and blood component usage", "transfusion reactions", "wastage of blood and blood products", and "average turnaround time". **Sampling Technique:** NA		Significant improvement in the quality of the process with reduced wastage of blood and blood components, lower incidence of transfusion reactions and lesser average turnaround time for the blood and blood component's issues.

Nomura et al. (2016)	**Location:** Brazil (in a general and public university hospital with 60 specialties and approximately 850 beds.) **Sample Size:** 224 medical records	**Study Period:** 2012-2013 **Study Design:** Observational study **Study Sample:** Hospitalizations in clinical and surgical units. **Sampling Technique:** Through PEPI software version 4.0		After the hospital accreditation, there were significant improvement in the documentation in 24 out of 29 items (82.8%).
Prerna Singh (Aug 2018)	**Location:** India **Sample Size:** 200 patient files	**Study Period:** NA **Study Design:** Observational, Prospective Study with	To analyze the health records documentation process in a tertiary care hospital as per the National	Higher compliance was observed in surgical patient files as compared to the medical patient records.

Table 2.1. Summarized Version of the Review of Literature. Continued

		Hypothesis testing **Study Setting:** A private hospital in Delhi, India **Sampling Technique:** Convenience Sampling **Study Tool:** Documentation Review Audit Tool.	Standards of Accreditation	Various areas of patient files where compliance was varying was also noted.
Ryan et al. (Sept. 2018)	**Location:** USA **Sample Size:** 821 US adults	**Study Period:** 2015 **Study Design:** Retrospective Observational Study **Study Setting:** Cleveland Clinic, Cleveland, Ohio. **Sampling Technique:** Random Sampling in patients receiving a Vit. D test. **Study Tool:** A multiplex assay to quantitatively assess the serum	To assess the adherence to medical regimens and medical records accuracy in polypharmacy patients in the United States	Poor adherence and inaccurate/incomplete medical records give rise to incomplete knowledge about the medication therapy in these patients.

		concentrations of medications followed by interview schedule		
Nugraheni et al. (July 2019)	**Location:** Indonesia **Sample Size:** NA	**Study Period:** NA **Study Design:** Qualitative Research **Study Setting:** Primary care centers of Indonesia. **Sampling Technique:** NA **Study Tool:** Participation included observation, non-	Assessing the management of medical records in Primary Care Centers in Indonesia	Partial fulfillment was observed for the Standard Criteria 8.4.1 and 8.4.2 while there was complete overall fulfillment for the Standard Criteria 8.4.3 and 8.4.4.

Table 2.1. Summarized Version of the Review of Literature. Continued

		structured interviews, and discussions.		
Sadagheyani H.E. (2019)	**Location:** Iran **Sample Size:** 1500 records	**Study period:** 2011 and 2017 **Study Design:** Analytical Cross-Sectional Study **Study Setting:** Besat Hospital in affiliation with Hamadan University of Medical Sciences, Iran. **Sampling Technique:** Systematic Sampling **Study Tool:** Researcher made checklist.	To assess the role accreditation in improvement of medical records documentation in Iran	Significant improvement in all forms was observed after the accreditation of documentation status as compared to previous arrangements

Attia et al. (May 2020)	**Location:** Saudi Arabia **Sample Size:** 18 percent of the medical records for each month.	**Study Period:** Jan 2014-Jun 2015 **Study Design:** Analytical Cross-Sectional Study **Study Setting:** A Private 30 bedded hospital in Saudi Arabia **Sampling Technique:** Random sampling **Study Tool:** Medical record completeness checklist.	To assess the impact of achieving accreditation standards in a hospital on the quality of electronic health records	After the accreditation, there was significant improvement in the compliance with complete medical records documentation
Sharifi et al. (2021)	**Location:** Iran **Sample Size:** 28 administrators and supervisors of nursing, medical	**Study Period: NA** **Study Design:** Qualitative Research. **Study Setting:** Five educational institution in affiliation with "AJUMS"	To describe the factors that affected the quality of medical records through the implementation n of accreditation	Three level of factors affecting the quality of records viz. organizational, environmental, and personal. **Facilitating factors:** Organizational structure,

	records, and accreditation	**Sampling Technique:** NA **Study Tool:** Semi-structured interview schedule.	models in hospitals	organizational culture, management support, individual characteristics, and perceived benefits and science and technology **Hindering factors:** Program structure, organizational structure, beliefs, justice, and individual characteristics.

Table 2.1. Summarized Version of the Review of Literature. Continue

CHAPTER 3:
METHODOLOGY

- **Study period:** 3th March to 3th June 2023
- **Study setting:** In-patient Department at Hinduja Hospital, Mumbai

- **Type of study:** Retrospective, Descriptive Study

- **Study population:** IPD patients at General ward, deluxe/exclusive and sharing ward.

- ***Inclusion criteria*** Cash or Insurance covered patient's stay of 24 hours or more at
- In patient areas
- ***Exclusion criteria:*** All patients in critical care areas in the hospital

- ***Study tools:*** MRD Checklist

- **Sampling Method:** Random sampling-
- Only IP are recorded
- **Sample size:** 150 MRD Files

- **Mode of Data collection:** Observation methods

- **Type of Data:** Quantitative

CHAPTER 4: RESULTS/ INTERPRETATION

4.1: Data collection

The major source for the information that was acquired was the patient's case files, which were available at the hospital. The data was gathered using quantitative techniques. Surveying and observation were the techniques employed. The development of a structured checklist (audit tool).

Using a few quality indicators as the standard (Table 1).

Table 1: Checklist for clinical audit of medical records of inpatients

Clinical audit checklist	Yes	No
▪ Admission Request Form		
▪ Sign, Name, Date and Time by pt/relative/guardian		
▪ Initial Assessment Done		
▪ History		
▪ Findings		
▪ Investigations		
▪ Plan of Treatment		
▪ Sign-Doctor		
▪ Name-Doctor		
▪ Date-Doctor		
▪ TIME-Doctor		
▪ Discharge Summary		
▪ Allergies, if any		
▪ History		
▪ Sign-JMS		
▪ Name-JMS		
▪ Date-JMS		
▪ Time-JMS		
▪ Vitals recorded		
▪ Plan of Care		
▪ Special needs		
▪ Special needs of time of discharge (on initial assessment		

- SIGN-JMS
- NAME-JMS
- DATE-JMS

- TIME-JMS
- SIGN-JMS
- NAME-CONSULTANT
- DATE-CONSULTANT
- TIME-CONSULTANT
- Assessment done within 2 hours-JMS
- Assessment done within 24 Hours Consultant
- Sign of Doctor
- Name of Doctor
- Sign of Patient or Patient Relative/Name/ate
- Sign of Witness
- Benefits Explained
- Alternatives given
- Risk Explained
- Risk Explained
- Nursing Care Plan
- Nursing Assessment Chart
- John Hopkins Fall Risk Assessment Tool
- Clinical Nursing Hand Off Communication Tool-(ISBAR)
- Pre-Anesthesia Assessment Document
- Operative Notes documents
- Operative Notes Sign By Surgeon
- Post Operative Plan Of Care Document
- Surgical Safety Checklist Completed
- Sign
- Date
- Time

Clinical audit checklist	Yes	No

- Nursing Administration Sign
- Nursing Administration Time
- For ICU- Counter Sign By Doctors
- Received by Name/ Date/ Time
- Informed by Name/ Date/ Time
- Intervention dose / Action Taken
- Dietician Referral
- Documentation of Diet on This Sheet
- Referral For Doctor
- Selected Urgent / Routine
- Date
- Time
- Name Of the Doctor Referred to
- Nutritional Screening Done
- Initial Nutritional Assessment Done
- Nutritional/ Diet Order Mentioned on Plan of Care
- Nutritional reassessment Done
- Patient Education on Diet and Nutrition Given
- Available
- Sign
- Date
- Time
- Referral Done Within One Hour For Urgent
- Referral Done Within 24 Hours Of Routine
- Discharge Summary Given
- Contains Patient's Condition At the Time Of Discharge
- Contains Follow-Up Advice
- Instruction On How To Get Urgent Care/ Symptoms To Look Out For
- LAMA Completely Filled

- Reasons For LAMA
- MLC Discharge Notification, Where Required
- Notification To Police When MLC Discharge Case
- Paediatric Assessment includes immunisation
- Paediatric Assessment-Growth Chart, growth, developmental
- Specimen signature form/filled
- PICU/ICU Counselling
- Counselling of Patients relatives by Dr

4.1: Problems identified

My understanding is that an open file audit of inpatient documentation is normally carried out in a hospital to examine the accuracy and completeness of patient medical record. Numerous issues or issues may be found during this process. Here are a few typical examples:

1. Insufficient documentation: Sometimes, crucial details including vital signs, med ication administration records, doctor orders, progress notes, and discharge instr uctions are missing from patient records.
2. Illegible handwriting: Healthcare workers frequently have bad handwriting, whi ch can make it challenging to effectively read the information in the patient reco rd.
3. Errors or discrepancies: Errors or discrepancies, such as improper medicine orde rs, incomplete or inaccurate diagnoses, and inconsistent paperwork, may be foun d in patient records
4. Lack of timeliness: In some instances, it's possible that patient records won't be f inished in time, which can impede the delivery of the right care.
5. Inconsistent paperwork: Inconsistent documentation, such as variations in the way information is recorded by various healthcare professionals, may be found in patient records.
6. Insufficient documentation: Patient records occasionally may not contain enough information to adequately reflect the patient's condition, course of treatment, and response to therapy.
7. Healthcare professionals may fail to properly document crucial information, such as the justification for a treatment choice, which can make it challenging to evaluate the calibre of the patient's care.

It's vital to remember that these problems could differ based on the particular hospital and the medical staff attending to the patient.

4.3: FINDINGS

1. ADMISSION REQUEST FORM (n=150):

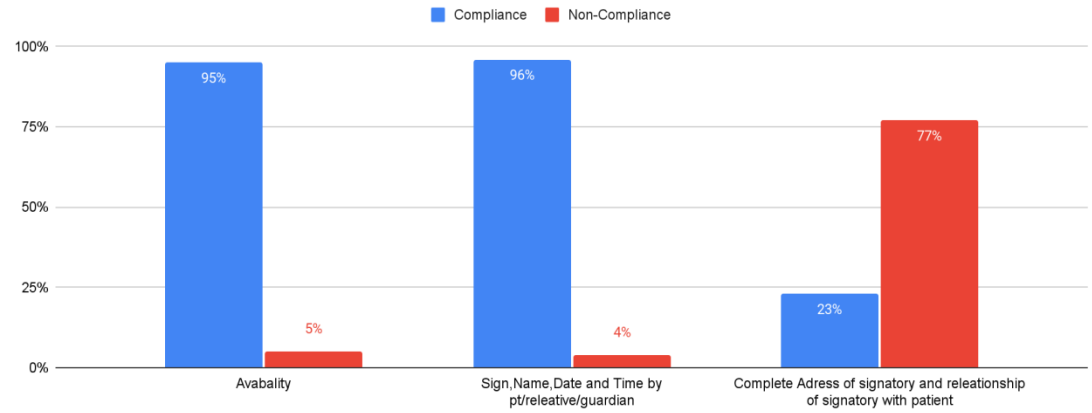

Fig 4.3.1: PERCENTAGE COMPLIANCE ON ADMISSION REQUEST FORM

2. EMERGENCY ASSESSMENT SHEET (n=47):

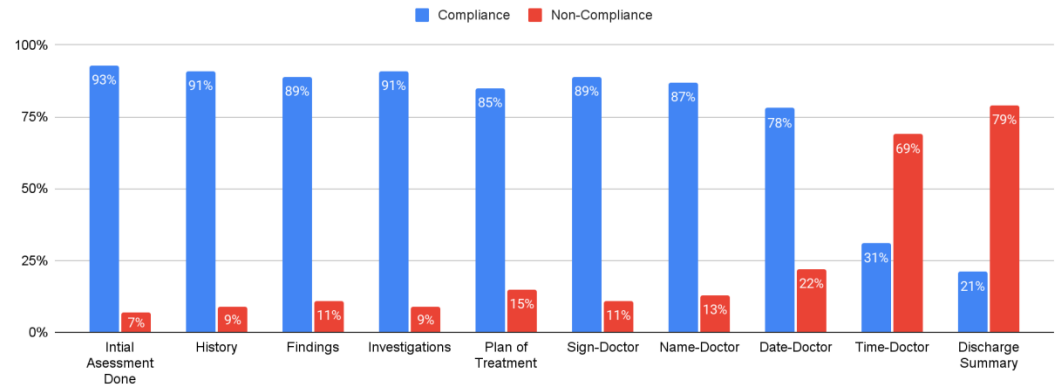

Fig 4.3.2: PERCENTAGE COMPLIANCE ON EMERGENCY ASSESSMENT SHEET

- There is a higher non-compliance rate for the discharge summary mention in the emergency assessment sheet and the doctor's time mention.
- Doctors sometimes failed to include the time in the emergency assessment sheet, which increased the noncompliance rate.

3. INITIAL ASSESSMENT HISTORY & PYSHICAL EXAMINATION

SHEET (n=150);

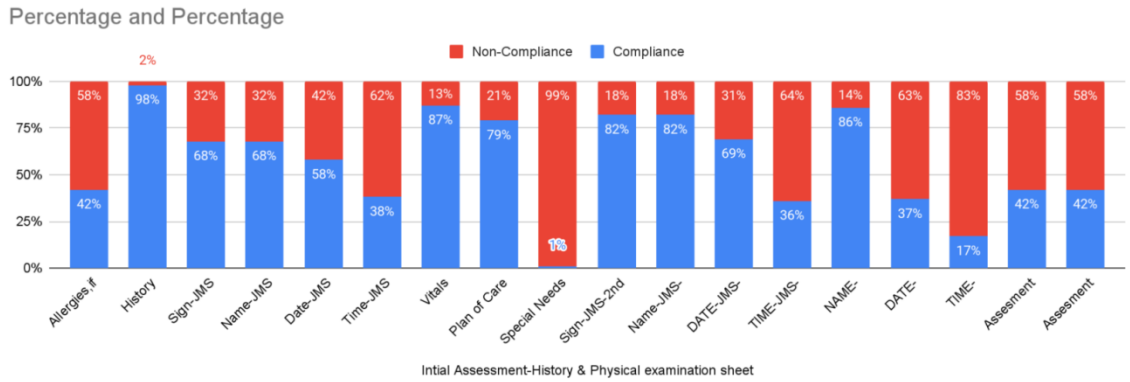

Fig 4.3.3: PERCENTAGE COMPLIANCE ON INITIAL ASSESSMENT HISTORY & PYSHICAL SHEET

4. CONSENT FORMS (n=150):

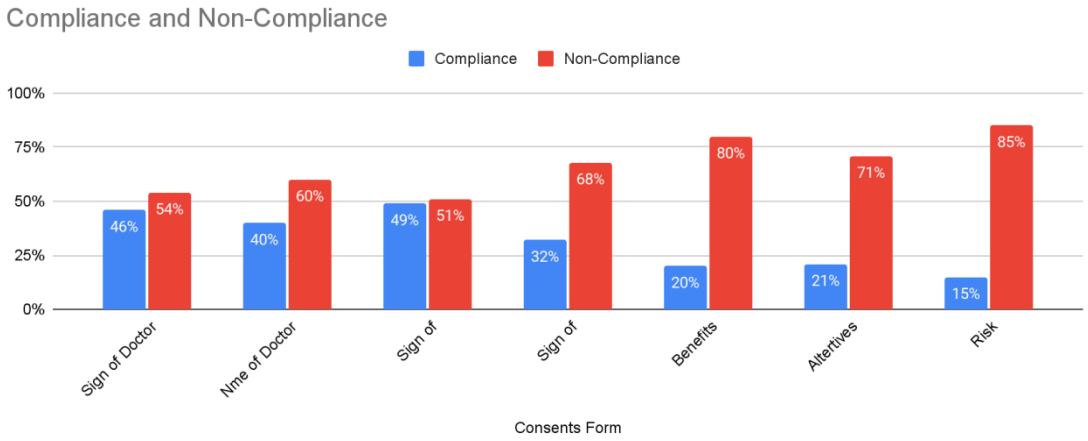

Fig 4.3.4: PERCENTAGE COMPLIANCE ON CONSENT FORMS

5. OPERATIVE NOTES (n=67):

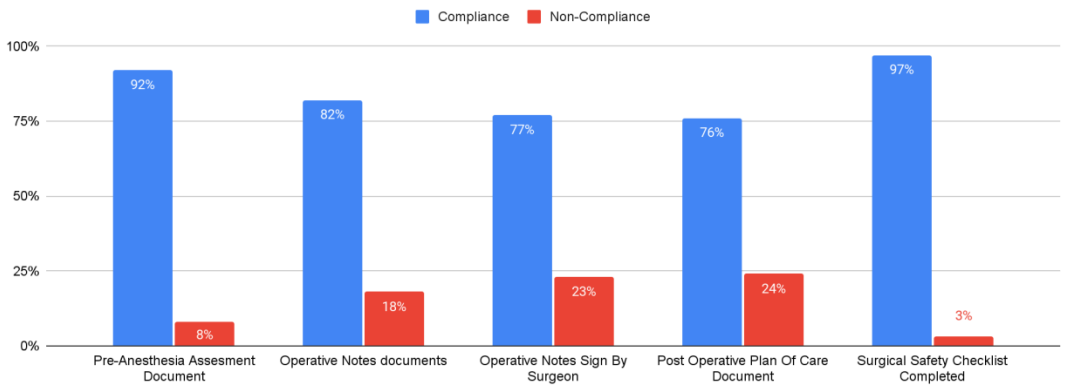

Fig 4.3.5: PERCENTAGE COMPLIANCE ON OPERATIVE NOTES

6. PROGRESS NOTES (n=150):

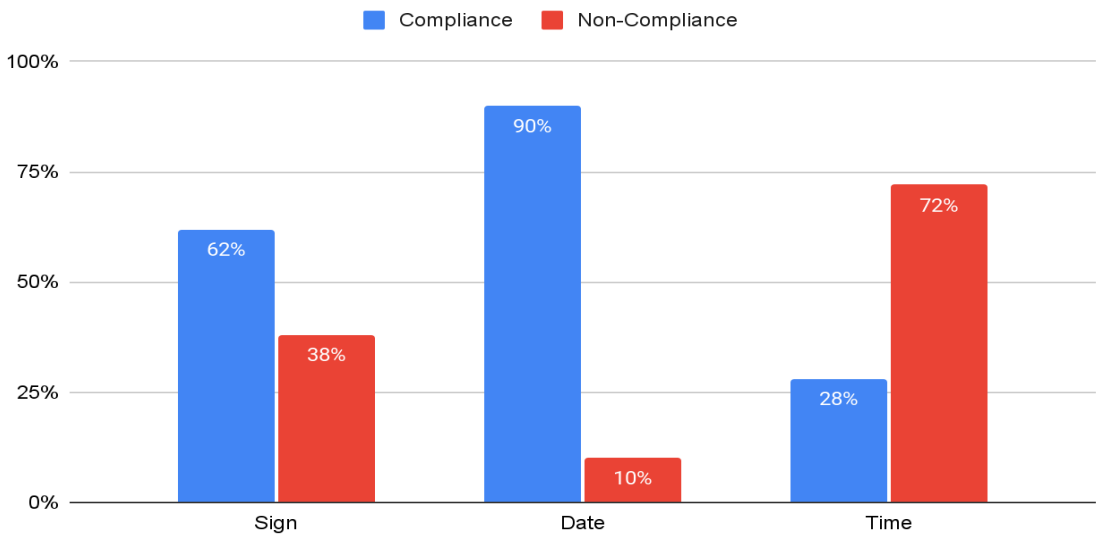

Fig 4.3.6: PERCENTAGE COMPLIANCE ON PROGRESS NOTES

7. DRUG ORDER & MEDICATION ADMINISTRATION SHEET (n=150):

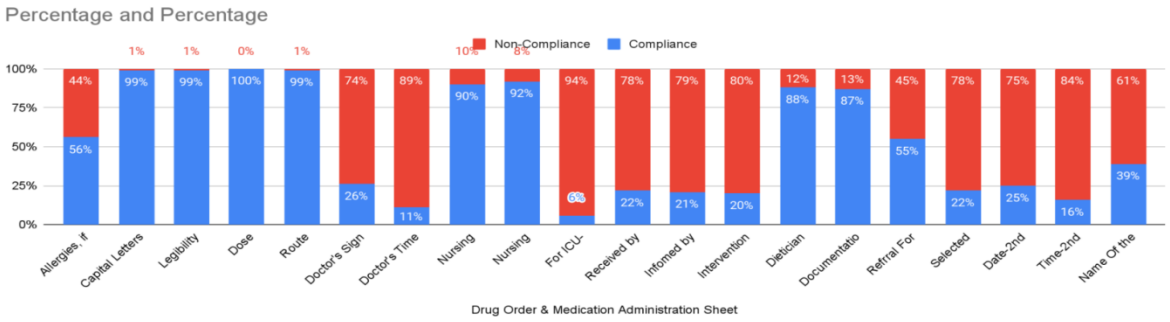

Fig 4.3.7: PERCENTAGE COMPLIANCE ON DRUG ORDER & MEDICATION ADMINISTRATION SHEET

8. REFERRAL NOTES (n=150):

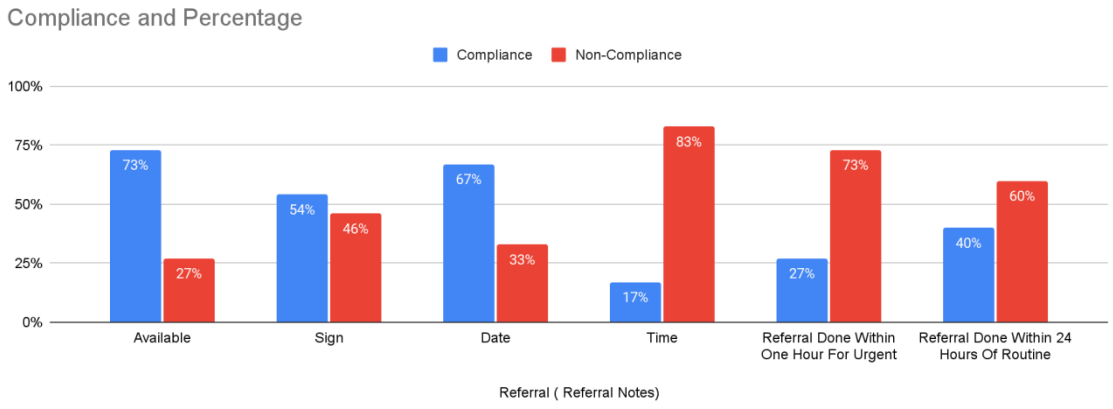

Fig 4.3.8: PERCENTAGE COMPLIANCE ON REFERRAL NOTES

9. DIETETICS (n=150):

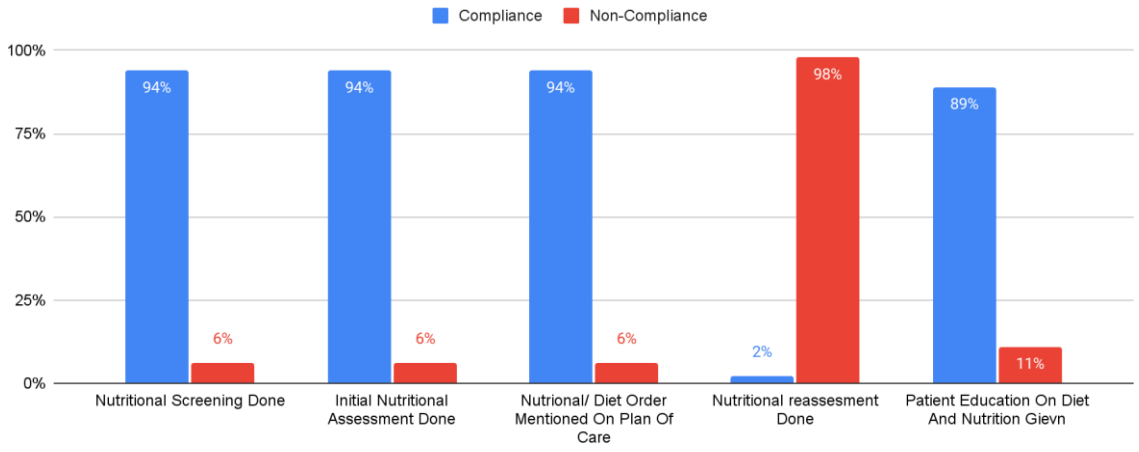

Fig 4.3.9: PERCENTAGE COMPLIANCE ON DIETETICS

10. DISCHARGE SUMMARY (n=20):

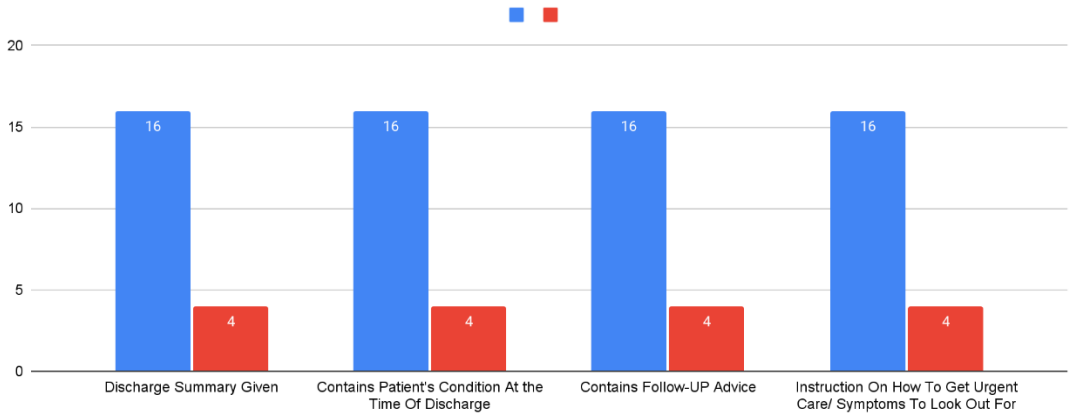

Fig 4.3.10: PERCENTAGE COMPLIANCE ON DISCHARGE SUMMARY

CHAPTER 5

RECOMMENDATION

- It is important to train the jms who are in charge of accurately and scientifically filling up the inpatient records.
- The documentation process should be subject to a medical audit every quarter.
- Rewarding the best performing department/unit and educating
- Jms doctors would remind consultants to sign the following inpatient records and to include the date and time.
- When an electronic patient record, such as a discharge summary, is implemented from the beginning, it will have a higher compliance rate and be able to be applied to other IPD documents, which will help to standardise, make patient information easier to record and exchange, and ultimately increase efficiency and patient safety.

CHAPTER 6: CONCLUSION

A detailed, accurate summary of each patient's individual care or interactions with hospital employees must be included in medical records by law. A very important and critical hospital document is the medical record. These records are necessary for both legal purposes and future hospital medical care arrangements. The systematic and orderly management of all hospital medical records should be preserved with every effort. All staff members must also be made aware of the importance of the medical records. By periodically auditing the medical records, the hospital may fix any record-keeping issues and improve patient care.

ETHICAL CONSIDERATIONS:

The proposed research is in line with the participants original consent for data collection as the required data is published on a public domain. However, any sensitive information with the potential to re-identify participants will be kept secure. Proper acknowledgement and referencing will be given in the research to not infringe upon the copyrights.

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