Review of inpatient medical record documentation in Multi Specality Tertiary Care Hospital.

Introduction

- A medical records enables healthcare professional to plan and evaluate a patient's treatment and ensures continuity of care among multiple providers.
- A study was conducted to do medical audit of documentation of inpatient medical records in multi specialty tertiary care hospital to assess whether the existing documentation procedure is as per laid down policy.

Documentation Required and Studied:

- Admission Request Form
- Emergency Assessment Sheet
- Initial Assessment-History & Physical examination sheet
- Consent Forms
- Operative Notes
- Progress Notes

Documentation Required and Studied:

- Drug Order & Medication Administration Sheet
- Dietetics Assessment sheet
- Referral Notes
- Discharge Summary

OBJECTIVES

- To assess whether the existing documentation procedure is in accordance with the policy established with the hospital
- To identify the lacunae in the same
- To propose possible solution.

METHODOLOGY

Study setting: In Patient Department at Hinduja Hospital,Mumbai

Type of Study: Retrospective, Descriptive Study

Study of Population: IPD Patients at General Ward, Deluxe/Exclusive,Sharing Ward

- **Inclusion Criteria**: All IP Patients transferred from ICU & OT.
- **Exclusion Criteria:** All patients in critical care areas in the hospital
- **Study Tools:** Medical Record Documentation Checklist

Sampling Method: Random Sampling

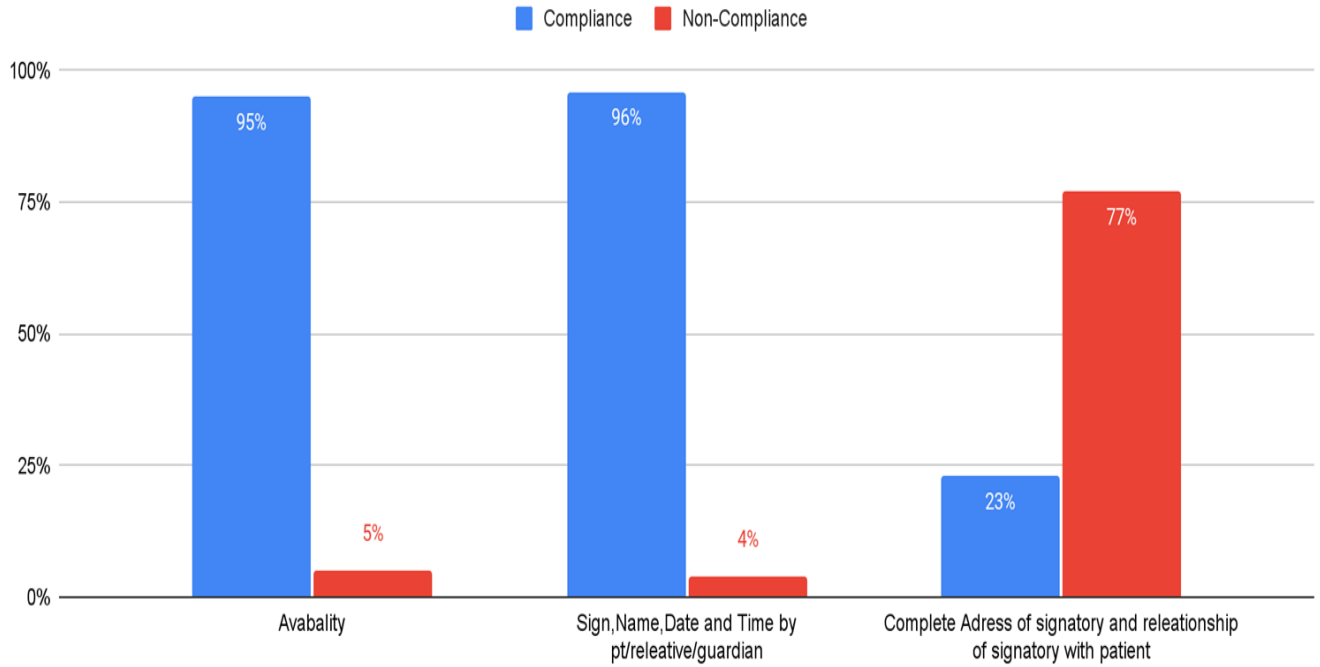
Only IP patients are taken

Sample Size:150 MRD FILES

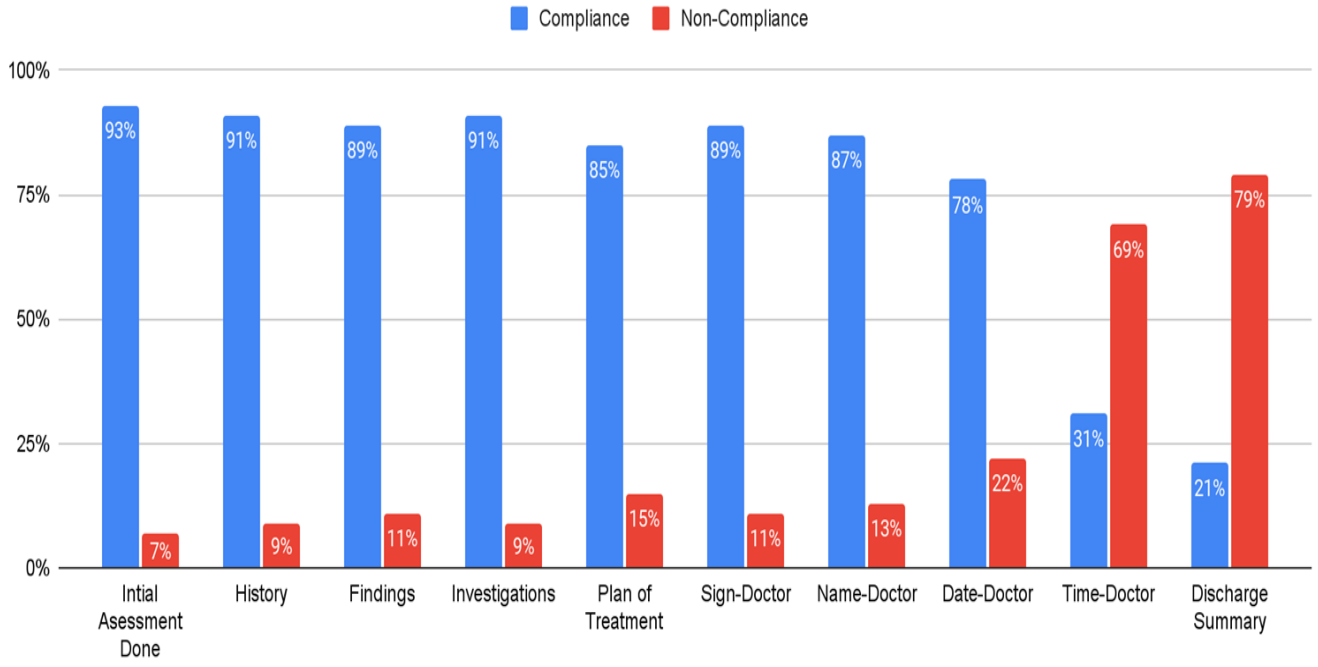
FINDINGS

Admission Request Form

n=150

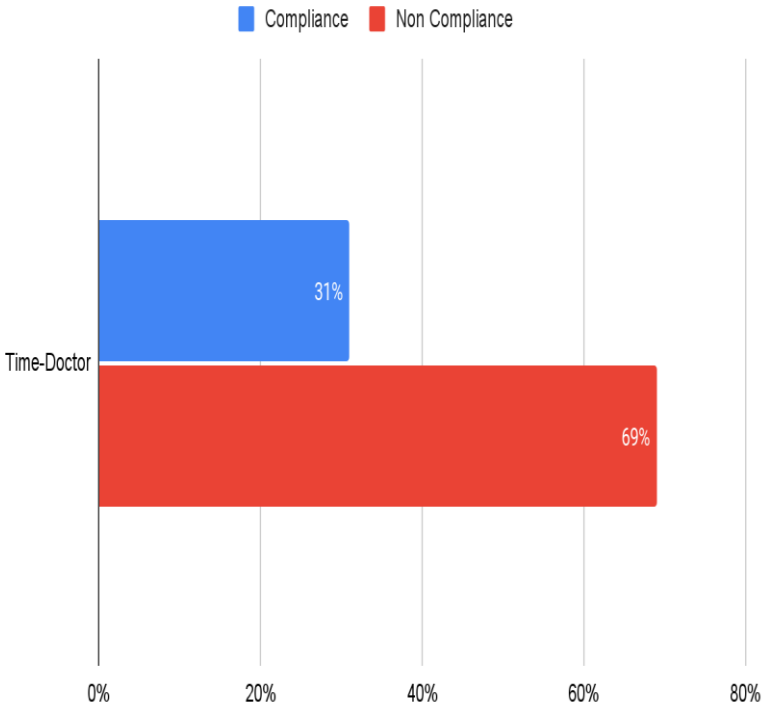


Emergency Assessment Sheet n=47

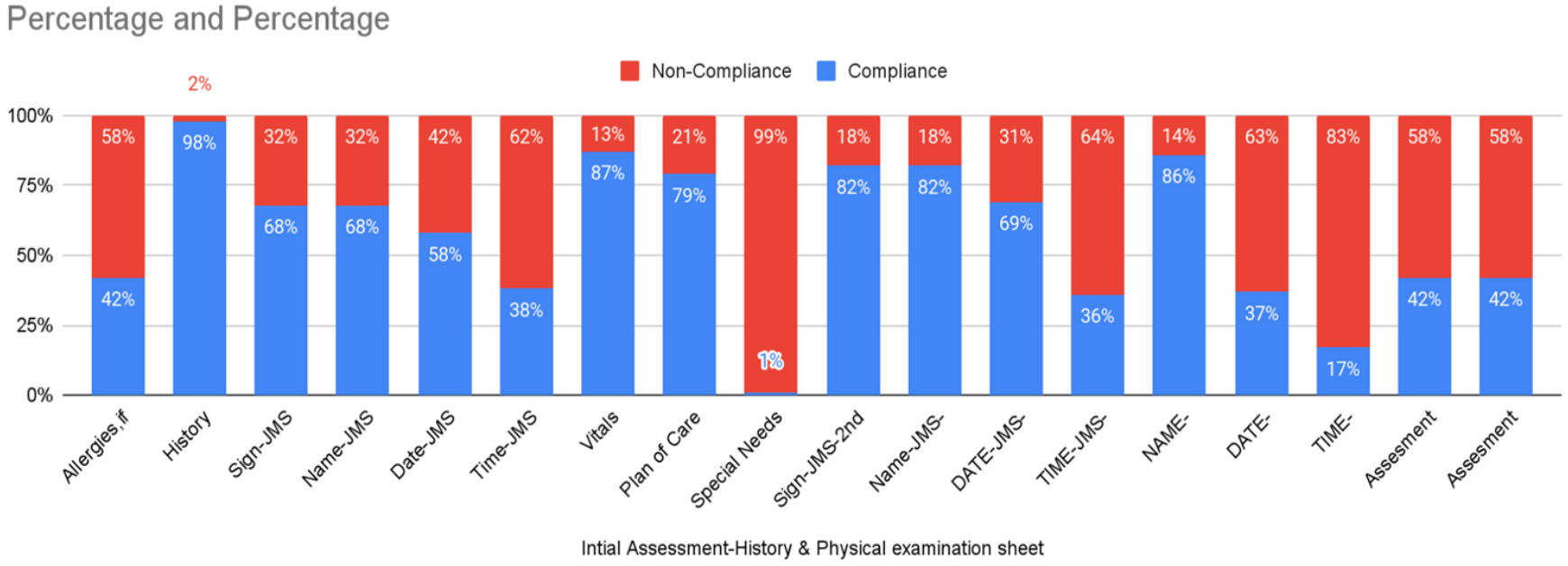


Analysis

- 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.



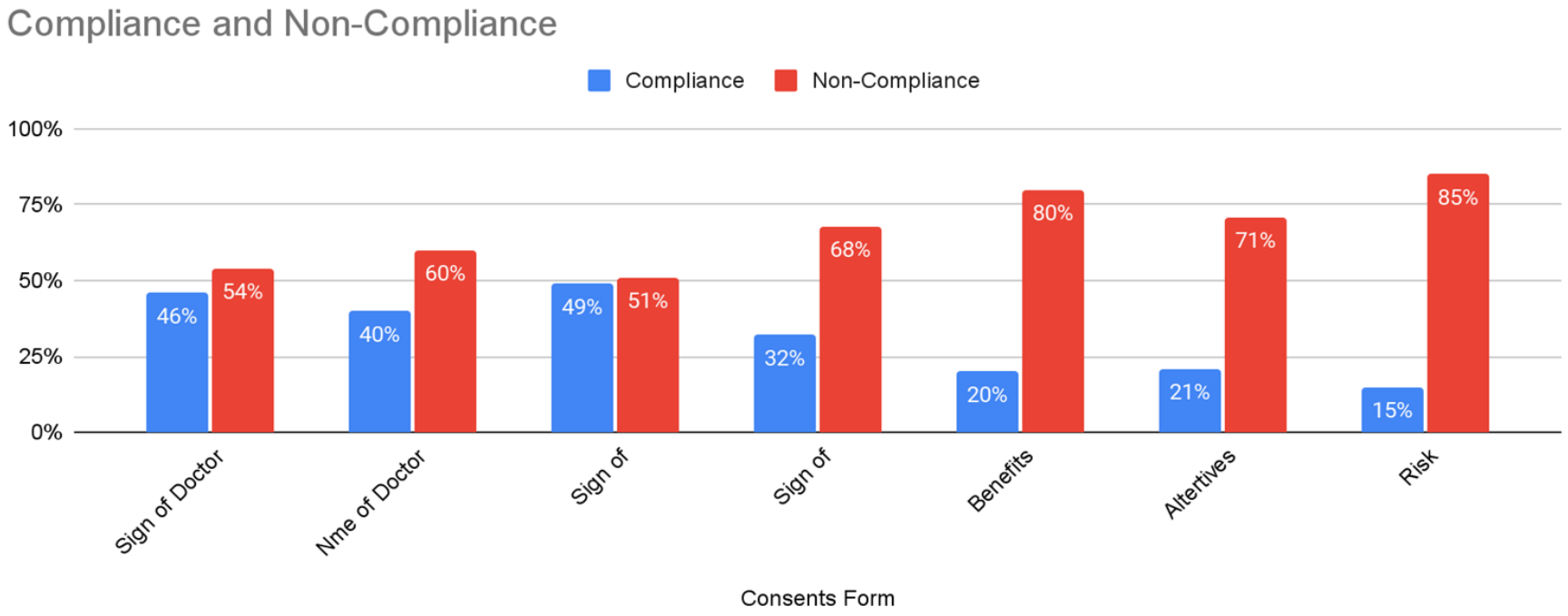
Initial Assessment History & Physical Examination n=150



Analysis

- Allergies,if any - **58%** Non-Compliance
- Time-JMS-**62%** Non-Compliance
- Date -CONSULTANT- **63%** Non-Compliance
- TIME-CONSULTANT-**83**% Non-Compliance
- Assessment done within 24 Hours Consultant-**58%**Non-Compliance

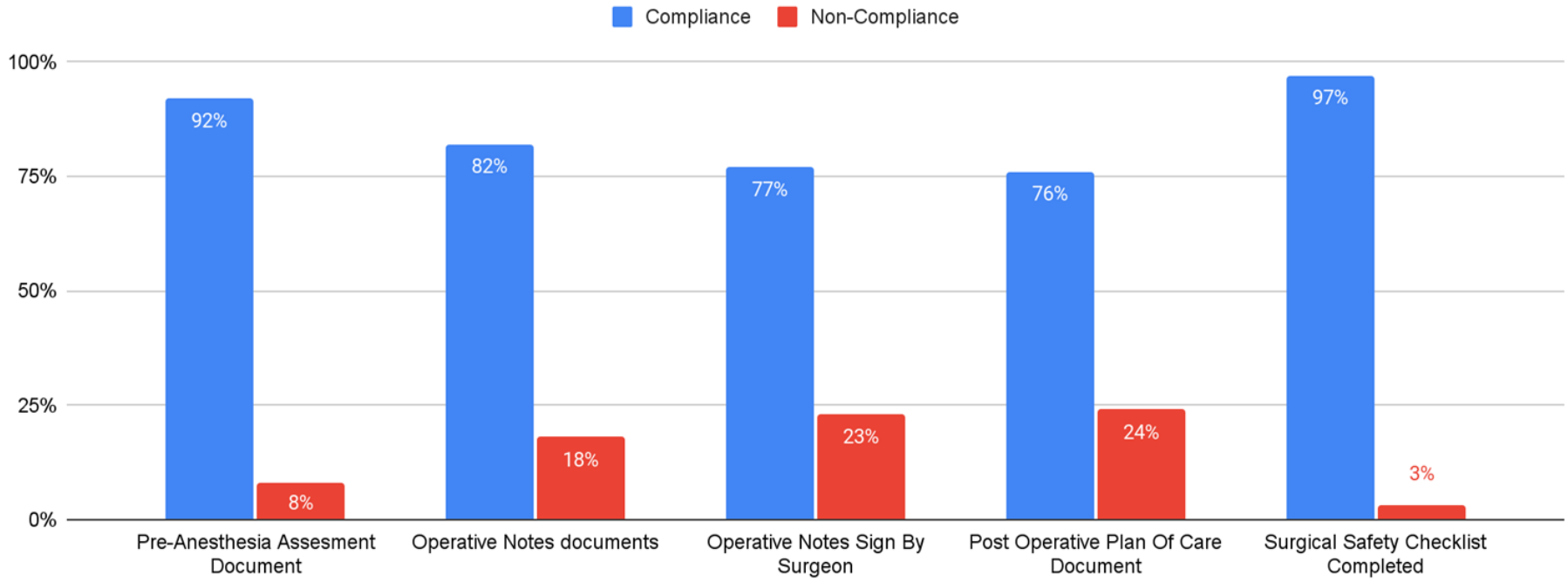
Consent Forms n=150



Analysis

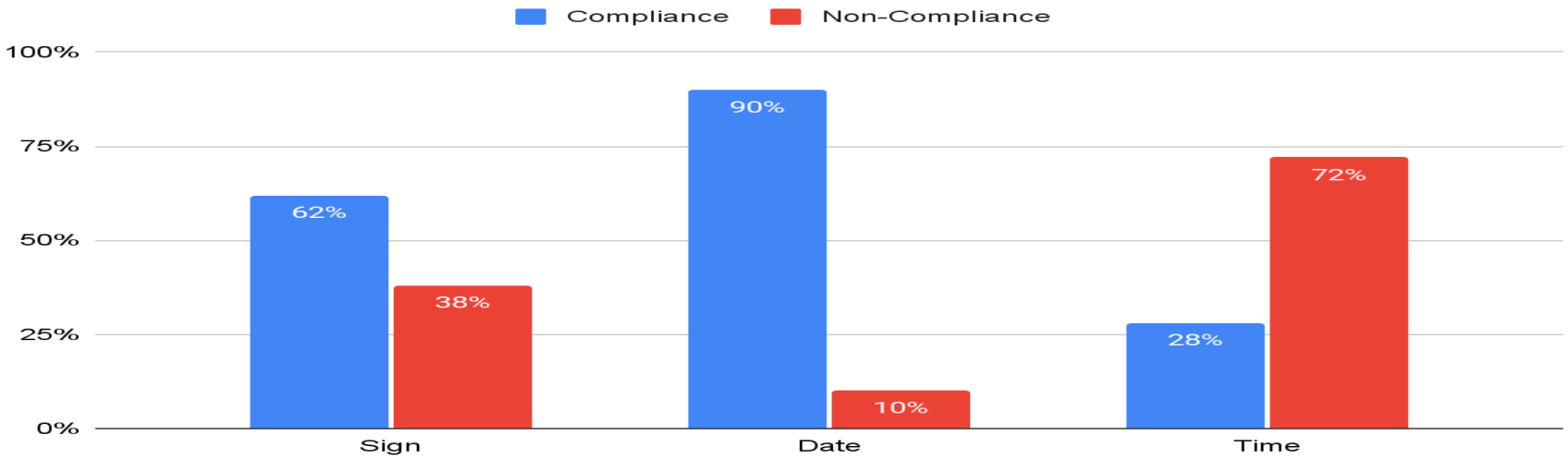
- All parts of consent forms have a non-compliance rate of higher than 50%.
- Doctors did not include the name,date and signature on Consent Forms.
- Benefits explained, Risk explained and Alternatives given was not mentioned
- Singh of witness was also shown to be infrequent.

Operative Notes n=67



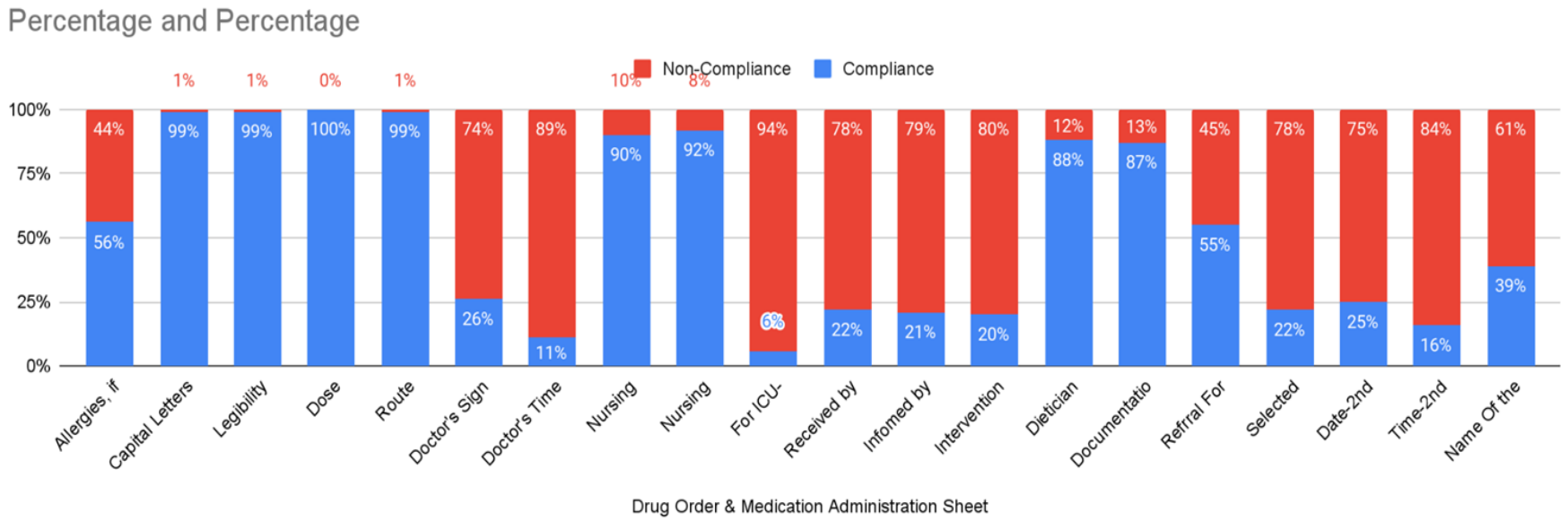
Progress Notes

n=150



- **<u>The timing was not included in the doctors' progress reports.</u>**

Drug Order & Medication Administration Sheet n=150



Analysis

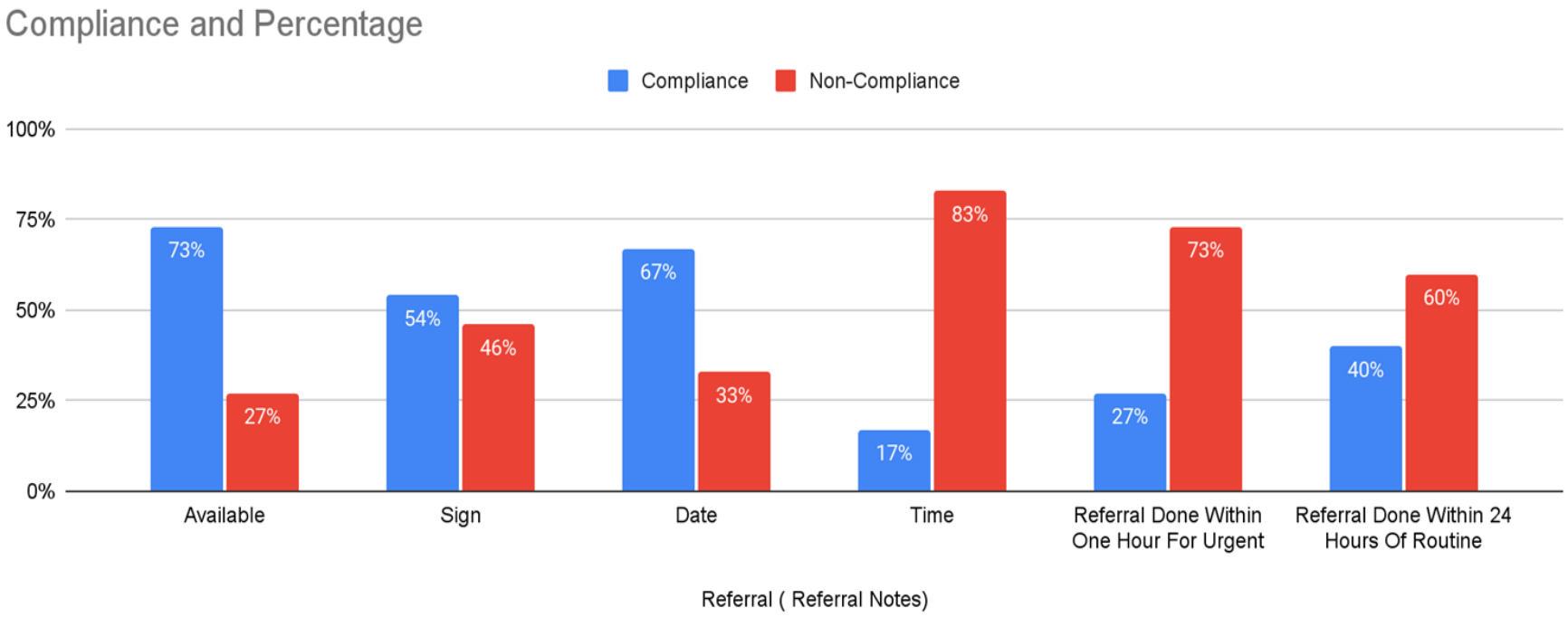
- Doctor's Sign-**74%** Non Compliance
- Doctor's Time- **89%** Non Compliance
- Selected Urgent / Routine-2nd Page- **78%** Non Compliance

Analysis

- Date-2nd Page- **75%** Non Compliance
- Time-2nd Page- **84%** Non Compliance
- Name Of the Doctor Referred to- **61%** Non Compliance

Referral Notes

n=150

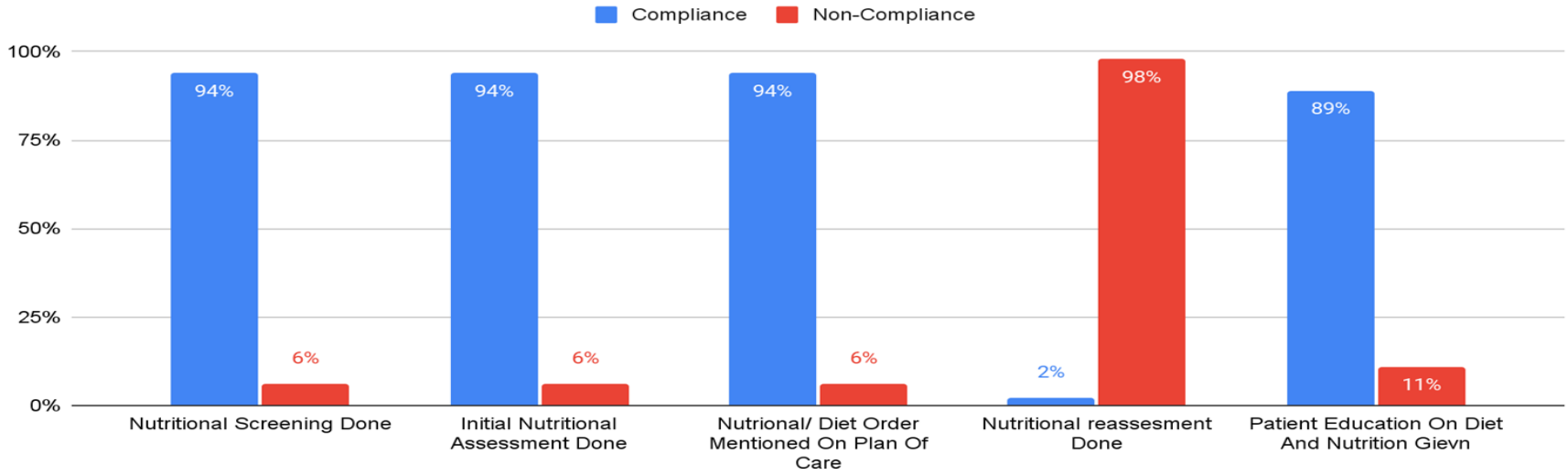


Analysis

- Time was hardly ever included by the doctors in referral notes.
- Doctors seldom ever filled out portions of referral notes such as referral done within 24 hours of routine."

Dietetics

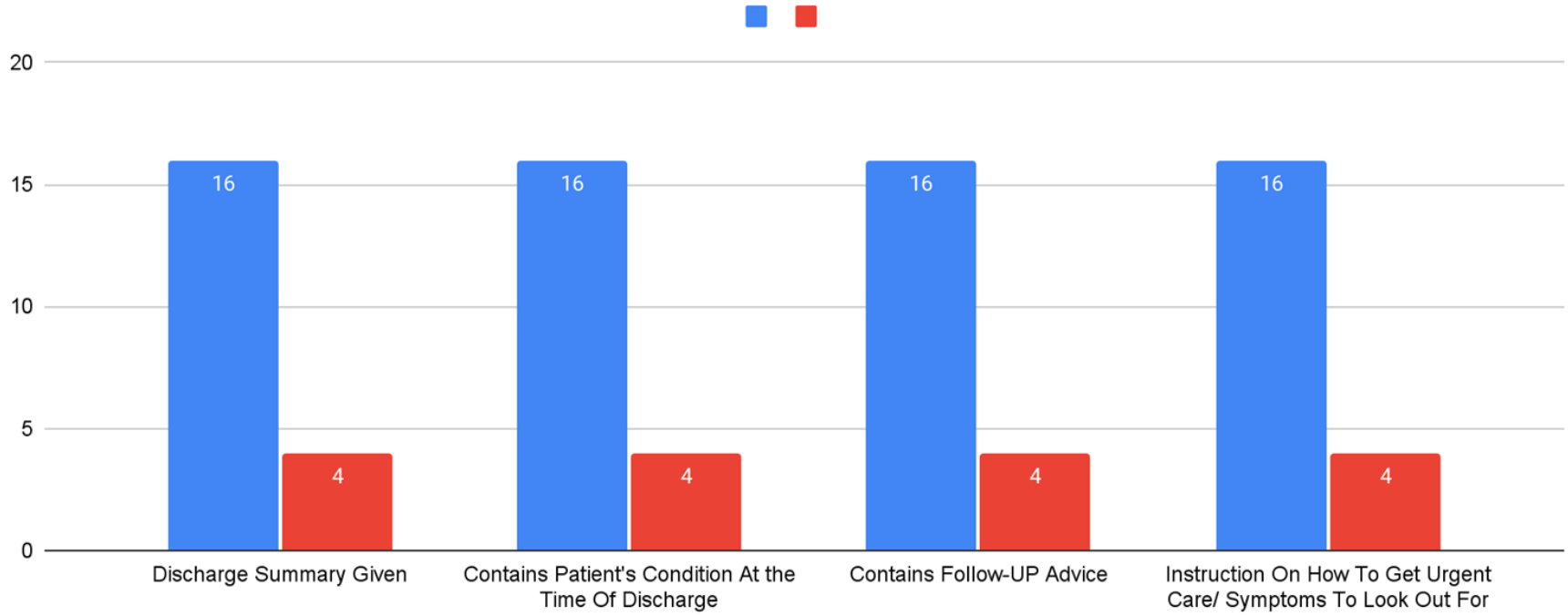
n=150



- **The nutritional reassessment done has a compliance rate of only 2%,**
- **Initial Nutritional Assessment done shows 94%**

Discharge Summary

n=20



Recommendation

- It is important to train the jms who are in charge of accurately and scientifically filling up the inpatient records.
- There should be quarterly medical audit of the documentation procedure.
- 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.