A study on Medical Record Documentation and its gap Analysis

INTRODUCTION

The Hospital initiates and maintains a standardized medical records for every patient assessed or treated and determine the records content format and location of entries. The medical records contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment. The hospital determine the specific data and information in the medical record needs to be present of each patient assessed or treated on an inpatient, outpatient or emergency basis.

RESEARCH QUESTION

What is the compliance rate for documentation of Inpatient medical records as per the Standard Operating guidelines of the Hospital?

OBJECTIVES

- To Assess the compliance in documentation in medical records as per the SOP’s of the Hospital.
- To identify gap against documentation and suggest action plan to address it.

REVIEW OF LITERATURE

- **Management of medical records: facts and figures for surgeons by Bali A, Bali D, Iyer N, Iyer M. 2011** Medical records are the document that explains all detail about the patient's history, clinical findings, diagnostic test results, pre and postoperative care, patient's progress and medication. If written correctly, notes will support the doctor about the correctness of treatment. In spite of knowing the importance of proper record keeping in India, it is still in the initial stages. Medical records are the one of the most important aspect on which practically almost every medico-legal battle is won or lost. This article discusses the various aspect of record maintenance.

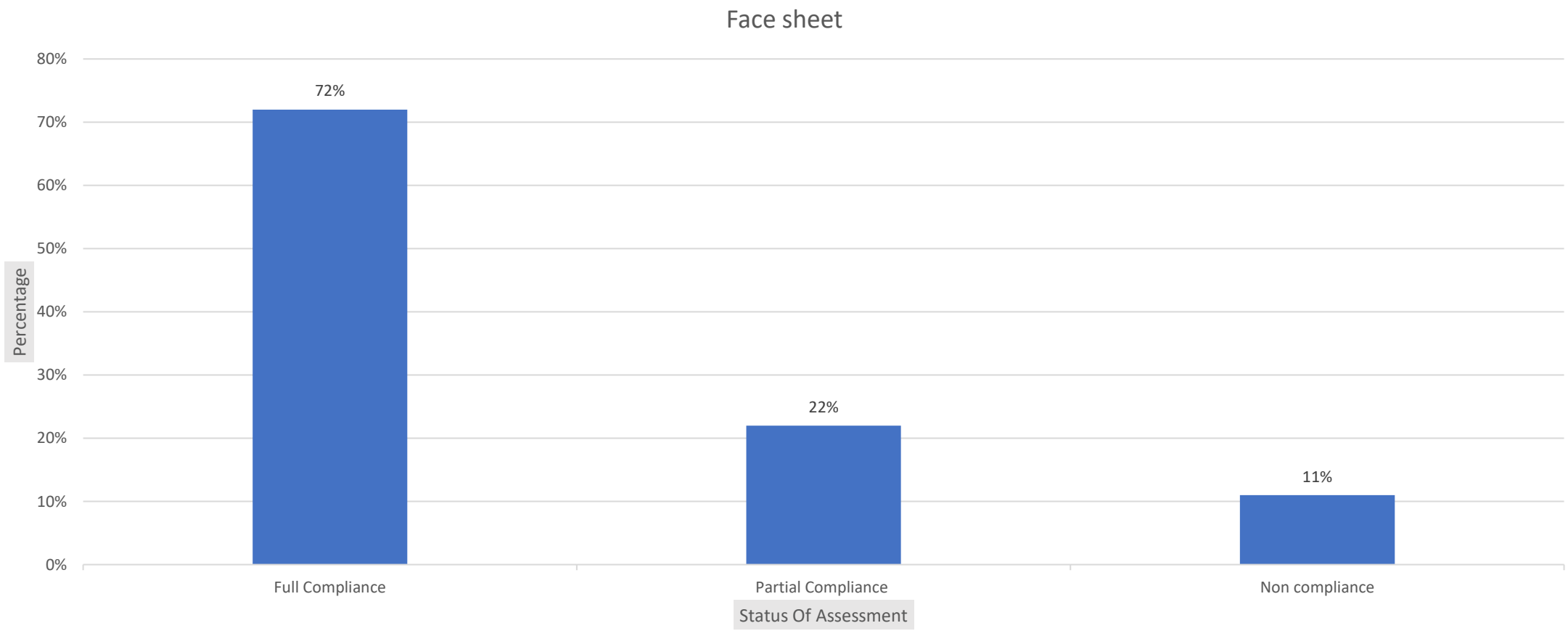
- **Defining and Improving Data Quality in Medical Registries: A Literature Review, Case Study, and Generic Framework by Danielle G. T. Arts, MSc, Nicolette F. de Keizer, PhD, Gert-Jan Schiffer, MD, PhD 2002**Registered values were found to be inaccurate if (1) a categorical value was not equal to the gold standard value or (2) a numerical value deviated from the gold standard value more than acceptable (e.g., a deviation in systolic blood pressure of > 10 mmHg below or above the gold standard systolic blood pressure). By means of a structured interview with the physicians responsible for the data collection process, we gained insight into the local organization of the data collection. This information and discussion of discovered data errors helped us to identify the causes of insufficient data quality. The causes of insufficient data quality that we found through the literature review and the case-study were grouped according to their place in the data collection process

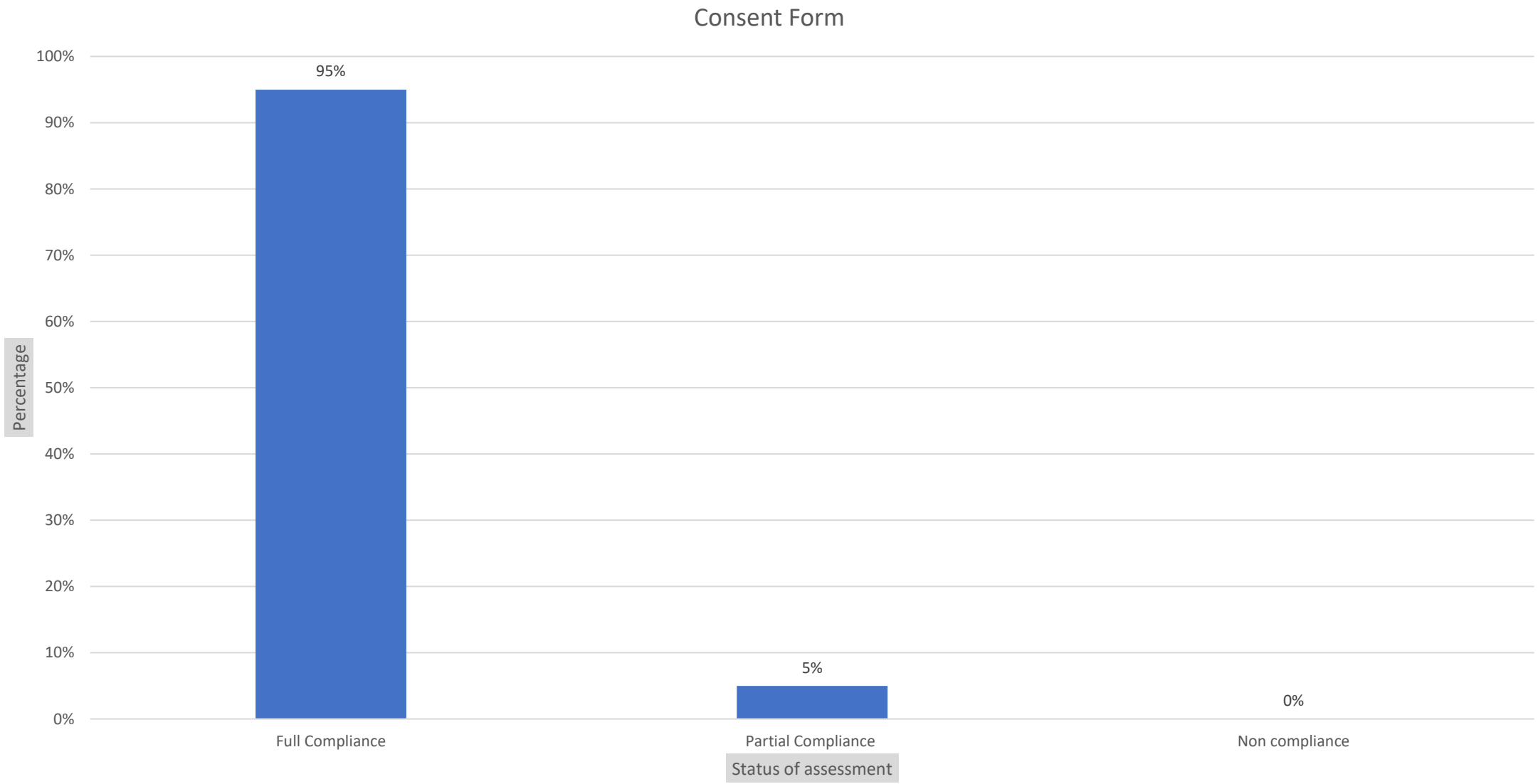
METHODOLOGY

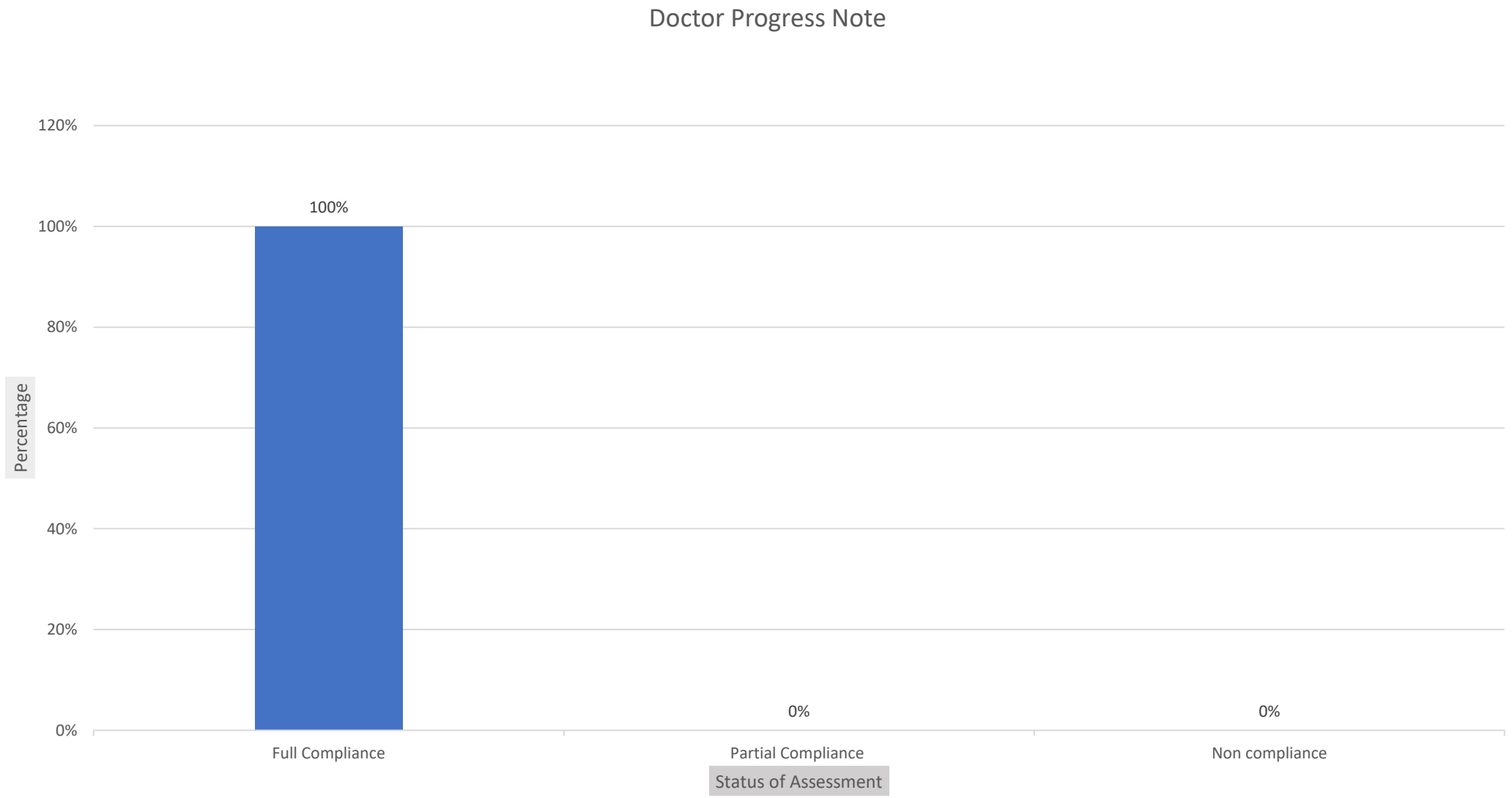
- **Study setting**: Park Hospital Karnal
- **Study Design**: Observational and Cross-sectional Study
- **Study duration**: 1month
- **Sample Size**: 180 total medically managed patient file.
- **Data collection Technique**: Primary data collected by checking files at the nursing stations of different wards (Active file) and by checking file of discharged patient in MRD (Passive file).
- **Method of Data Collection**: Standardized Audit tool for both Active and Passive file were provided by the hospital. (Inpatient Checklist)
- **Variable and their meaning**: Audit of IPD files was conducted with the help of a checklist. Data were collected and marked in the completeness checklist as C (Compliance), PC (Partial Compliance), NC (Non-Compliance) or NA (Not Applicable).

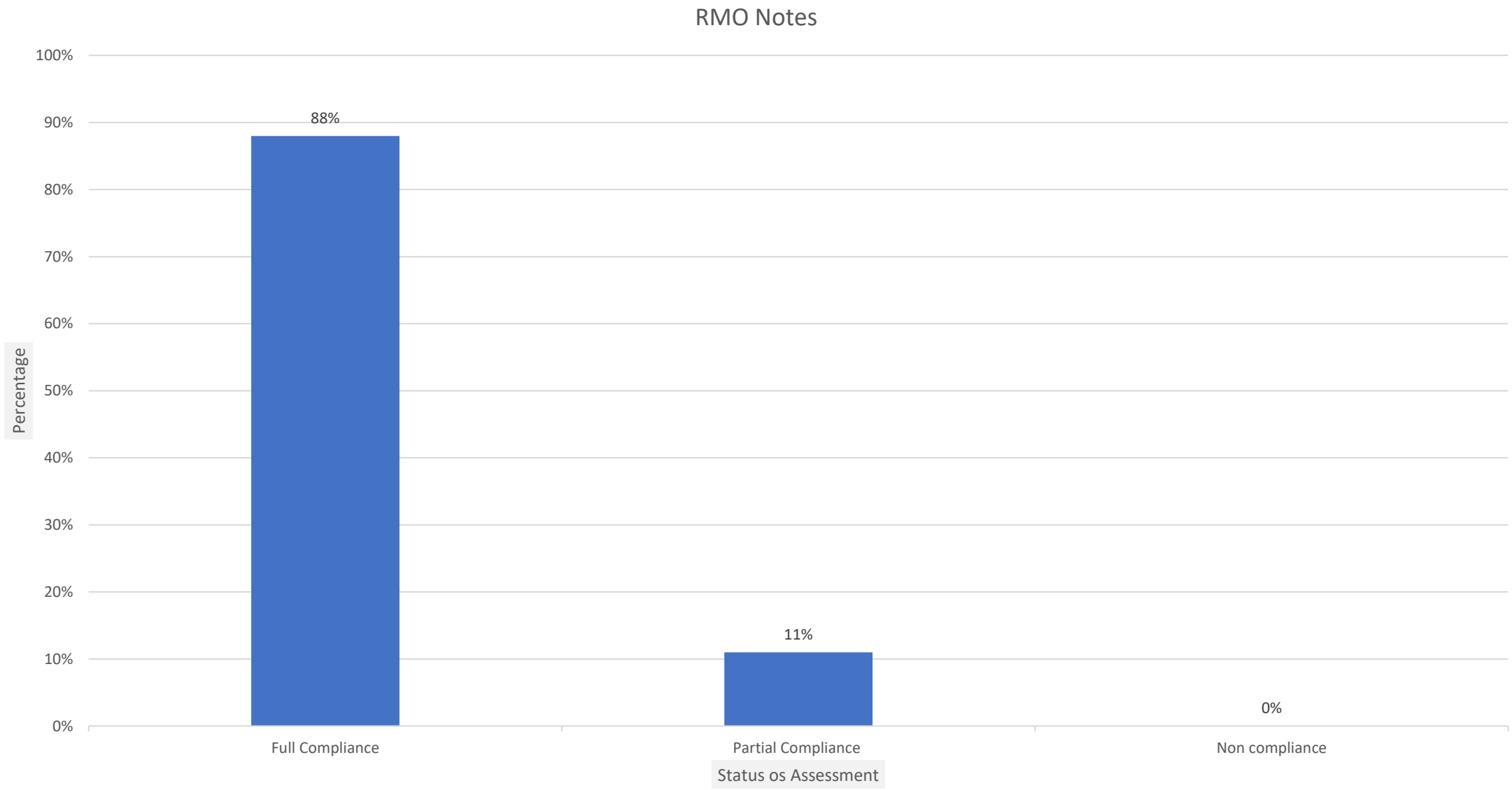
Parameters	To be found in	Description
Face-sheet	Active & Passive file	Mainly focuses on the date and time of admission and discharge, signature of front office executive etc.
Consent Form	Active and Passive file both	Mainly focus on the risk related to patient, procedure related to surgery described to the patient or not, signature of patient attendant on consent forms etc.
Doctor Progress Note	Active and Passive both File	Patient related progress note on daily basis provided on CPRS by the main Consultant.
RMO Progress Note	Active and Passive File	If patient is admitted in the hospital Resident Medical officer progress note have to be found in CPRS
Plan of Care	Active and Passive File	This area focuses on the progress note made by the doctors every day
Transfer/ Handover form	Active and Passive-file	When a patient is transferred from one ward to another for procedure or further management, a transfer information form is to be filled

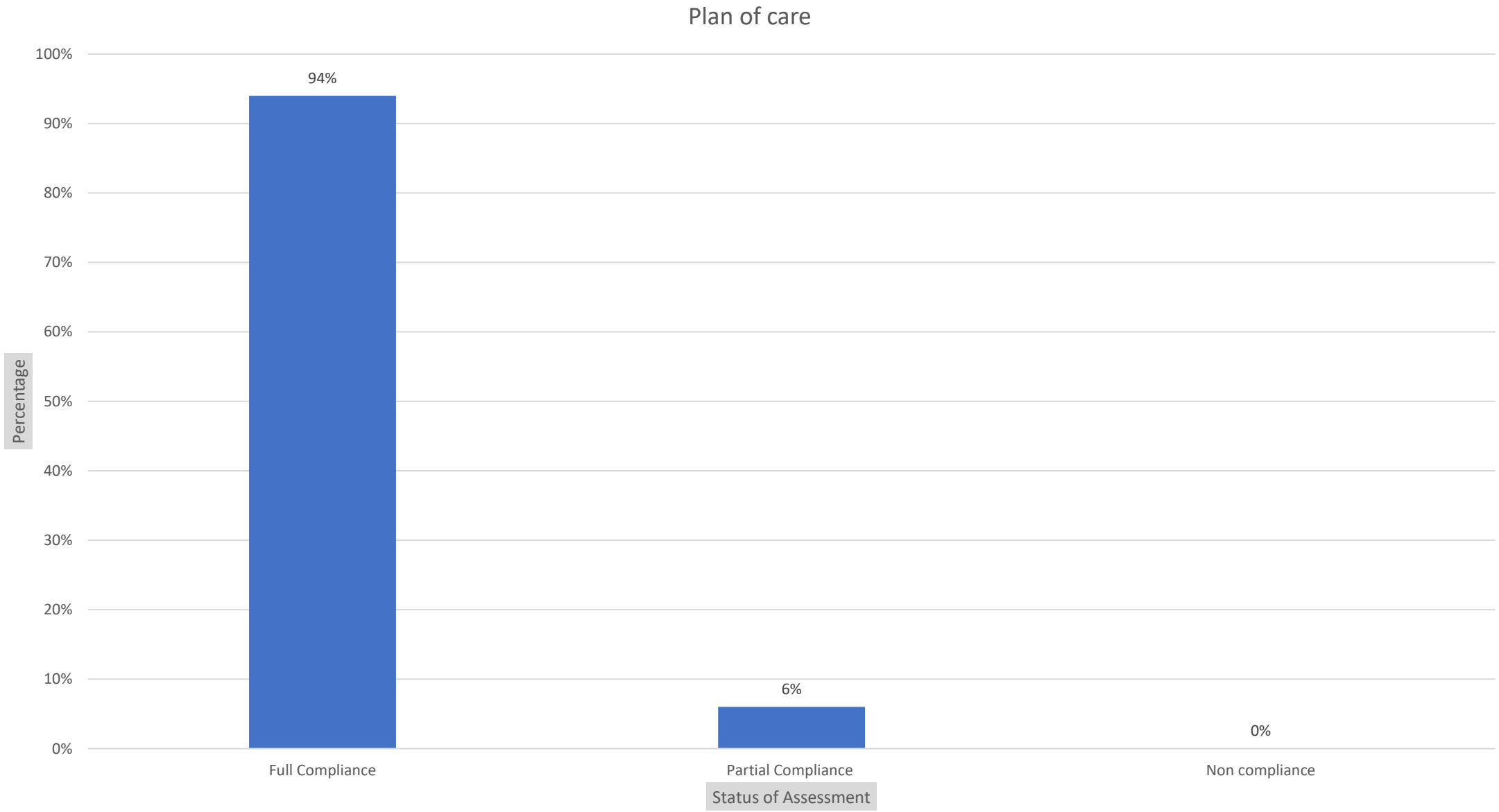
Result

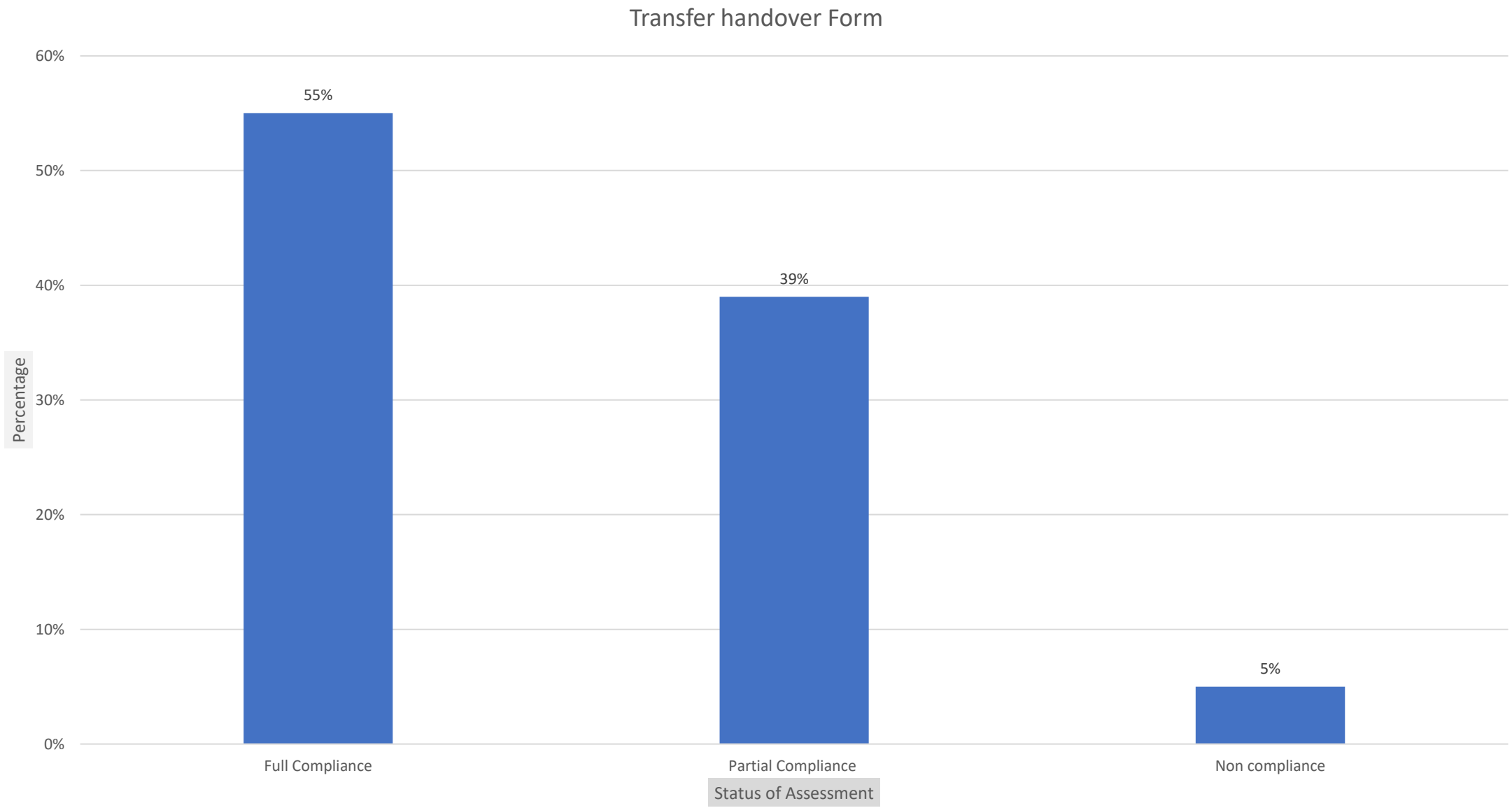

Face sheet
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percentage
72%
22%
11%
Full Compliance
Partial Compliance
Non compliance
Status Of Assessment


Consent Form
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percentage
95%
5%
0%
Full Compliance
Partial Compliance
Non compliance
Status of assessment


Doctor Progress Note
120%
100%
80%
60%
40%
20%
0%
Percentage
100%
0%
0%
Full Compliance
Partial Compliance
Non compliance
Status of Assessment


RMO Notes
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percentage
88%
11%
0%
Full Compliance
Partial Compliance
Non compliance
Status os Assessment


Plan of care
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percentage
94%
6%
0%
Full Compliance
Partial Compliance
Non compliance
Status of Assessment


Transfer handover Form
60%
50%
40%
30%
20%
10%
0%
Percentage
55%
39%
5%
Full Compliance
Partial Compliance
Non compliance
Status of Assessment

Discussion

Lowest level of compliance is found in:

- Transfer Handover Note
- Face sheet

In order to increase the compliance percentage:

- In order to increase the Compliance Percentage During the meeting all the Parameters Legging Behind is discussed.
- Front office Executive were asked to pay attention on filling of the Face sheet
- Resident were asked to pay attention towards filling of transfer handover note and patient family communication records
- Resident were asked to mention the date, time an ID no. along with there signature below every note made on the CPRS

Suggestion

- The Hospital need to Focus Training for Doctors at the time of Joining the Hospital Which Include all forms and formats used for Documentation of the records.
- There Should be regular training and audit should be done conducted by the medical administration department for the compliance as per the NABH guidelines.
- Floor manager Should check the files in the daily rounds.
- The file should also be checked again by ward in charge before sending it to the MRD. Audit checklist for the ward in charge should be revised.
- Incomplete files to be tagged with colored stickers and comments written on that to complete patient file documentation.
- Using of ‘NA’ if some part of the documentation is not applicable for a particular patient, it should be documented as Not Applicable or NA. Leaving the space blank, implies that the part has been overlooked or has not been documented.

CONCLUSION

Maintaining a complete medical record is not only important to comply with accreditation and licensing requirement, but also as a proof to establish that the adequate care that a patient received in the organisation.

Medical record department has become an essential and important department of each and every hospital. Documents develop by the hospital are widely used to, achieve regulatory and standardization in the recording and presentation of the information.

This report highlights the area of medical records of Hospital that need more concern and attention. Overall study shows that the documentation standards in the hospital is satisfactory.

To keep the standard and to improve them, the gap or the findings stated should be managed.

Reference

- Prema Singh, Sakshi Joshi, Analysis of health record documentation as per the national standard accreditation with special emphasis on tertiary care hospital;2017
- Robin Mann, John Williams, Standard in medical record keeping; 2003
- Medical Records Organization and Management -- GD Mogli
- Park hospital MRD Manual
- Principal of Hospital Administration and Planning (2nd edition) – BM Sakharkar