Study on Medical Records Documentation and its Gap Analysis

By

Kushal Pal

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2018-2020

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Certificate of Scholar

This is certify that the dissertation titled ‘A Study on Medical Records Documentation and its Gap Analysis’ submitted by Kushal Pal enrolment no. IIHMR-U/01/2018-20/0764 under the supervision of Dr.Neetu Purohit for award of MBA in Hospital and Health of the University carried out during the period from 25 March 2020 to 15 June 2020 embodies my original work has not formed the basis for the award of any degree, diploma associate ship, fellowship, title in this or any other institute or other similar intuition of higher learning.

Signature

Acknowledgement

At the outset, I would like to articulate this project as small journey which was a remarkable learning experience for me. The successful completion of this project is only because of the extraordinary support, guidance, counselling and motivation from my respectable staff, of IIHMR University and my organization Park Group of Hospital, Karnal.

This journey could not be completed without support of my family and friends. I express my deep gratitude to Dr. Neetu Purohit (Professor) mentor for this project. Through the support provided by him, I have imparted knowledge on the avenues which this project has opened and explored. His directions in making me think about unique conceptual and practical aspects of Health & Safety which has lifted this project at this stage of successful completion.

I extend my gratitude to my Manager and all my colleagues, friends for their encouragement, support, guidance and assistance for undergoing industrial training and for preparing the project report.

ABBREVIATIONS USED

1. MRD – Medical Record Department
2. ICD – International Classification of Disease
3. ICPM – International Classification of Procedure in Medicine
4. IP – In-Patient
5. OP – Out-Patient
6. MLC – Medical Legal Case
7. LAMA – Leave Against Medical Advice
8. EMR – Electronic Medical Record
9. CPRS – Computerized Patient Record System
10. RMO – Resident Medical Officer
11. PCC – Patient Care Coordinator
12. HIS – Hospital Information System

About the Organization

Park group of Hospital is India's fastest growing super speciality hospital chain and currently operating in Delhi NCR and Haryana with over 1500 beds. Park hospital group is committed to providing comprehensive personalized healthcare of the highest quality at low-cost to people of all age. Park hospital is the best affordable hospital in northern India accredited by NABH.

Inspired by the noble vision of delivering personalized healthcare of the highest quality at affordable rates, Hospital Park Group is a 35-year-old healthcare provider established by Dr. Ajit Gupta. The first hospital was established in Malviya Nager South Delhi in 1982 Under Dr. Ajit Gupta's expert guidance and with his rich experience, our group has evolved into one of the fastest growing super chain.

Park Hospital, Karnal is one of the pioneer corporate Hospital in Karnal devoted to restorative, careful and rehabilitative consideration of the patients Commissioned in April 2017. The clinic operational with 50 bad relations with is occupied with giving the therapeutic administrations, at Karnal Haryana. Park Group of Hospitals are NABH (National Accreditation Board of Hospital and Healthcare Providers) certified Hospitals.

NABH is a constituent Board of quality Council of India, establish to set up benchmark of progress for Healthcare industry of India. NABH carries out activities like accreditation of healthcare facilitates quality promotions IEC activities, education and training of quality and patient safety and endorsement of various healthcare quality course/workshops.

Park Group of Hospital is one of the oldest empanelled hospital with the central government (CGHS), State Governments (DGHS, DGS, ESI), Semi Government, ECHS in Delhi NCR and Haryana. We also tied up with all major TPA (Third Party Administrations) for claims and cashless health insurance.

Brand Commitment

Vision

Our hospital is committed to deliver high quality personalized care to people of all ages and in every stage of life.

Mission

To be leading healthcare provider, providing comprehensive quality healthcare at affordable cost.

Our Specialty

- Cardiac Surgery
- Interventional Cardiology
- Neurology, Spine and Neurosurgery
- Orthopaedic and Joint Replacement
- Cancer Care Center
- Obstetrics and Gynaecology
- Critical Care
- General and Laparoscopic Surgery
- Renal Science, Urology and Kidney Transplant

A Study on Medical records Documentation and its Gap Analysis

1. INTRODUCTION

Medical Records are an essential component in modern health management. It is the only reliable proof of treatment given to a patient and is the basic indicator in accessing health status of the community. The safer existence of the institution is depending on this. Health information of different nature at various levels could be generated from medical records. Accurate and reliable information is needed for comparison of health status of community and basic data for planning health care activities and health budgeting could be obtain from Medical records. All these factors and the present-day challenge imposed by 'Right to information act 2005, Consumer protection act 1986', Medical council of India regulations, etc. emphasis the strengthening of medical records maintenance system so as to beneficiate all walks of people in the community. Central Bureau of health intelligences- the nodal agencies for health information in the country also insist the strengthening of medical records system and implementing ICD-10 and ICPM of WHO in classification and coding of morbidity and mortality cases. In the NABH schedule, has a completely separate audit parameter for the MRD.

The Quick list for NABH audit for medical records contains the following which are checked thoroughly during the audit:

1. Security and Confidentiality
2. Destruction of case records
3. Medical Record Audit
4. Transfer Notes
5. Birth and death reports
6. Retention Policy
7. System for Access to records
8. Case records sampling
9. Statutory Documents
10. Fire safety

Audit to assure the compliance of Inpatient file may be a time-consuming process but the advantages far outweigh the disadvantage. A chart analysis is used in the simplest term of inpatient file audit to determine what is being done properly and what needs to be changed based on the comprehensive assessments that can be conducted by staff within an organization. Audits carried out by n third parties are generally to be reviewed.

Documentation is a medium of communication where information is processed. Quality documentation encourages formal, reliable and efficient communication among caregivers and enables patient care quality and autonomy and health. The medical records are documents that tell the story of patients and physicians every time they meet with hospital personnel involved in their care. In addition to telling patient story, all legal regulatory and auditing that facilitates continuity and individuality of care will meet complete accurate medical record. Quality of the documentation, accuracy, need for development can be monitored through audit instruments. Audit is the process of collecting and evaluating patient information from patient reports and other documents.

Clinical record-keeping is an important component of good medical practice and quality healthcare delivery. Regardless of the form of records, maintaining good clinical records should allow for continuity of care and should enhance communication between various healthcare professionals. Consequently, clinical records should be updated by all multidisciplinary members, where appropriate. Clinical reports are also important tools for auditing the quality of healthcare facilities provided and can also be used to investigate medical accidents, concerns of patients and cases of reimbursement.

Continuity in clinical reports is vitally important for patient care when many different healthcare practitioners are involved in the diagnosis of a single patient in the modern medical setting

Ensuring that clinical notes are up-to - date and accurately completed with sufficient information will ensure that all relevant health-care workers are provided with the correct information and will assist them in possible future decisions. It, in effect, would help the patient with less reporting time wasted and by avoiding false diagnosis or prescriptions of ineffective therapies.

The aim of full and reliable documentation on patient records is to promote quality and continuity of care. It creates a means of communication about healthcare status, preventive health services, treatment, planning and care delivery between providers and patient / patient relatives.

A medical record file should consist the following items-

Manual Records

- Face-Sheet
- Admission Request Form
- Discharge Summary
- Death Summary
- LAMA and Discharge on Request Form
- Zero Line ECG
- Informed consent/High risk consent form
- Anaesthesia Records
- Pre-operative Check list (Nursing)
- Surgical Safety Checklist
- Physician Order Sheet
- Blood Sugar Report
- Intake-Output Chart
- Critical Care Flow Sheet
- Investigation (Order)/Reports
- Code Blue—Crisis Notes Template
- Pending Report Status
- Nutrition care Status
- Family Meeting Records

EHR (Electronic Health Record)

- Emergency Assessment Sheet
- Discharge summary
- MLC/Death/LAMA Summary
- IP Assessment/Plan of care
- Neonatal assessment sheet
- Doctors Process note
- Transfer Order
- Operation/ Procedure Notes
- Post-Operative order
- Doctor Note on Blood Transfusion
- Nurses Admission Assessment
- Nursing Progress Note
- Clinical Chart
- Vitals Signature
- Dietetics Assessment Notes and Daily Dietetics Notes
- Rehabilitation Therapy
- Psychologist Activity Sheet
- Monitoring of patient undergoing Blood/Component Transfusion

Authority to make entry in medical records

The following Medical and Health care professional are authorized to make entries in the medical records:

- Clinician in charge- Counter sign, doctor's progress note, OT notes, Procedure note, critical care progress note
- Emergency room doctor- Emergency initial assessment, Emergency progress notes, procedure notes
- Junior consultant- Doctors progress note, OT notes, Critical care progress note, procedure note
- Resident-initial medical assessment, doctor progress note, Blood transfusion note, transfer notes
- Other consultants who are taking care of the patient- counter sign., doctor progress note OT notes Critical care progress notes, Procedure notes
- Diagnostics (including pathology, radiology, cardiology)
- Any technician (dialysis) who is providing care- dialysis notes, Endoscopy notes.
- Nurse in charge
- Nursing staff taking care of patient- initial nursing assessment, nursing progress note, nursing care plan, vitals monitoring, medication administration, intake output chart etc.

Other support staff but not limited to:

- Nutritionist- Nutritional Assessment, Dietetic Notes.
- Physiotherapist- Physiotherapy notes.

2. 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 gained insight into the local organization of the data collection. This information and discussion of discovered data errors helped to identify the causes of insufficient data quality. The causes of insufficient data quality that found through the literature review and the case-study were grouped according to their place in the data collection process

Sixty-six percent assessed information precision, 57% information culmination, and 23% information likeness. The assorted variety in information component, ponder setting, populace, wellbeing condition, and EHR framework considered inside this collection of writing made reaching explicit inference with respect to EHR information quality testing. (Electronic Health Records and the Reliability and Validity of Quality Measures, (Jinnet B. Fowles).

3. RESEARCH QUESTION

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

4. OBJECTIVES

1. To Assess the compliance in documentation in medical records as per the SOP's of the Hospital.

2. To identify gap against documentation and suggest action plan to address it.

5. METHODOLOGY

- **Study setting**: Park Hospital Karnal

- **Study Design**: Observational and Cross-sectional Study
  The file is separated in two ways --
  1. Active file - The file which are in the respective ward and the patient are yet to be discharged from the hospital.
  2. Passive file – The file received in MRD after the patient has been discharged. For studying such file, a retrospective study was done.

- **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).

Understanding Documentation Parameter

As per the audit tool kit/ checklist, there are certain parameters on which the documentation standard depends on. Each documentation parameter has been judged with variables 'Compliance' 'Partial Compliance' and 'Non-Compliance'. If a parameter has a higher non-compliance rate, than that area needs to be focused more for maintaining a better documentation standard.

There is some common parameter used for Active and Passive file for both. However, the closed file audit that is done in MRD is more detailed in nature.

The table provide as an idea about the parameter and the common characteristics that are found of in the files Active and Passive both checklists.

Important parameter that are exclusively found in the passive file or parameter only to be found in active file, are also noted in the following table

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 is focus 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

6. Results

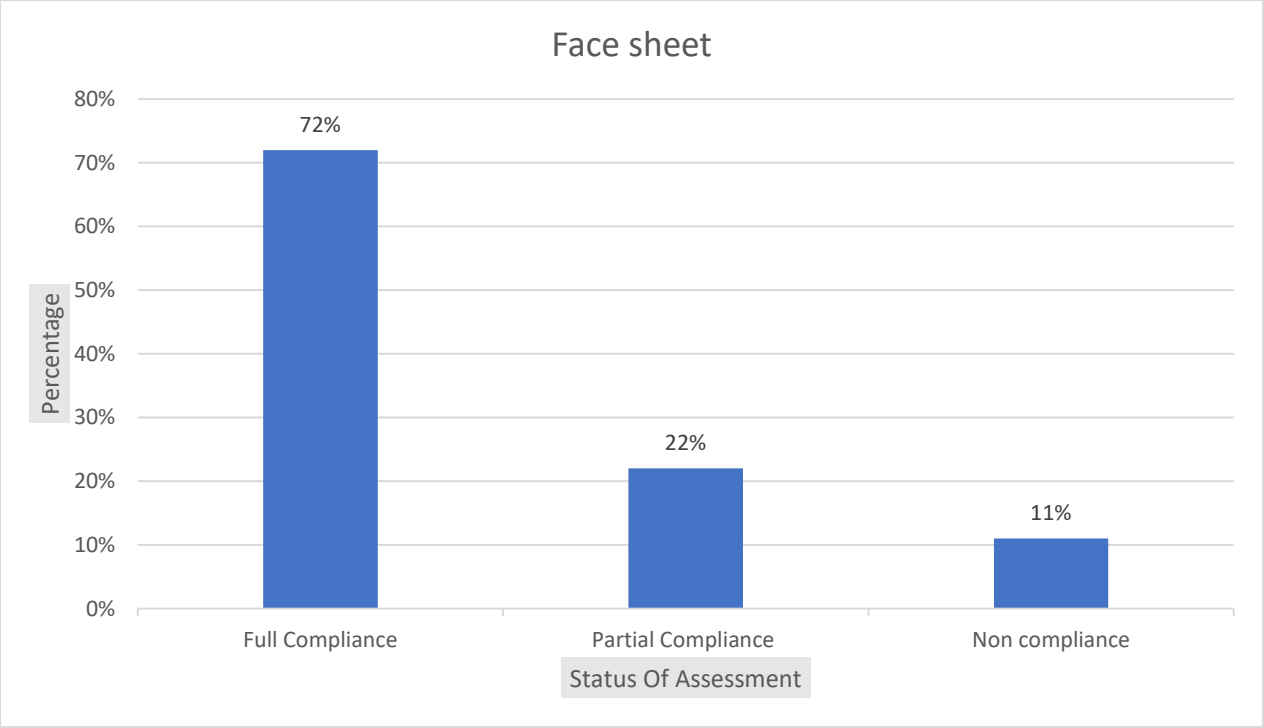

Figure 1.- Face sheet (focuses on the Date and time of admission and Signature of front office executive)

It observed that 72% compliance, 22% partial compliance and 11% non-compliance was there in the Face sheet.

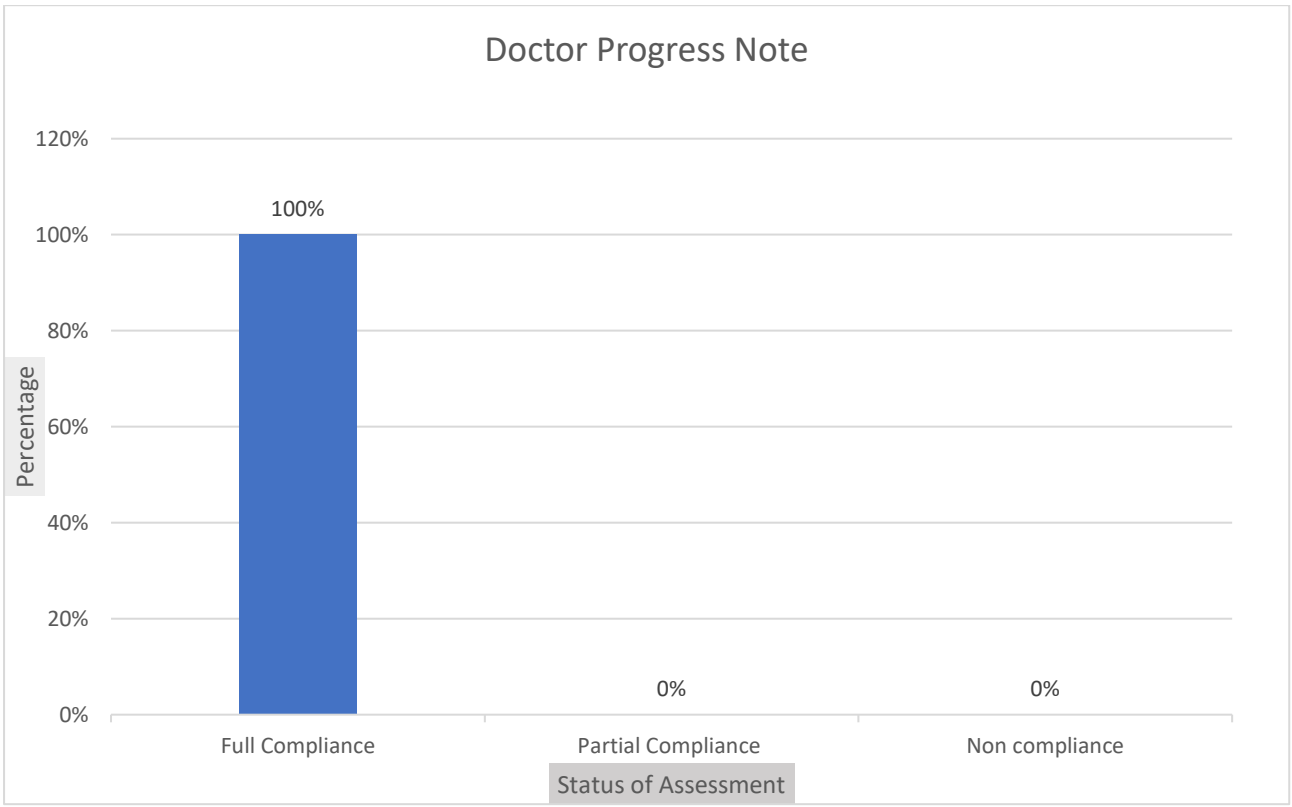

Figure 2.- Doctor Progress Note (Patient related progress note on daily basis provided on CPRS by the main Consultant)

it shows 100% Full compliance in Doctors progress notes.

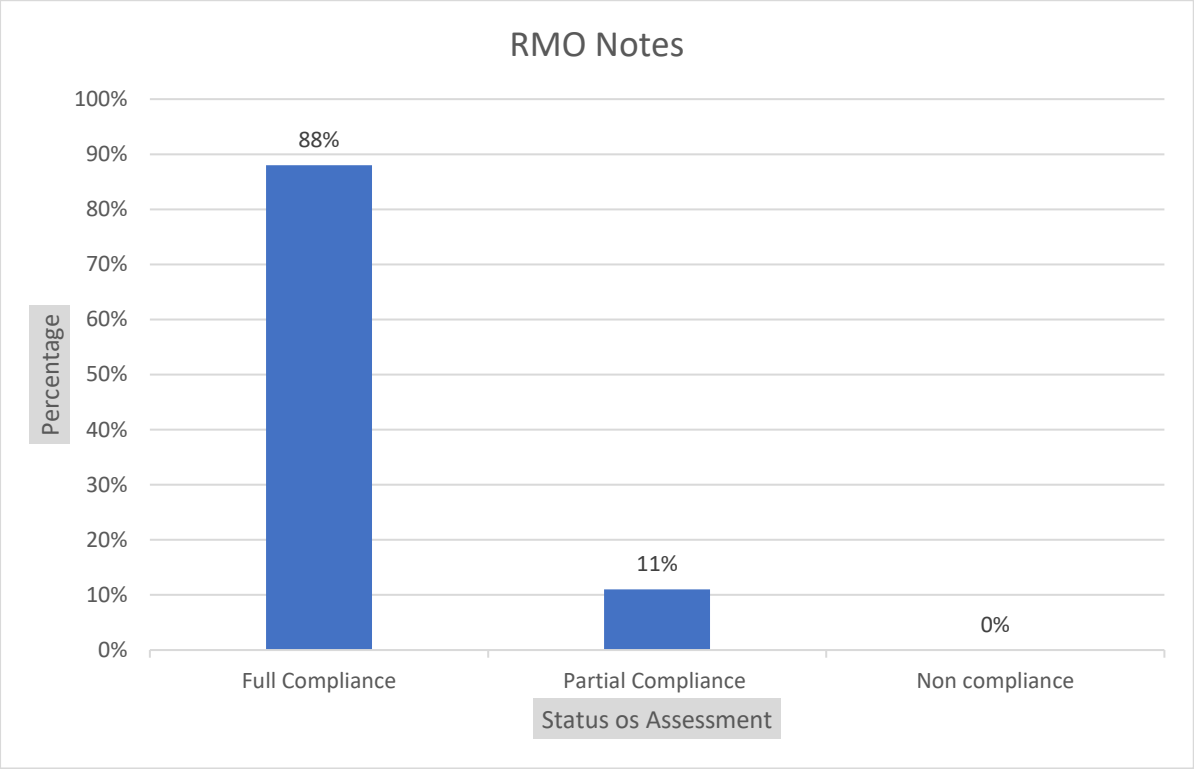

Figure 3. RMO Notes (Patient is admitted in the hospital Resident Medical officer progress note have to be found in CPRS)

it shows 88% Full compliance and 11% partial compliance in RMO notes.

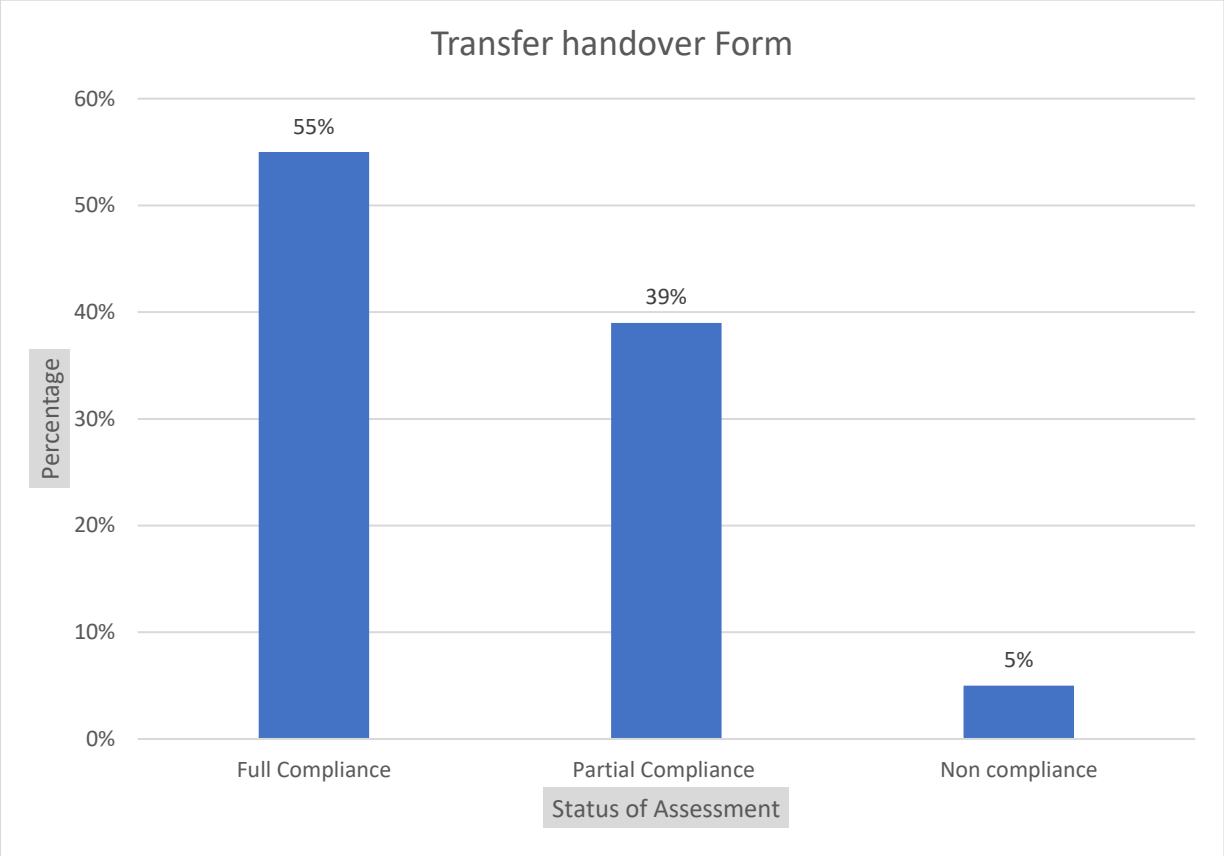

Figure 4. Transfer Handover Notes (focus on the progress note made by the doctors every day)

it shows 55% full compliance, 39% partial compliance and 5%non-compliance in it.

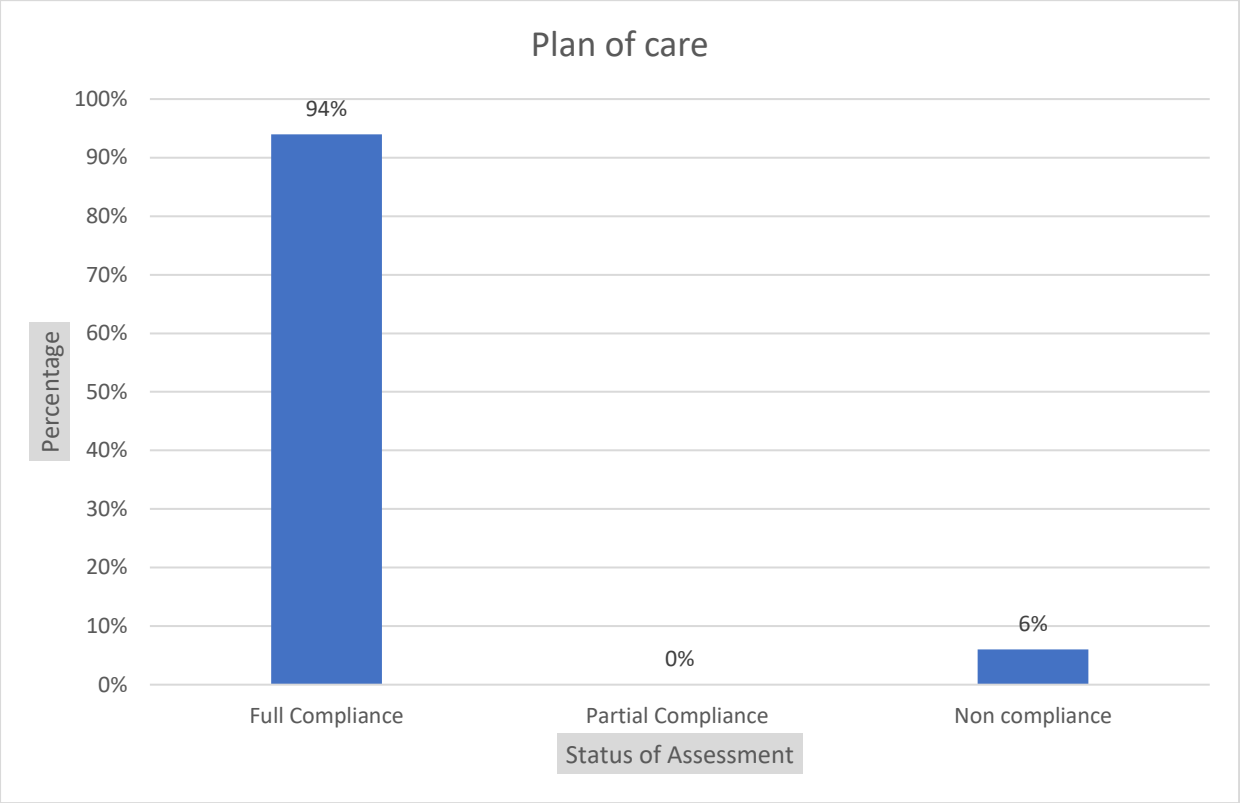

Figure 5. Plan of care (focus on the progress note made by the doctors every day)

it shows that 94% Full compliance and 6% non-compliance.

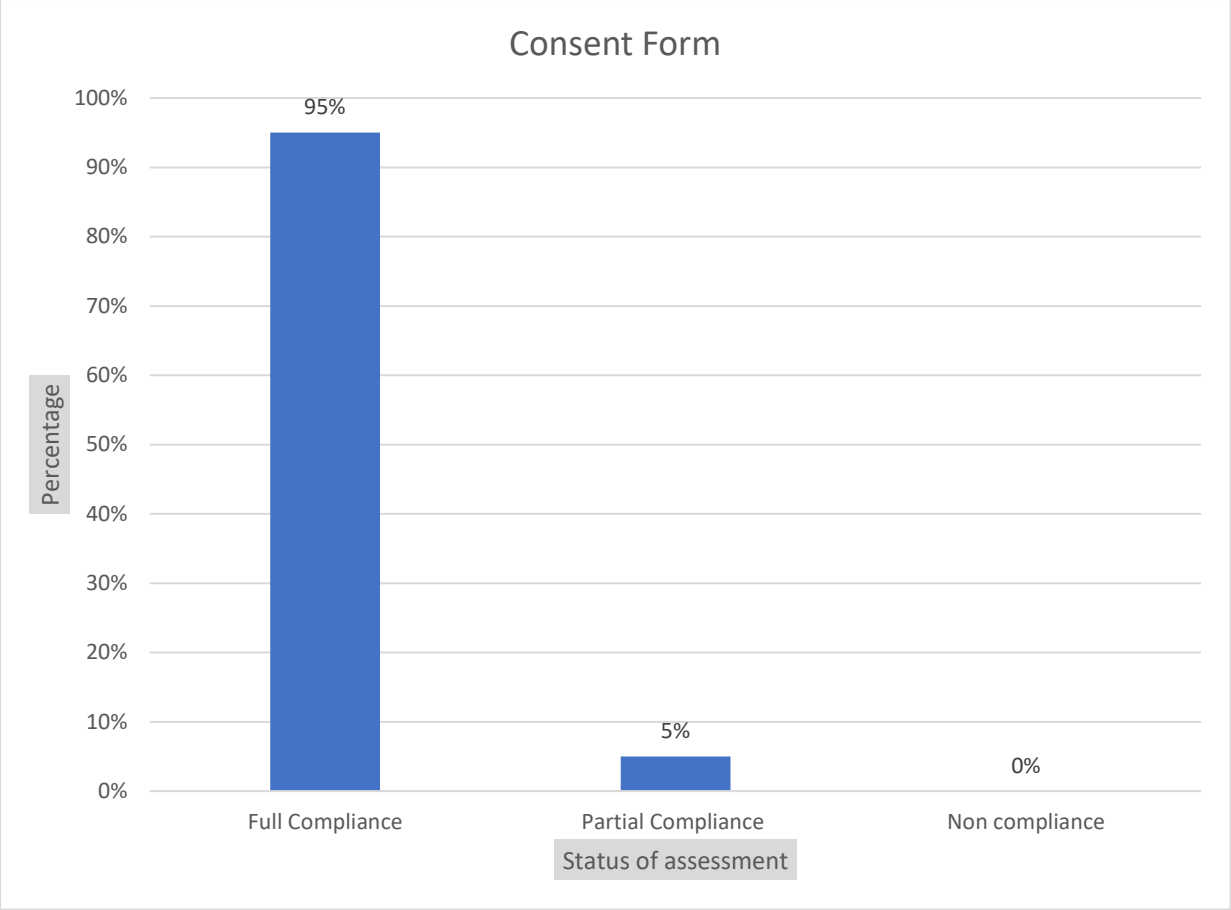

Figure 6. Consent Forms (focus on the risk related to patient, procedure related to surgery described to the patient or not, signature of patient attendant on consent forms)

it shows 95% Full Compliance and 5% partial compliance in it.

7. Discussion

The primary purpose of health record is to provide documentation of care provided to the patients. They vary with care settings, legal jurisdiction and location, Records should be maintained in a manner that ensure regulation, accreditation standards, professional practice and legal standards. Maintenance of complete records is important is important not only for the sake of licensing and accreditation requirements but also to establish the fact that patient received adequate care.

Lowest level of Compliance is found in Transfer Hand over form and in the Face Sheet.

Main problem found in the Transfer Handover form is not filled up properly and in face-sheet there is also the same problem is identified (Date, Time and Signature and id no.).

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.

8. Suggestions

- 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 coloured 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

1. Prema Singh, Sakshi Joshi, Analysis of health record documentation as per the national standard accreditation with special emphasis on tertiary care hospital;2017

2. Robin Mann, John Williams, Standard in medical record keeping; 2003

3. Medical Records Organization and Management -- GD Mogli

4. Park hospital MRD Manual

5. Principal of Hospital Administration and Planning (2nd edition) – BM Sakharkar

Annexure

Sr. no.	Month Date and Time Audit: Auditor:
1.	Face-sheet 1. Date of admission 2. Date of Discharge 3. Condition at the time of discharge 4. Signature of front office executive
2.	Unit
3.	Parameter Audited
4.	Initial Assessment
5.	Emergency Assessment
6.	Time of arrival
7.	Time of assessment
8.	Source of history
9.	Past history
10.	Allergies
11.	Provisional diagnosis
12.	Pain assessment done or not
13.	Current medication mention or not
14.	Diet history
15.	Plan of care
16.	Social/Economical history
17.	Psychological Assessment
18.	Family Education
19.	Date time sign. Name of doctor present

20.	Consultant counter signed within 24 hour of admission
21.	Patient and Family Education 1. Doctor nurse Physiotherapy and dietician should be filled. 2. Upper section which include healthcare literacy,Barriers,Belifs
22.	Patient and Family Communication Records 1. To be filled by doctor or team member 2. Signature of witness, Patient and doctor
23.	Progress Note Doctor 1. To check for notes (2 notes) per day 2. ID, Date ,Time, name, signature
24.	RMO NOTES
25.	Date ,time ,sign., name of doctor present
26.	Any cutting and overwriting in records
27.	Medication order 1. Order to be in Capital 2. For SOS indication and maximum dose for 24 hours 3. Signature, ID and name on medication chart 4. Medication order should be written on medication chart.
28.	Consent 1. No abbreviation to be used 2. Alternative, Indication risk to be written 3. Signature of patient, witness and doctor
29.	Anaesthesia record 1. Consent Form 2. Pre-operative checklist 3. Safety Checklist
30.	Operation Notes 1. Start and end time of surgery 2. Incision 3. Pre- and Post-operative Diagnosis 4. Blood loss 5. Blood Product replaced if any 6. Specimen for HPE

	7. Complication 8. Condition at end of the procedure 9. Signature and name of doctor
31.	Restrain Order 1. To check date and time 2. Reason for restrain 3. Attendant signature
32.	ICU 1. Admission Criteria at the time of admission 2. Discharge Criteria at the time of discharge from Icu to Ward
33.	Denial Consent In case denial for any procedure and treatment the should be filled
34.	Transfer Handover Form
35.	Others: