Audit of Documentation of Medical Records as Per NABH Standards

By

Ritu Chandel

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2018-2020

The IIHMR University, Jaipur

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Lineage Healthcare Limited

PATIENT SAFETY & QUALITY OF CARE
NABH
PRE ACCREDITED

Ref: LINEAGE/HR/PRO/07/20

4th July, 2020

CERTIFICATE OF COMPLETION

This is to certify that **Dr. Ritu Chandel**, MBA student of IIHMR, Jaipur has satisfactorily completed a project on "**ACTIVE AUDIT OF DOCUMENTATION OF MEDICAL RECORDS**" in our organization under the guidance of **Dr. Sandeep Sharma (Manager – Admin - Clinical Services)** from **6th March, 2020** to **20th March, 2020.**

During the period her conduct and performance were good.

For **Lineage Healthcare Limited**

Authorized Signatory

ACKNOWLEDGEMENT

This report has been prepared for the dissertation that has been done in the Cocoon Hospital, Jaipur with the purpose of fulfilling the requirements of the course of MBA in Health and Hospital Management.

The aim of this dissertation is to be familiar to the practical aspect and use of theoretical knowledge and clarifying the career goals, so I have successfully completed this dissertation and compiled this report as summary and the conclusion that have drawn from my experience.

I would like to express my sincere gratitude to my internship coordinator **Dr. Sandeep Sharma** (Admin-Quality Head), **Rajendra Kumar** (MRD Department) who have given their valuable time & given me chance to learn something despite having their busy schedule.

I am also thankful to **Mrs.Tannu Sharma** (Admin-HR) for their co-operative support, and also for giving me an opportunity to have practical experience in this organization.

Thus, I have gained valuable work experience in Cocoon Hospital which will help me in my future career goals.

Most importantly I would like to express my sincere gratitude to my mentor **Dr. Arindam Das** without his support this could not have been possible.

Sincerely,

Dr.Ritu Chandel

Cocoon Hospital,

Jaipur.

Cocoon – "The Hospotel by Lineage Healthcare"

Giving birth to a child is not an illness; it is a journey of joy and celebration and a unique experience for the parents. In this journey of life, the mother & child need utmost love and care. While delivering the baby, she needs an atmosphere as comforting as a home and yet with all the modern amenities and expertise of professionals, to ensure care and security.

Location-

Plot No – 14, Airport Plaza, Durgapura, Tonk Road, Jaipur (Rajasthan) 302016.

Mission-

Excellence in the provision of health care services to Mankind.

- ✧ Excellent service to our guests, customers, and physicians is our most important consideration.
- ✧ We will provide our services with integrity. Our actions will enhance our reputation and reflect the trust placed in us by those we serve.
- ✧ Our employees are our most important resource. We will attract exceptional individuals at all levels of the organization and provide fair compensation

and opportunities for personal and professional growth. We will recognize and reward employees who achieve excellence in their work.

- ✧ We are committed to 'serving' diverse needs of the young and old, the rich and poor, and those living in urban and rural communities, with sensitivity to cultural differences.
- ✧ We will reflect the caring and noble nature of our mission in all that we do. Our services must be of high quality, cost-effective, and accessible, achieving a balance between community needs and available resources.
- ✧ It is our intent to be a model health care system. We will strive to be a learning organization and global leader in health care delivery.
- ✧ We will maintain the financial strength necessary to fulfill our mission.

Vision-

Aspiration to deliver "extraordinary care in all its dimensions" with our vision, which is to provide:

- ✧ The best clinical practice delivered in a consistent and integrated way.
- ✧ Lowest appropriate cost to the population we serve.
- ✧ A service experience supported by systems and processes that focuses on patients, enrollee, families, and one another.
- ✧ A genuine care and concern in our interactions with patients, families, and one another.

Core Values-

- ✧ Mutual respect - "We treat others the way we want to be treated."
- ✧ Accountability - “We accept responsibility for our actions, attitudes and mistakes."
- ✧ Trust - "We can count on each other."
- ✧ Excellence - “We do our best at all times and look for ways to do it even better."

Specialties-

- ✧ Obstetrics
- ✧ Antenatal Care
- ✧ Birthing
- ✧ Laparoscopic Gyane. Surgery
- ✧ Neonatology
- ✧ Stem Cell Preservation
- ✧ Cosmetology & Cosmetic Surgeries
- ✧ Value Added Services

INFRASTRUCTURE & FLOOR MAPS-

Basement-

- ✧ Administration Department
- ✧ Diagnostic Lab
- ✧ General Store
- ✧ Gas Manifold Room

Ground Floor-

- ✧ Reception and Help Desk
- ✧ Cocoon Shoppe
- ✧ CRM/Billing Department
- ✧ Board Room
- ✧ Waiting Area
- ✧ Cafe Gazebo
- ✧ Pharmacy

First Floor-

- ✧ OPD Chambers
- ✧ Examination Room
- ✧ Sample Collection Room
- ✧ OPD Billing Counter
- ✧ Waiting Area for Patients

Second Floor-

- ✧ IPD Rooms
- ✧ Nursing Station
- ✧ Store Room

Third Floor-

- ✧ IPD Rooms
- ✧ Nursing Station
- ✧ Store Room

Fourth Floor-

- ✧ Doctor’s Chamber
- ✧ NICU/Nursery
- ✧ Feeding Area
- ✧ Cosmetology Centre
- ✧ Cheers Room (Celebration Room)
- ✧ MRD Department
- ✧ USG

Fifth Floor-

- ✧ Two OT”s
- ✧ Three LDR Rooms
- ✧ SICU/Recovery Room
- ✧ Doctor’s Room
- ✧ Staff’s Changing Rooms

Sixth Floor-

- ✧ CSSD
- ✧ Staff Cafeteria
- ✧ Biomedical Engineer’s Room
- ✧ Dietitians Room

AUDIT OF DOCUMENTATION OF MEDICAL RECORDS AS PER NABH STANDARDS

1. INTRODUCTION-

Medical records enable health care professionals to plan and evaluate patient treatments and ensure continuity of care among multiple providers. The quality of care a patient receives depends directly on the accuracy and clarity of the information contained in the medical record. Maintaining complete records is important not only for compliance with licensing and certification requirements, but also for enabling health care providers to determine that patients have received appropriate care. Clinical audit is a quality improvement process that aims to improve the quality of patient care and results by systematically reviewing care according to specific standards/standards, so changes can be implemented if needed.
The National Institute of Clinical Excellence (NICE) defines clinical review as: "A quality improvement process designed to improve patient care and outcomes through a systematic review of clear standards and implementation of changes."

2. OBJECTIVE-

Medical audit of documentation of inpatient medical record in a gynaecology hospital.

- ✧ To assess the compliance of medical records per NABH standards.

3. LITERATURE REVIEW-

Many studies have been done on medical record department and document compliance. A brief abstract of some of the studies are described below-

The study entitled “Quality improvement of medical records through internal auditing: a comparative analysis” was conducted to assess the efficacy of internal audit as a tool to improve the quality of medical records in hospital setting. The program was carried out in a third level teaching hospital. Trained ad hoc evaluation teams carried out two

retrospective assessments of quality of medical records using a random sampling strategy. The quality assessment was performed using a 48-items evaluation grid divided into 9 domains: General; Patient Medical History and Physical Examination; Daily Clinical Progress Notes; Daily Nursing Progress Notes; Drug Therapy Chart; Pain Chart; Discharge Summary; Surgery Register; Informed Consent. After the first evaluation of 1.460 medical records, an audit departmental program was set up. The second evaluation was carried out after the internal auditing for 1.402 medical records. Compared to the first analysis, a significant quality amelioration in all the sections of the medical chart was shown with the second analysis, with an increase of all the scores above 50%. (E.Azzolini, G.Furia, A.Cambrie, W.Ricciardi, M.Volpe, A.Poscia 2019)

The study entitled "Evaluation of Audit of Medical Inpatient Records in a District General Hospital" was conducted to evaluate medical inpatient records in a hospital. Random sample of 188 notes per year drawn systematically from notes from four selected one month periods and audited by two audit nurses and most hospital physicians. General quality of routine clerking, assessment, clinical management, and discharge, according to a standardised, criterion based questionnaire developed in the hospital. 1988 was the year preceding the start of audit in the hospital, 1989 the year of active audit with implicit and loosely defined criteria, and 1990 the year after introduction and circulation of explicit criteria for note keeping. Documentation of discharge and notification of discharge to general practitioners was not significantly improved. Extended audit of note keeping failed to sustain an initial improvement in practice; this may be due to coincidental decline in feedback to doctors about their performance. (J. Gabbay, A J Layton 1992)

The study entitled "Analysis of Health Record Documentation Process As Per The National Standards Of Accreditation with special emphasis on Tertiary Care Hospital" aims to review the health records and evaluate them to find the incongruity in the documentation of patient's data by doctors, nurses and other health care providers involved in the documentation process. The study was conducted in X Hospital in Delhi. A total of 200 patients files reviewed and primary data collected by checking the patient files at nursing stations, wards and critical areas. A documentation review audit tool was then prepared (as per objective elements mentioned by NABH) taking into consideration the important aspects of documentation in the health records. The files were checked as per the parameters mentioned in the audit tool. To

measure the compliance, three options were included i.e. Full compliance, Partial compliance and Non compliance. Then the percentage (%) compliance was calculated for each health record form. Data interpretation and analysis was done and major non-compliance were reported to the doctors, nurses and paramedical staff along with reasons for their non-conformity with the NABH standards. Possible suggestions and recommendations were also reported. This helped in bringing down the percentage of non-compliance. (Prerna Singh, Sakhi John, 2017).

3.1 Six key Attributes of Medical Record File-

1. **Accuracy of the medical record-**

The accuracy of data refers to the accuracy of the collected data. It should reflect data provided by actual sources.

2. Accessibility of the medical record-

Accessibility is related to the ease of retrieving data.

3. Comprehensiveness of data-

All necessary data components should be recorded in the record and imply that the chart is complete.

4. Consistency of information in the medical record-

The consistency of the medical record refers to the fact that the data is reliable and the integrity of the data is not compromised, no matter how often or how the data is retrieved, viewed, stored, or processed.

5. Timeliness of information-

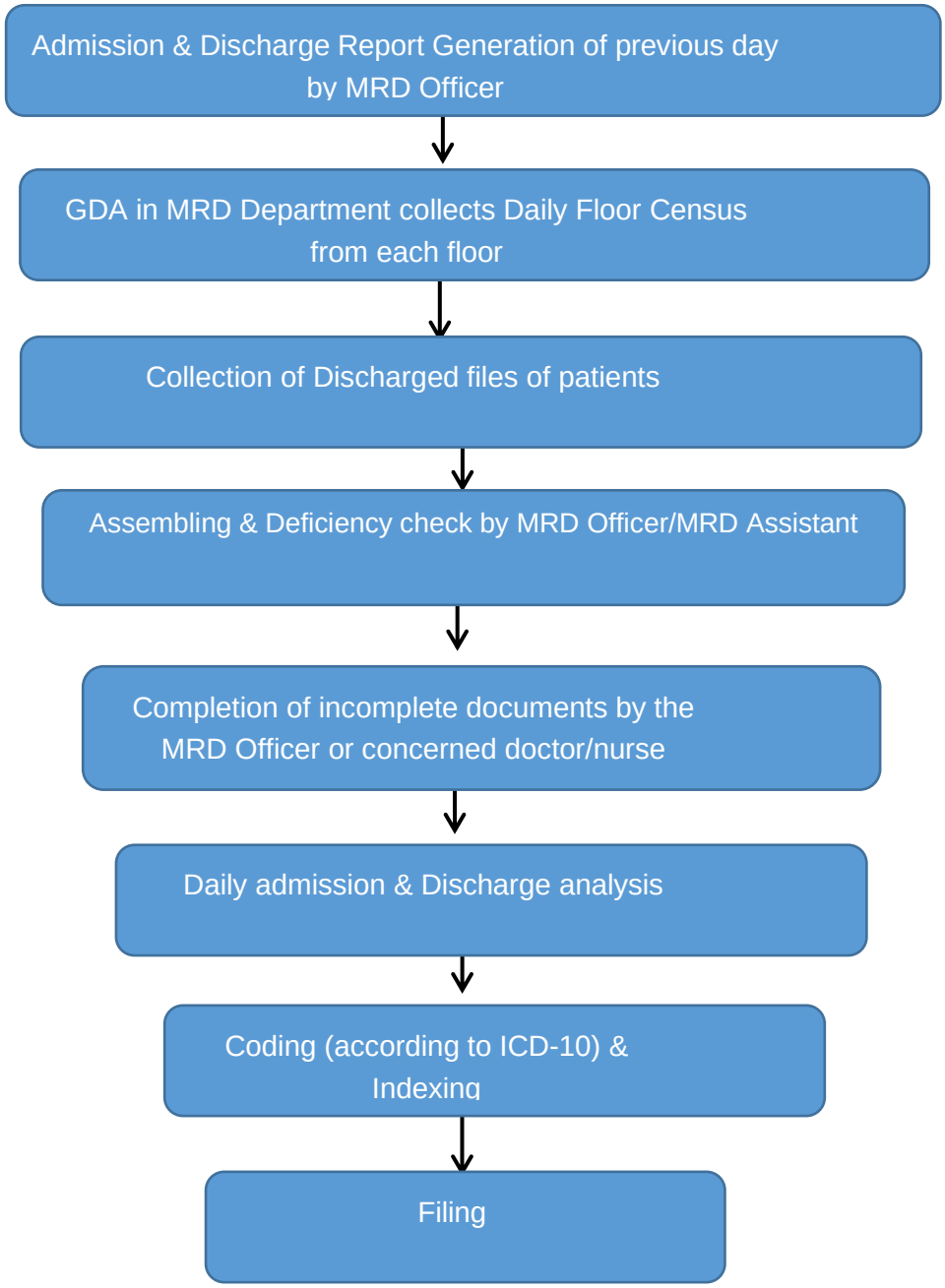
The time to record data is a key part of the data. Health care records should reflect current information recorded as close to real time as possible.

6. Relevancy of the medical records-

This helps to obtain the cooperation of law firms in obtaining information.

MEDICAL RECORD DEPARTMENT

WORK FLOW-



RECORD RETENTION PERIOD-

- IP Record : 05 years
- Emergency Register : 02 years
- MLC Records : Not to be destroyed.
- Birth/Death Register : Not to be destroyed.
- OPD Documents : Handed over to the Patient Relatives.

4. RESEARCH METHODOLOGY-

- ✧ **Study Location:** The study was conducted in Cocoon Hospital, Jaipur.
- ✧ **Study Duration:** The study duration was 45 days.
- ✧ **Study Design:** The type of study was Observational study.
- ✧ **Sampling Method:** Convenience Sampling method was used for this study
- ✧ **Sample Size:** 80 samples were studied during this study**.**
- ✧ **Inclusion Criteria-** Medical Record Files of all the IPD wards.
- ✧ **Exclusion Criteria-** Medical Record Files of NICU ward, Emergency ward and Medical Record Files of new born babies.
- ✧ **Study Area:** The study area was Medical Record Department of the Cocoon Hospital, Jaipur.

5. DATA COLLECTION METHOD-

- ✧ **Data Type:** The Quantitative type of data was used in this study.
- ✧ **Data Collection Tool:** Developed a audit tool with 21 checklist points keeping few of the quality indicators serve as the benchmark to carry out the study.
- ✧ **Data Collection Method:**
    - ✧ **Primary Data Source:** Through Medical Record Active Audit Checklist and direct observations. The source was the medical record files of the last one month and seventeen days available in the Medical record department.

6. DATA ANALYSIS-

DATA ANALYSIS: The data was entered & analyzed using Microsoft Excel Software. The data relating to the parameter maintained is calculated as percentages for comparison purposes.

Quality Indicators for Medical Records according to NABH Standards are:

- ✧ Percentage of medical records in which plan of care is documented and countersigned.
- ✧ Percentage of medical records in which nursing care plan is documented.
- ✧ Percentage of medication chart with error prone abbreviations.
- ✧ Percentage of medical records having incomplete consent.
- ✧ Percentage of medical records named, signed, dated and timed by doctor.

ETHICAL CONSIDERATIONS:

Since there was no intervention in the patient's care process, all information in this study was kept confidential for ethical considerations in this study.

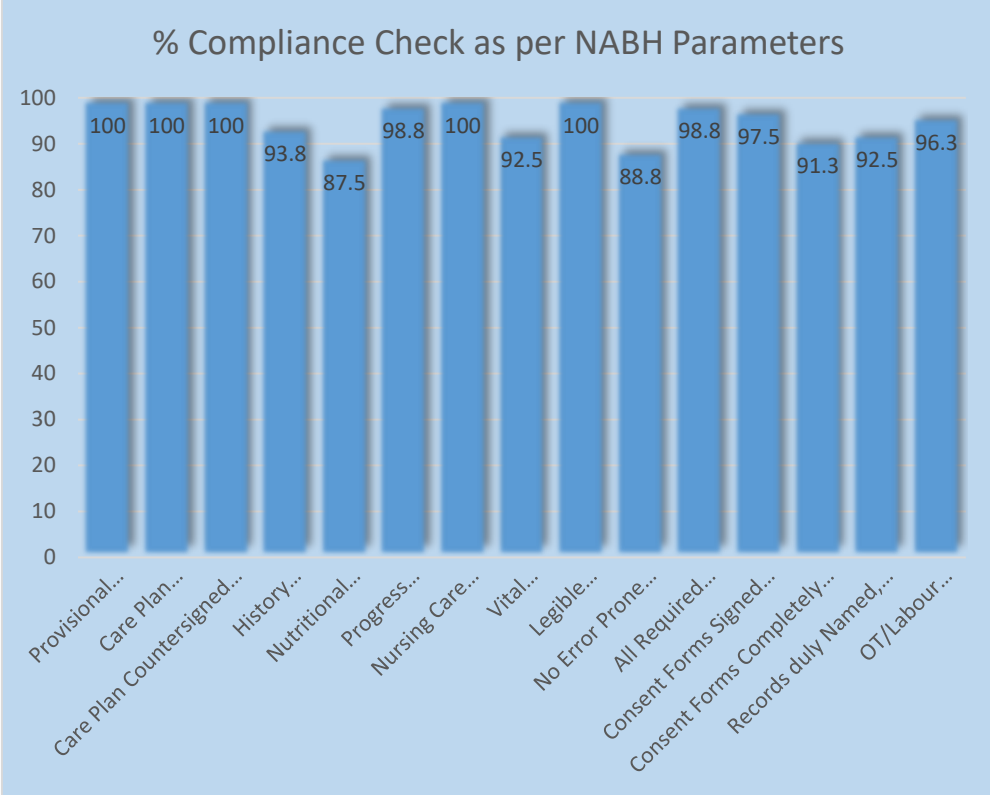


Figure 7.1 Graphical Representation of Medical Records

Interpretation:

There was **More than 95% Compliance** in following parameters- Provisional Diagnosis care plan documented, Care Plan countersigned with name by Clinician, Nursing Care Plan documented and signed, Legible Handwriting in Medication Chart, Progress & Daily Order sheet, All required Consent Forms, Consent Form signed by correct person and OT/Labour checklist signed.

Less than 95% Compliance was observed in following parameters- Past History sheet, Vital Monitoring sheet, Records duly Named, Signed, Dated and Timed By Doctor, Consent Form completely Filled & Signed, No Error Prone Abbreviation in Medical Record and Nutritional Assessment.

Time of Initial Assessment-

The average time estimated for the initial assessment by the nursing staff for eighty respondents was **16.6 minutes.**

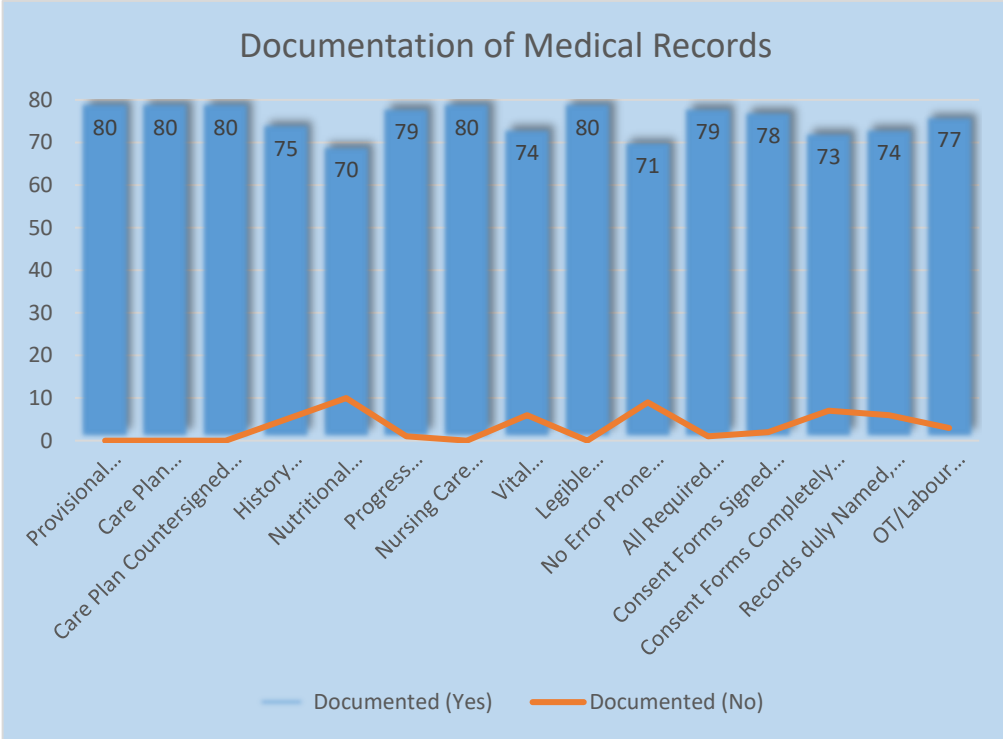


Figure7.2 Graphical Representation of the Documentation of Medical Records

Interpretation-

It was observed that documentation was complete in record files in these categories- Provisional diagnosis care plan documented, Care plan countersigned, Nursing care plan documented and signed, Legible handwriting in medication chart and documentation was seen incomplete in the categories- History sheet, nutritional assessment, vital monitoring sheet, abbreviation in medication chart, consent form completely filled & signed and records duly named, signed, dated and timed.

8. DISCUSSION-

- ✧ Because of this lockdown situation Dietician was not there, And different Dieticians were accessible on calls as it were.
- ✧ Some of the Doctors don't adhere to the guidelines given in medication chart. Prescriptions ought to consistently be written in " Capital Letters"
- ✧ Past history sheet was not filled totally, a portion of that stayed blank. For instance type of care, date of discharge from hospital, Rehabilitation services, etc.

- ✧ While doing active audit I saw that in few files the section for the name, date and time of attending consultant remained blank.
- ✧ Training should be given to all the staff members including the different departments about the importance of documentation process of the medical records.
- ✧ Audit Checklist ought to briefly be attached with the each medical record so its function-ability would be done by the other staff members also and crush it in after the fulfillment of work.

9. SUGGESTIONS-

Clinical documentation is one of the crucial areas where the maintenance, creation, and management of medical records are done. The committee in charge of medical records should coordinate with medical staff to avoid confusion and allow effective communication which eventually leads to faster identification of the right medical strategy.

Corrective Action & Preventive Action Form: The CAPA form must contain the "Identified Problem", and the problem has been described in writing, and should be concise and clear, but complete. The description should contain enough data so that the specific problem can be easily understood. It should mainly consist of two parts,
Evidence documents should be attached to the form.

Action Plan: In order to be effective, all changes should be made and changes must be communicated to all employees, departments, consultants, etc. who have been or will be affected.

10. CONCLUSION-

Medical records are technically valid health records and should provide a comprehensive and correct description of each patient's care details or contact with hospital staff. Medical records are very important documents in the hospital. These records are important for legal purposes and required hospital medical plans. All possible steps should be taken to ensure the systematic and orderly maintenance of all hospital medical records. The importance of medical records should also be communicated to all employees. Regular review of the medical records will help to determine the possible defects of the medical records, and the hospital can improve and deal with them.

11. REFERENCES-

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ANNEXURE

ACTIVE AUDIT CHECKLIST

1	S.No.	
2	IPD No.	
3	Patient’s Name	
4	Consultant	
5	Provisional Diagnosis	
6	Care Plan Documented	
7	Care plan Countersigned with name by Clinician	
8	Past History Sheet	
9	Time of Initial Assessment	
10	Nutritional Assessment	
11	Progress Notes	

Cont…

12	Nursing Care Plan Documented and Signed	
13	Vital Monitoring Sheet	
14	Legible Handwriting in Medication Chart	
15	No Error prone Abbreviation in Medication Chart	
16	All required Consent Forms	
17	Consent Forms signed by correct person	
18	Consent forms completely filled and signed	
19	Records duly named, signed, dated and timed by Doctor	
20	Surgical Checklist (OT/Labour)	
21	Remarks	