AUDIT OF DOCUMENTATION OF MEDICAL RECORDS AS PER NABH STANDARDS

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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.

OBJECTIVE

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

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

MRD WORK FLOW

Admission & Discharge Report Generation of previous day by MRD Officer

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GDA in MRD Department collects Daily Floor Census from each floor

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Files of discharged patients collected

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Assembling & Deficiency check by MRD Officer/MRD Assistant

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Completion of incomplete documents by the MRD Officer or concerned doctor/nurse

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Daily admission & Discharge analysis → Coding (according to ICD-10) & Indexing → Filing

RESEARCH METHODOLOGY

- Study Location: Cocoon Hospital, Jaipur.
- Study Area: Medical Record Department of the Cocoon Hospital, Jaipur.
- Study Duration: 45 days.
- Study Design: Observational study design.
- Sampling Method: Convenience Sampling method.
- Sample Size: 80
    - 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.

DATA COLLECTION

- Data Type: Quantitative

- Data Collection Tool: Developed a audit tool with 21 checklist points keeping few of the quality indicators serve as the bench-mark to carry out the study.

- Data Collection Method:
  - Primary Data Source: Through Medical Record Active Audit Checklist and direct observations.

  - Secondary Data Source: Medical Record Files

ACTIVE AUDIT CHECKLIST

1. S. No.
2. IPD No.
3. Patient's Name
4. Consultant Name
5. Provisional Diagnosis & Treatment Details Available
6. Care Plan Documented
7. Care Plan Countersigned with name by Clinician
8. Past History
9. Time of Initial Assessment
10. Nutritional Assessment
11. Progress & Daily Order Sheet
12. Nursing Care Plan Documented & Signed

ACTIVE AUDIT CHECKLIST

13. Vital Monitoring Sheet & Intake Output Chart
14. Legible Handwriting In Medication Chart
15. No Error Prone Abbreviation in Medical Record
16. All Required Consent Forms
17. Consent Form signed by correct person
18. Consent Form completely Filled & Signed
19. Records duly Named, Signed, Dated and Timed By Doctor
20. Surgical Safety Checklist Signed
21. Remarks

DATA ANALYSIS

DATA ANALYSIS:

- The data was entered & analyzed using Microsoft Excel Software.
- The data relating to the parameters maintained is calculated as percentages for comparison purpose.

RESULTS

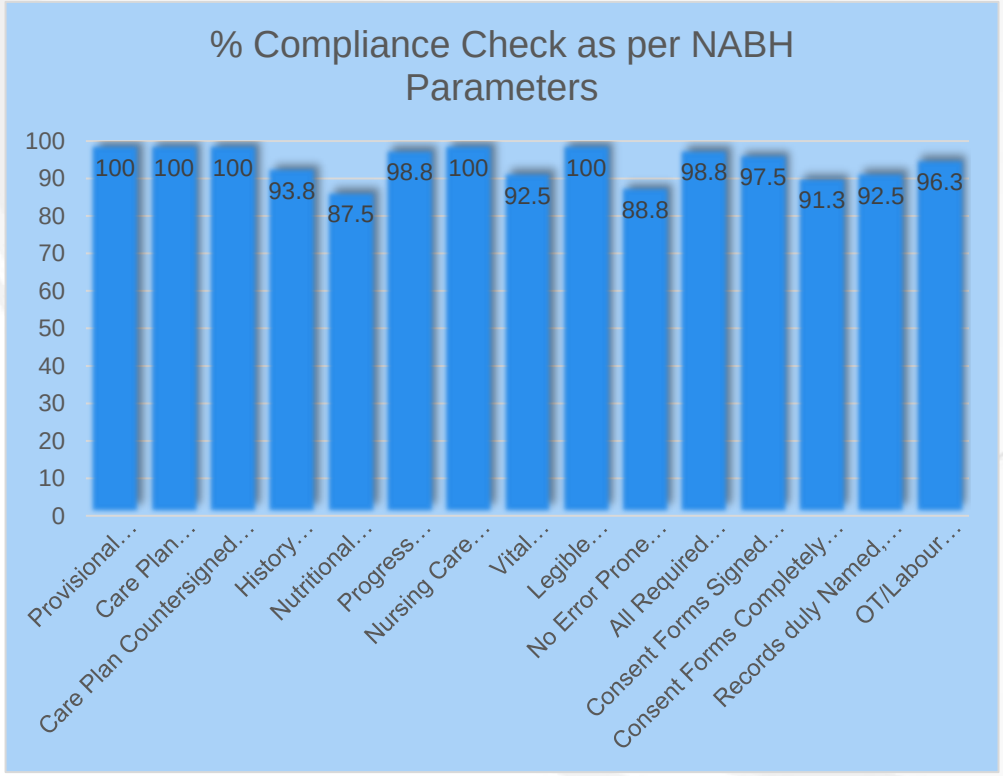

Figure 1. Graphical Representation of Compliance Check

Interpretation-

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 f ollowing 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.

RESULTS

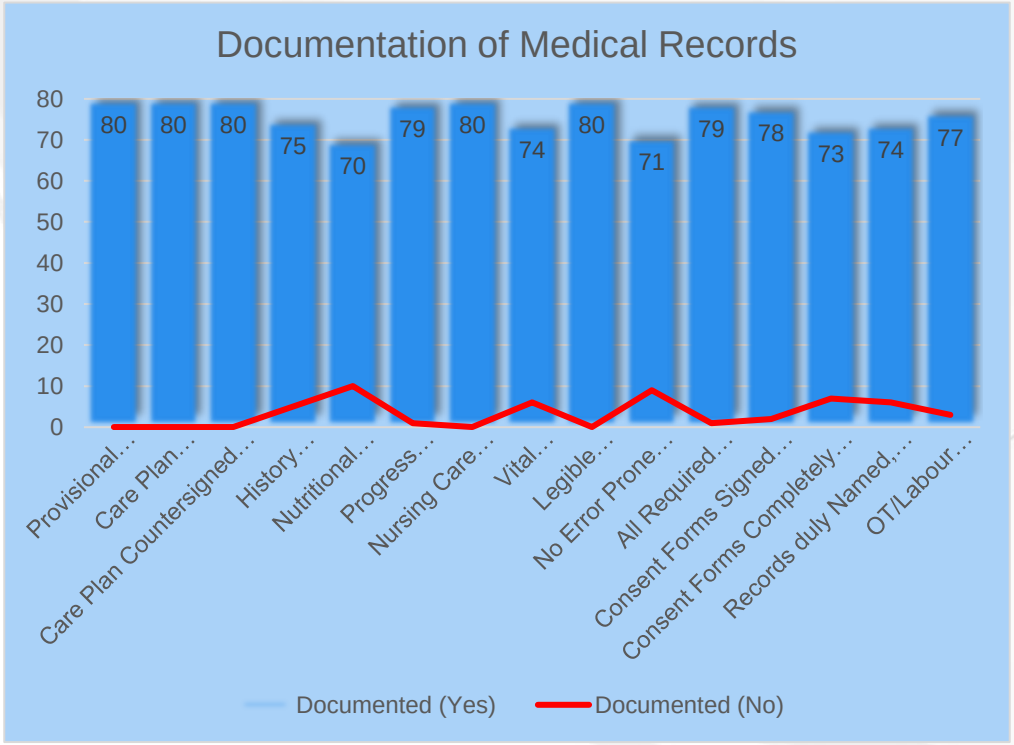

Figure 2. Graphical Representation of Completeness of Medical Records

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.

RESULTS

Time of Initial Assessment-

The average time estimated for the initi
al
assessment by the nursing staff for the
respondents was 16.6 minutes.

DISCUSSION

- Dieticians were not available because of the lockdown, they were only available on phone calls.
- 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.

SUGGESTIONS

- 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 should be briefly attached with the each medical record so its function-ability would be done by the other staff members also and destroy it in after the completion of work.

Corrective Action & Preventive Action Form:
The CAPA form must contain the "Identified Problem", and the problem has been described in writing. The description should contain enough data so that the specific problem can be easily understood. It should mainly consist of -

1. Evidence documents should be attached to the form.
2. Action Plan: In order to be effective, all changes should be made and must be communi -cated to all employees, departments, consultants, etc. who have been or will be included.

CONCLUSION

- The active audit tool used in this study have proven their value for measuring the quality of medical records documentation and organisational appropriateness. The results of this study shows that Full compliance rate is achieved in five parameters and other parameters have partial compliance.

- Medical records are very important documents in the hospital. These records are important for legal purpose and required hospital medical plans.

- Monthly audit of the medical records will help to determine the possible defeciencies of the medical records, so that hospital can improve and deal with it.

REFERENCES

1.Singh. M, Patnaik. S, Sridhar. B (2017). Medical Audit of Documentation of Inpatient Medical Record in a Multispecialty Hospital in India. Retrieved from https://www.researchgate.net/

2.Michael I. Kourakos (2017). Enhancing Self-Management in Diabetes: The Value of Therapeutic Educat ion. Retrieved from https://www.ijhsr.org/IJHSR_Vol.7_Issue.6_June2017/43.pdf

3.Medical Records checklist and quality indicators for NABH accreditation preparation (April 19, 2020). Re trieved from https://expresshealthcaremanagement.blogspot.com/2017/05/medical-records-checklist-qualit y-indicator-NABH-accreditation.html

4.Thomas. J (2009). Medical records and issues in negligence. Retrieved from https://www.ncbi.nlm.nih.g ov/pmc/articles/PMC2779965/

5.Dosumo EB, Dosumo OO, Lawal FB. Quality of records keeping undergraduate dental students in Ibada n, Nigéria. Ann Ib Postgrad Med 2012 Jun;10(1):13-17.

6.Robertson AR, Fernando B, Morrison Z, Kalra D, Sheikh A. Structuring and coding in health care record s: a qualitative analysis using diabetes as a case study. J Innov Health Inform. 2015; 22(2):275-83. PubM ed |Google Scholar

THANK YOU