Documentation Audit of Medical Records in A Tertiary Care Set Up

By

Sunaina Sharma

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2018-2020

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ACKNOWLEDGMENT

For a management student, the power of knowledge is an attainable unless an element of practical observation and practical performance is not added. I consider myself fortunate for having being provided an opportunity to pursue my dissertation from Nayati Medicity, Mathura.

I would also like to thank my mentor **Dr Sandesh Sharma** for his able guidance and support, unflinching help and motivation at every step of completion of this report.

It is my genuine pleasure to express my very special thanks and gratitude to **Dr Prateek Singh** whose dedication and keen interest had been solely and mainly responsible for the completion of this report. His timely advice, meticulous scrutiny, scholarly advice and scientific approach have helped me to a great extend to complete this task. He has been a constant guiding light and source of illumination to me. It entirely goes to him credit that this report has attained this final shape.

I am also grateful to all the department heads and staffs for giving me time in spite of their hectic schedule .Without their active cooperation and participation , it would not have been possible to accomplish my task.

DECLARATION

I do hereby declare that I am a student of 2nd year, MBA in Hospital and Healthcare Management, IIHMR University, Jaipur, Rajasthan session 2018-2020.
I would like to state that I have carried out my Internship on the topic **"Descriptive study on Documentation audit of medical records in a Tertiary care set up"** under the guidance of **Dr Prateek Singh** at Nayati Medicity, Mathura for the partial fulfillment for the degree of MBA in Hospital and Healthcare Management.
This project work is my own and has not been submitted to any of the other Institute or University for the purpose of award of any degree or diploma.

Sunaina Sharma
MBA- HM 23
2018-2020

Table of Content

Abbreviations

NABH – National Accreditation Board for Hospital

SOP – Standard Operating Protocol

ER – Emergency Room

ICU – Intensive Care Unit

MRD – Medical Record Department

UHID – Unique health identification number

IPD – Inpatient department

PAC – Pre anaesthetic assessment

POC – Plan of Care

LAMA – Leave against Medical Advice

EMR – Electronic Medical Record

D/T – Date and Time

MLC – Medico legal Case

List of Figure

Title

A Descriptive study on Documentation audit of medical records in a Tertiary care set up.

Introduction

Quality of health care is based upon accurate, consistent and complete documentation of medical records. The health care quality can be assessed indirectly by analyzing the details present in medical records. Medical records are thus important documents that provide the overall details of the patient's history, medication plans, diagnostic tests, clinical findings, Pre and post-operative care, patients progress and follow up's. Medical health records are essential records which provide patient details at individual level and also provide details of contact with the hospital personnel's. It also form an important part of patient's present and future health care.

The main purpose of maintaining proper medical records is to record the facts regarding the patient's health conditions in order to provide continuity of care to the patient. Medical record has legal and medical relevance thus it needs to be completed, legible and is of high quality. Proper maintaining of medical record would also be required at the time of Medico-legal purpose or to dispose claims of insurance. Medical file audit is essential to improve the quality of healthcare delivery to the patient.

The best way to improve the quality of documentation of medical record is through regular audit of the medical record. The objective of medical audit is to evaluate healthcare quality which would result in improvement in all the activities within the hospital by promoting correction in the deficits found during the audit. Thus medial record audit is the great tool of attaining and maintaining the quality of healthcare delivery. The goal of medical audit is to provide better care delivery and to improve the financial health of the organization. Medical audit also helps in identifying the opportunity for improvement and thus provide mechanism through which action is taken to make and sustain those improvements. With the help of this study healthcare facility would therefore encourage better documentation in order to improve standard of clinical practices and better quality of health care services.

Research question

Q1) Does the existing documentation procedure is in accordance with the SOP established by the hospital?

Q2) what are the lacunae in the existing documentation procedure?

AIM

The aim of the study is:-

- To access whether the existing documentation procedure is in accordance with the standard operating procedure established by the hospital.
- To access the lacunae in the same and to propose some possible solutions.

The audit is to insure that all clinical records are maintained to the highest standard as well as providing a benchmark to continually improve the quality and accuracy of Clinical records.

Objective

The objective of the study is:-

- To access whether the documentation is being done as per the SOP's of the hospital.
- To recommend effective solution whenever required.

Research Methodology

Keeping the aim & objective of the project in mind the study design is as follows.

Type of Study: Retrospective, Descriptive, Cross-sectional study

Study Approach: Qualitative study

Study time: 1 Month (24 February- 24 March)

Location of Study: Hospital premises, Nayati Medicity, Mathura

Study Population: Patient from inpatient ward, ICU, ER, Procedural Room

- **Inclusion Criteria:** Patients who were admitted in the hospital premises for more than 24 hours
- **Exclusion Criteria:** Patients from day care were not included in the study.
- **Study tool:** Audit form checklist

Type of Data: Primary Data, Secondary Data

Sample Size: 83 (10% of total number of discharge within one month. Total number of discharge were 830)

Sampling Technique: Convenience Sampling

Data Collection Procedure: A Preexisting File Audit Checklist consisting of 30 indicators were used in order to collect the data. By the mean of convenience sampling in-patients files were audited in order to check the compliance of the file.

- Primary data were captured through interacting with HOD'S, nurses and by viewing patient's file.
- Secondary data were captured through EMR.

Tool for analysis of data: Self designed Ms Excel Sheet.

Plan of Analysis: As per the NABH and hospital protocols a preexisting checklist consisting of 30 indicators were used in order to check the patient file compliance. An excel sheet were prepared indicating all the thirty indicators under the three categories mentioned below in order to check the patient file compliance.

- Complete - 1
- Incomplete - 0
- Not applicable - NA

Based on the above category whole analysis was done by finding out the percentage compliance of each indicator.

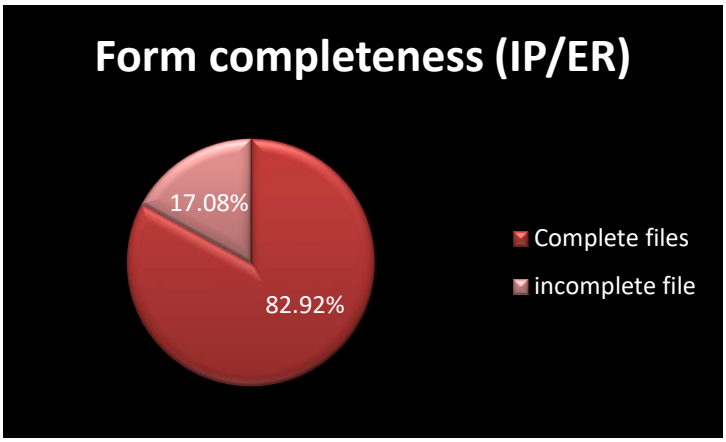
Following 30 indicators were chosen as per NABH in order to audit patient file.

	Indicator	Description
a)	**Assessment from Emergency & IPD**	
1	Form completeness	Mainly focuses on Patient name, UHID, Consultant signature with date and time
2	provisional diagnosis	Focuses on Patient's illness diagnosis listed
3	plan of care/ treatment planned	Focuses on category of plan of care and treatment such as list of medicines to be taken
4	Time of Initial Assessment Emergency	Focuses on time of Emergency assessment, doctors signature, triage category
5	Time of Initial assessment (IPD)	Focuses on time of initial assessment started with doctor signature
6	Consultant counter sign	Focuses on time of initial assessment started with doctor signature
B)	**Other Assessment**	
7	Nutritional Assessment	Focuses on time of initial assessment started with doctor signature
8	Physiotherapy Assessment	Focuses on time of initial assessment started with doctor signature
c)	**Consents**	
9	Operation	Focuses on completeness - correct place signature by patient, attendant, Consultant
10	Anesthesia	Focuses on completeness - correct place signature by patient, attendant, Anesthetist
11	Blood transfusion	Focuses on completeness - correct place signature by patient, attendant, Consultant
12	Restraint	Focuses on completeness - correct place signature by patient, attendant, Consultant
13	High risk	Focuses on completeness - correct place signature by patient, attendant, Consultant
14	Admission form	Focuses on completeness - correct place signature by patient, attendant, Consultant
d)	**Progress Notes**	
15	Date & Time of notes	Focuses on date and time mentioned by the treating doctor
16	Legibility	Focuses on clarity in writing the progress notes
17	Sign, of Consultant	Focuses on progress note signed by the doctor
e)	**Drug Order sheet**	
18	Allergies documented	Focuses on list of allergies documented, if any
19	Written in capital letter	Focuses on drug order sheet containing medicines written in capital letter
20	Nurse sign	Focuses on drug sheet signed by nurse against each medicines

		after administered by patient
f)	**Anesthesia Record**	
21	PAC	Focuses on Anesthesia notes Completeness
22	Recovery score	Focuses on score mentioned on Anesthesia Record
23	Anesthetist name &sign	Focuses on anesthetist name with signature
g)	**Surgery Record**	
24	Post OP Notes	Focuses on post-operative surgery record mentioned by the surgeon
25	Surgical Safety Checklist	Focuses on list of all the indicators in the checklist is ticked
26	Pre-Operative checklist	Focuses on list of all the indicators in the checklist is ticked
27	discharge form recovery area	
28	Antibiotic within 60mins of surgery	Focuses on time anesthesia dose of antibiotic given within 60 min of surgery
29	Pre-operative Anesthesia Notes	Focuses on Pre-operative Anesthesia notes
30	Discharge/LAMA/Death Summary	Focuses on Signature of consultant and patient.

a) Assessment from Emergency and IPD

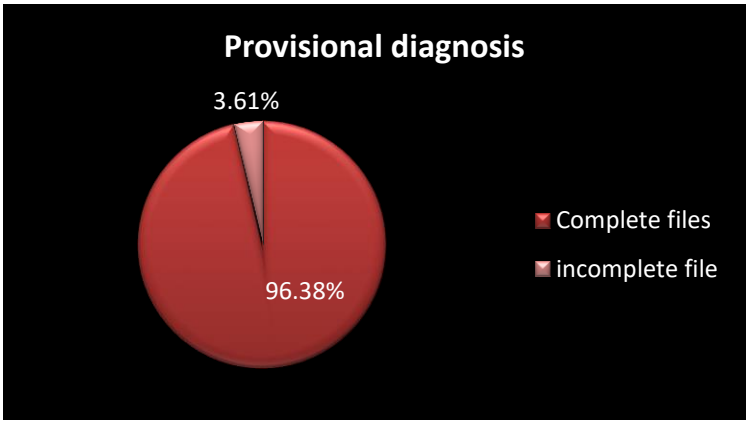
1) It focuses on overall form Completeness



Interpretation

- During the audit, it was observed that out of 83 files, 68 files were found to be complete whereas 14 files were found to be incomplete.
- Reason for incompleteness is missing Patient's name, time etc.

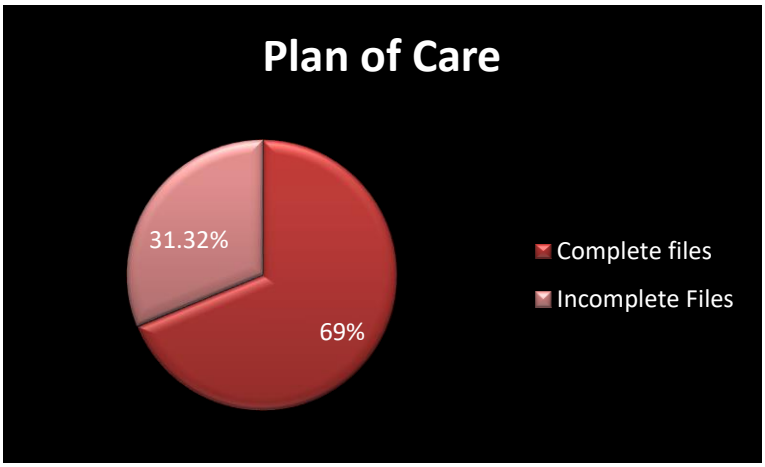
2) Provisional Diagnosis



Interpretation

- The above pie chart depicts that out of 83 files, 80 files were found to be complete whereas 3 files were found to be incomplete.
- At times patient diagnosis missed in the initial assessment form.

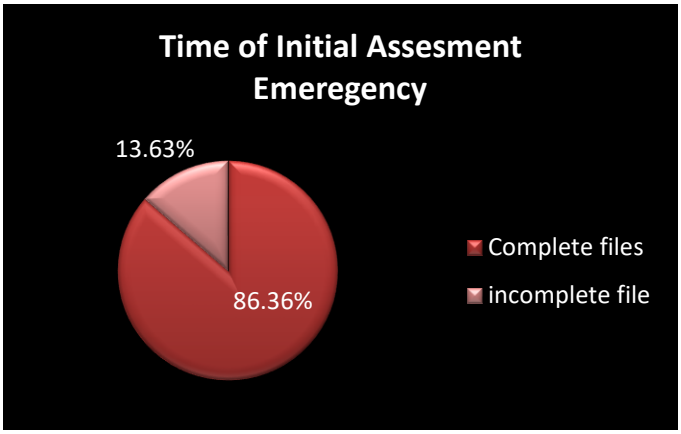
3) Plan of Care



Interpretation

- The above pie chart depicts that out of 83 files, 57 were found to be complete whereas 26 were found to be incomplete.
- Reason of incompleteness was at times in EMR plan of care column left blank.

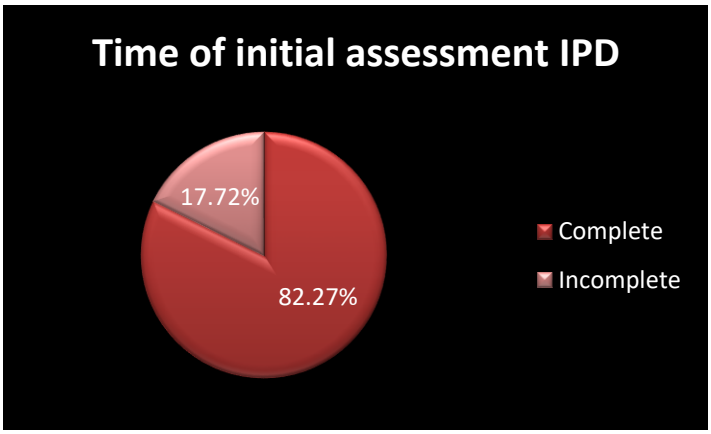
4) Time of Initial Assessment of Emergency



Interpretation

- The above pie chart depicts that out of 83 files, 38 were found to be complete, 6 were found to be incomplete and 39 files were not applicable under this parameter.
- Reason of incompleteness at times time was not mentioned on Emergency initial assessment form.

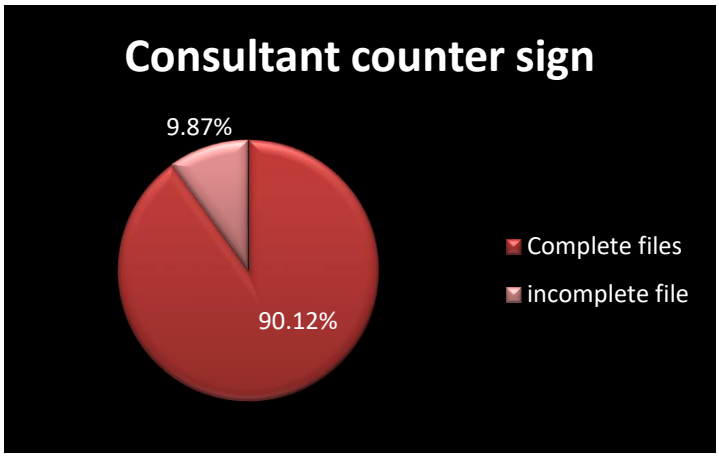
5) Time of initial assessment IPD



Interpretation

- The above Pie chart depicts that out of 83 files, 65 were fully complete, and 14 were incomplete.
- Reason for incompleteness was no time mentioned in the assessment form.

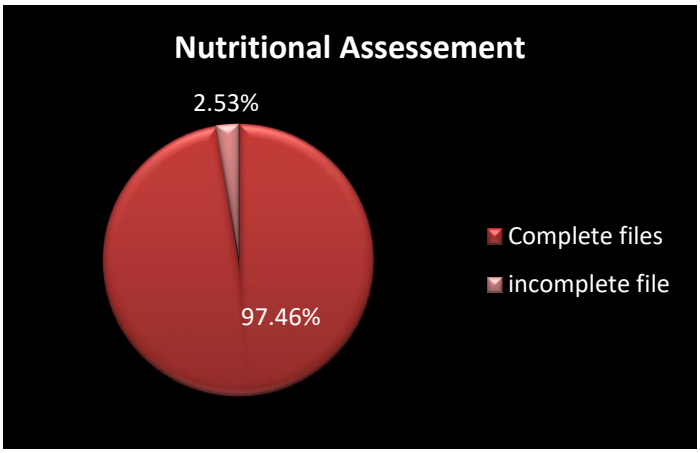
6) Consultant counter sign



Interpretation

- The above pie chart depicts that out of 83 files, 73 files were found to be complete whereas 10 files were found to be incomplete.
- Reason for incompleteness was EMR does not have slot for consultant counter sign.

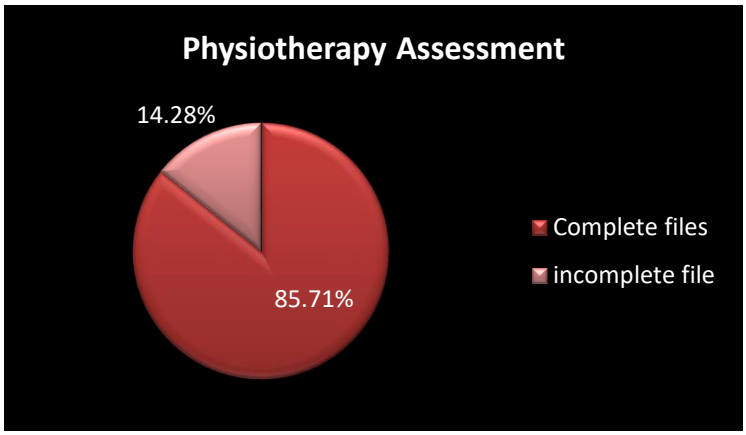
7) Nutritional Assessment



Interpretation

- The above pie chart depicts out of 83 files audit, 77 were found to be complete, and 2 were found to be incomplete while 4 file audit shows not applicable for the above indicator.

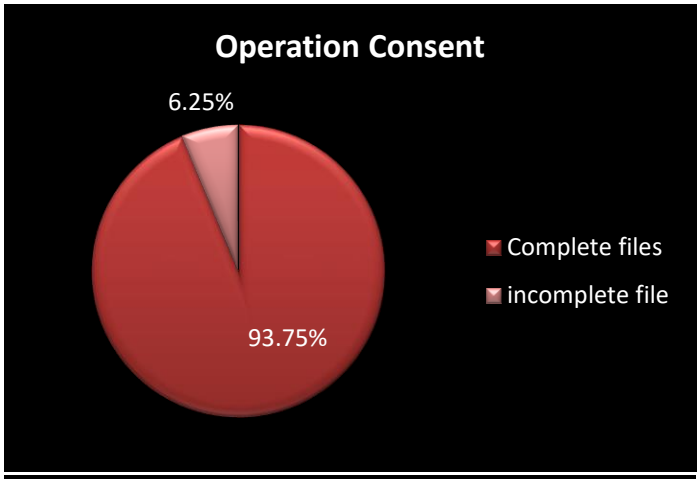
8) Physiotherapy Assessment



Interpretation

- The above pie chart depicts that out of 83 files audit, 18 were found to be complete, 3 were found to be incomplete while 62 files were not applicable under this parameter.

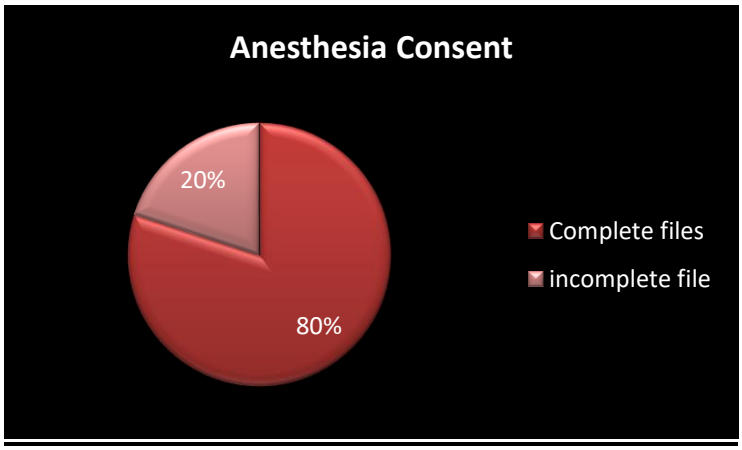
9) Operation Consent



Interpretation

- The above pie chart depicts that out of 83 files audit, 30 files were found to be complete, 2 files were found to be incomplete while 51 file were not applicable under this parameter.
- Reason for incompleteness was missing patient /attendant/ consultant signature on the consent form.

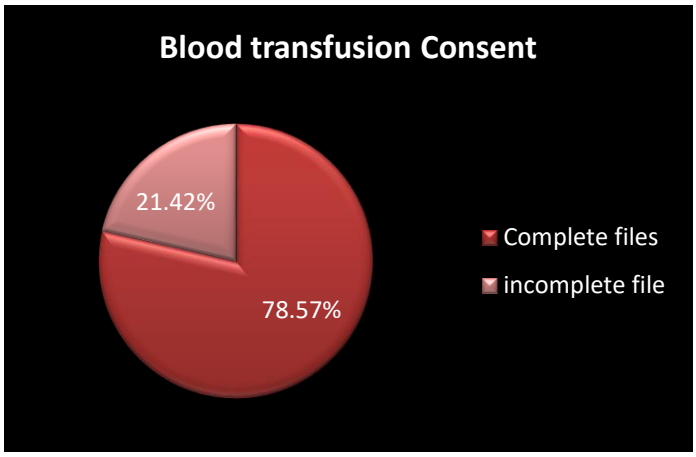
10) Anesthesia consent



Interpretation

- The above pie chart depicts that out of 83 files audit, 16 files were found to be complete, 4 files were found to be incomplete and 63 files were not applicable under above parameter.
- Reason of incompleteness was missing patient/attendant/Anesthetist signature on consent form.

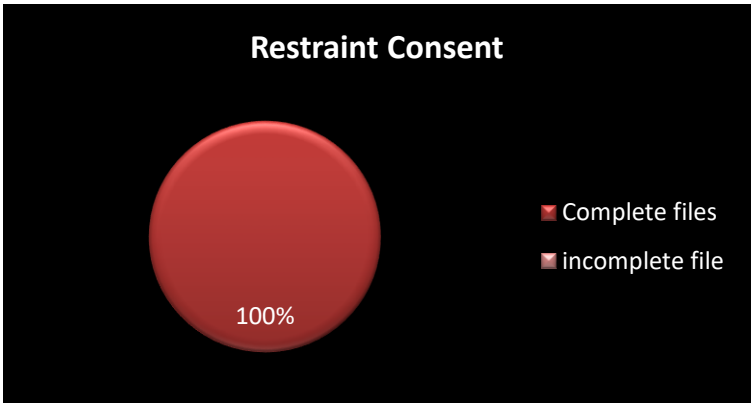
11) Blood transfusion consent



Interpretation

- The above pie chart depicts that out of 83 files audit, 11 were found to be complete, 3 were find to be incomplete and 69 files were found to be not applicable under this parameter.
- The reasons of incompleteness were patient/attendant/Anesthetist signature on consent form.

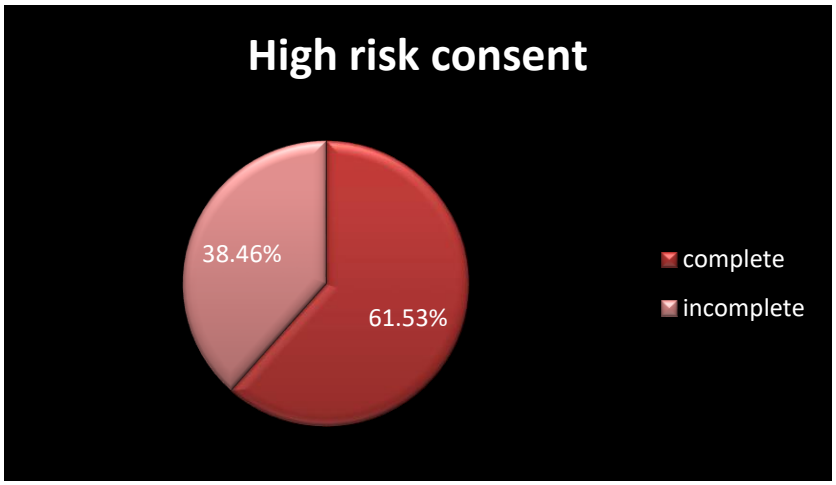
12) Restrain Consent Form



Interpretation

- The above pie chart shows 100% compliance for the above indicator.

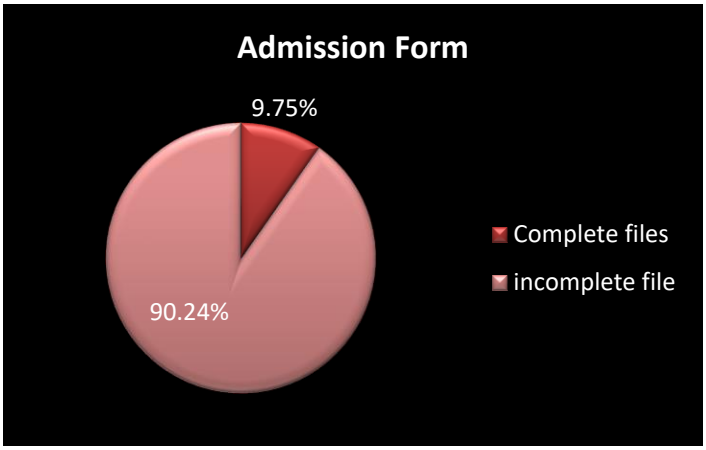
13) High risk Consent



Interpretation

- The above pie chart depicts that out of 83 files audit, 8 files were found to be complete, 5 were found to be incomplete and 70 files were found to be not applicable under this indicator.
- The reasons of incompleteness were patient/attendant/Anesthetist signature on consent form.

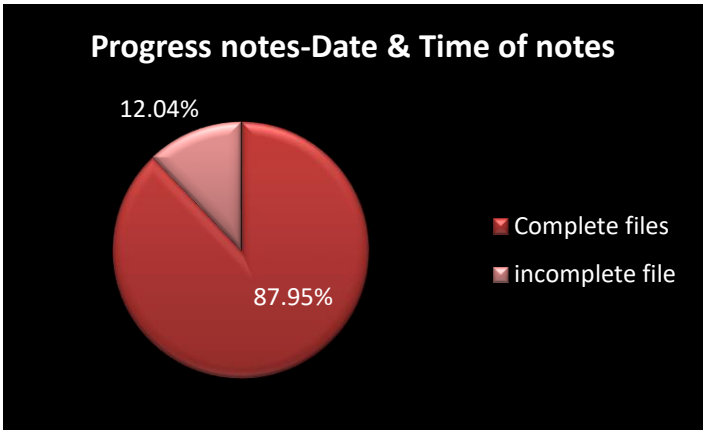
14) Admission Consent Form



Interpretation

- The above pie chart depicts that out of 83 files audit, 8 were found to be complete while 74 files were found to be incomplete.
- Reason of incompleteness was missing sign of consultant or their representative.

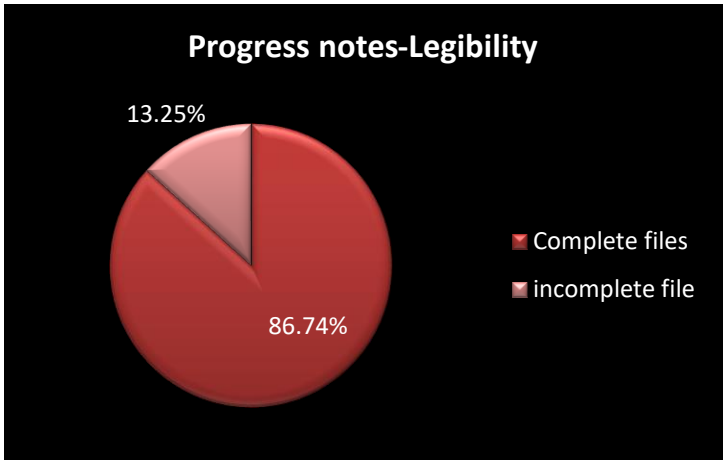
15) Progress Notes- Date & Time



Interpretation

- The above pie chart depicts that out of 83 files audit, 73 were found to be complete while 10 files were found to be incomplete.
- Reason of incompleteness was missing date & time on the progress notes.

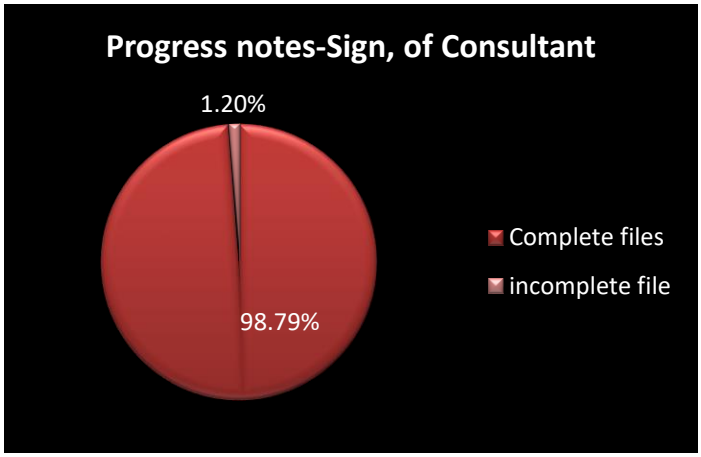
16) Progress Notes – Legibility



Interpretation

- The above pie chart depicts that out of 83 files audit, 72 were found to be complete while 11 files were found to be incomplete.
- Reason of incompleteness was legibility of progress notes.

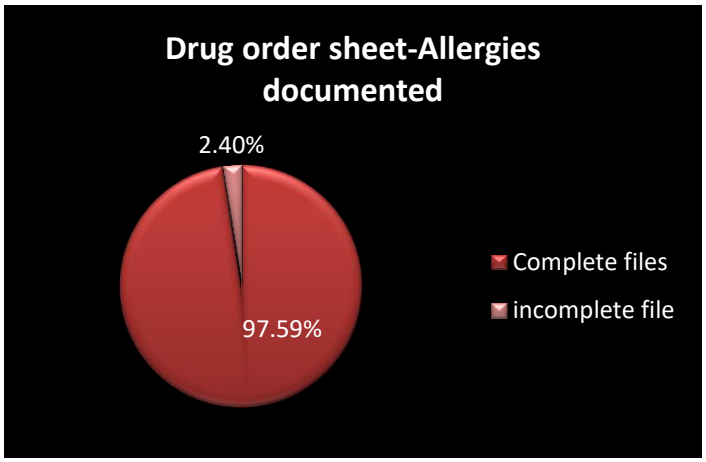
17) **Progress Notes – Sign of Consultant**



Interpretation

- The above pie chart depicts that out of 83 files audit, 82 were found to be complete while 1 file were found to be incomplete.

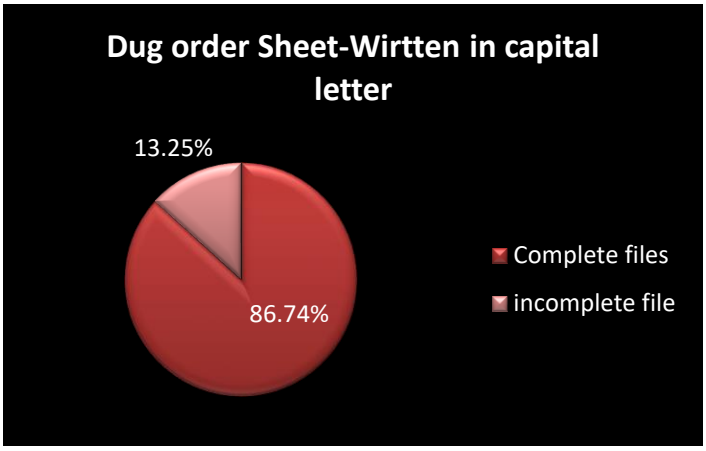
18) Drug order sheet- Allergies Documented



Interpretation

- The above pie chart depicts that out of 83 files audit, 81 were found to be complete while 2 files were found to be incomplete.
- Reason of incompleteness was at times allergies documented were found to be left blank.

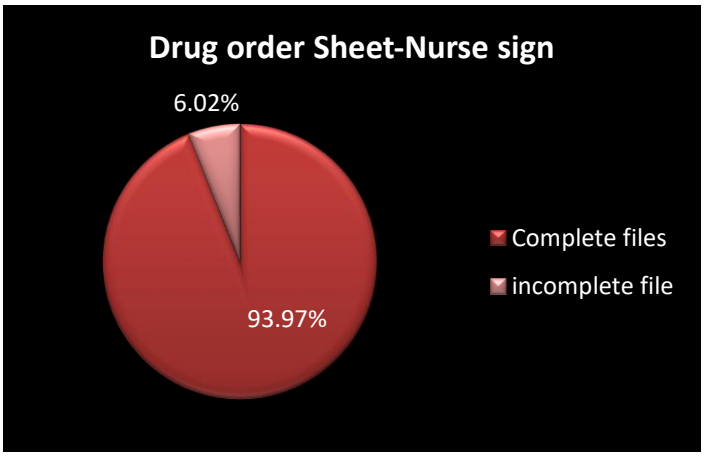
19) Drug order sheet- Written in Capital letter



Interpretation

- The above pie chart depicts that out of 83 files audit, 72 were found to be complete while 11 files were found to be incomplete.
- Reason for incompleteness was medications were not written in capital letters.

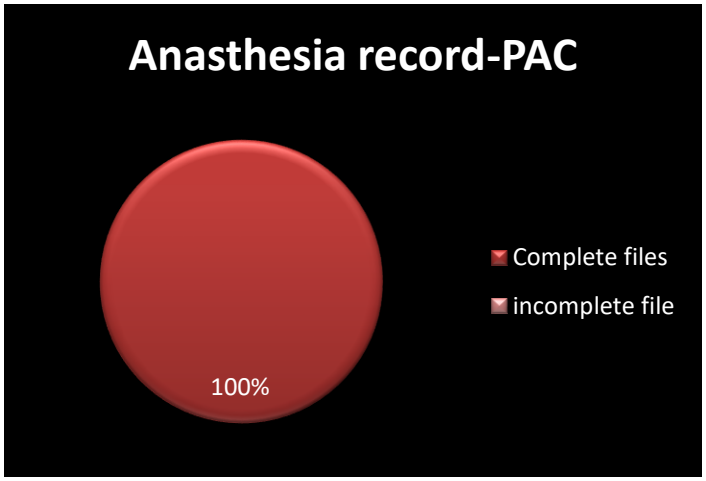
20) Drug order sheet- Nurse signature



Interpretation

- The above pie chart depicts that out of 83 files audit, 78 were found to be complete while 5 files were found to be incomplete.

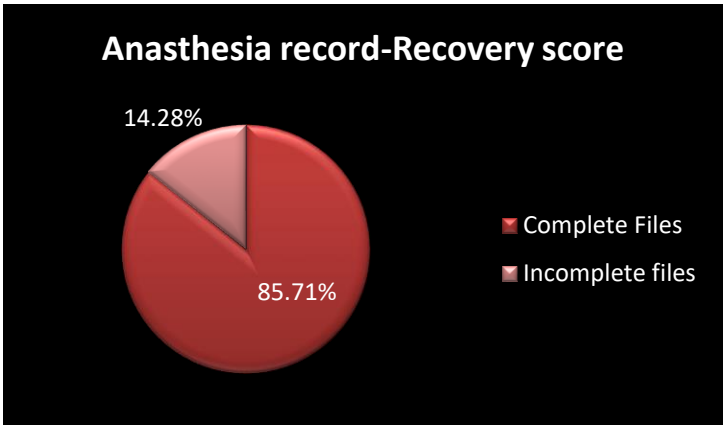
21) Anesthesia Record- PAC



Interpretation

- The above pie chart depicts that the Anesthesia record- PAC was found to be fully complete.

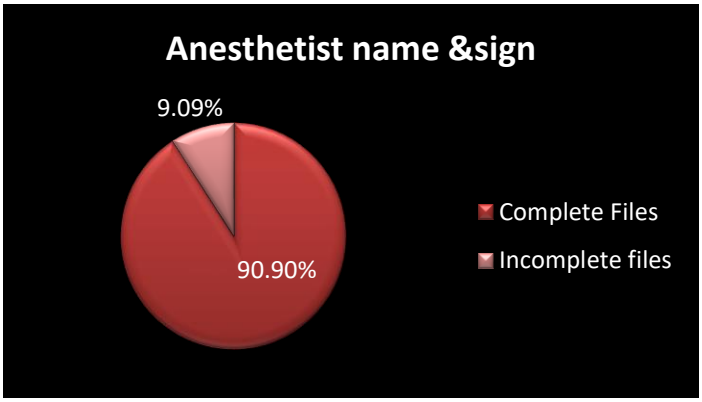
22) Anesthesia Record- Recovery Score



Interpretation

- The above pie chart depicts that out of 83 files audit, 18 were found to be complete while 3 files were found to be incomplete and 62 was found to be not applicable under above indicator.
- Reason for incompleteness was missing recovery score from Anesthesia Record.

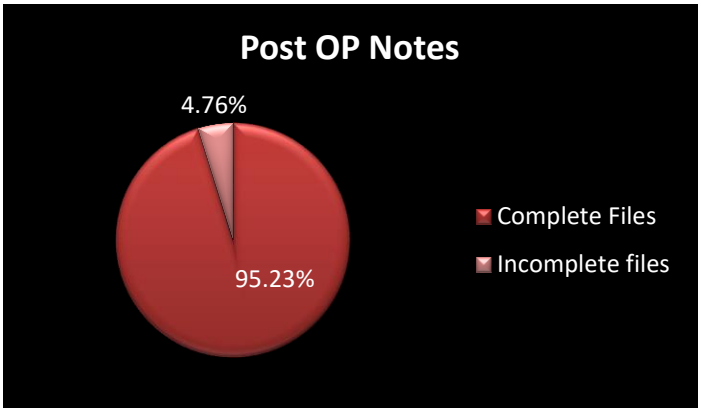
23) Anesthetist name and sign



Interpretation

- The above pie chart depicts that out of 83 files audit, 20 were found to be complete while 2 files were found to be incomplete and 61 was found to be not applicable under above indicator.
- The reason of incompleteness was missing name of anesthetist.

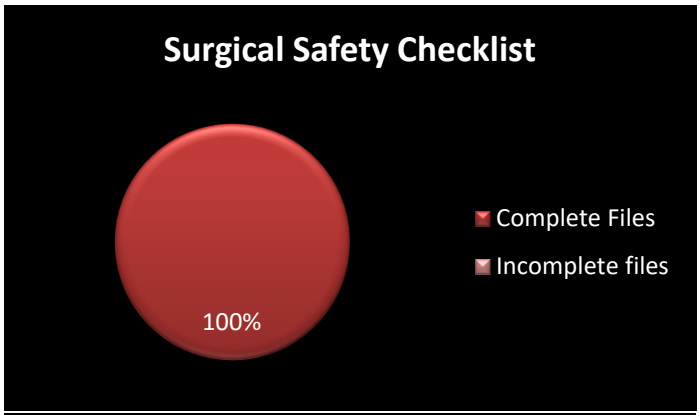
24) Surgery record – post operative notes



Interpretation

- The above pie chart depicts that out of 83 files audit, 20 were found to be complete while 1 file were found to be incomplete and 6 was found to be not applicable under above indicator.

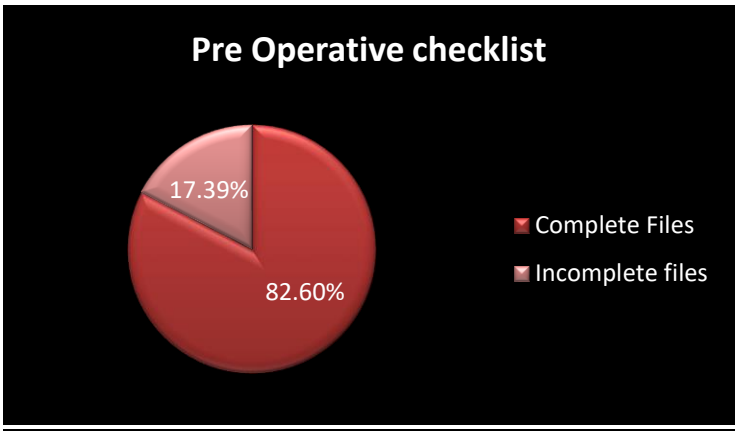
25) Surgery record – Surgical safety checklist



Interpretation

- The above pie chart depicts that surgical safety Checklist was fully compliant as per policy.

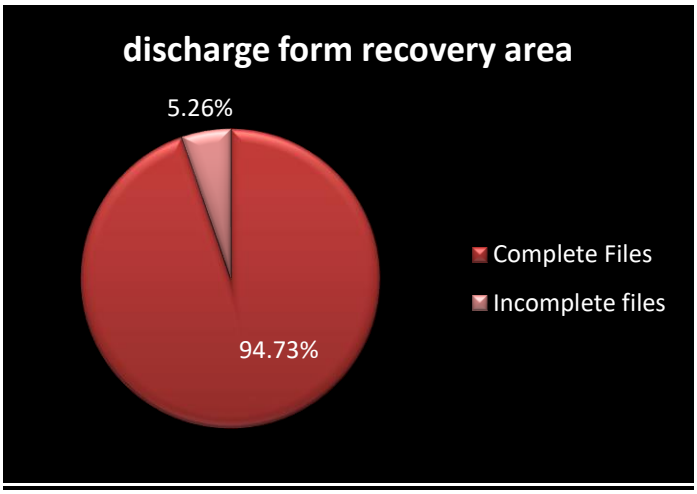
26) Surgery record- Pre Operative Checklist



Interpretation

- The above pie chart depicts that out of 83 files audit, 19 were found to be complete while 3 file were found to be incomplete and 60 was found to be not applicable under above indicator.

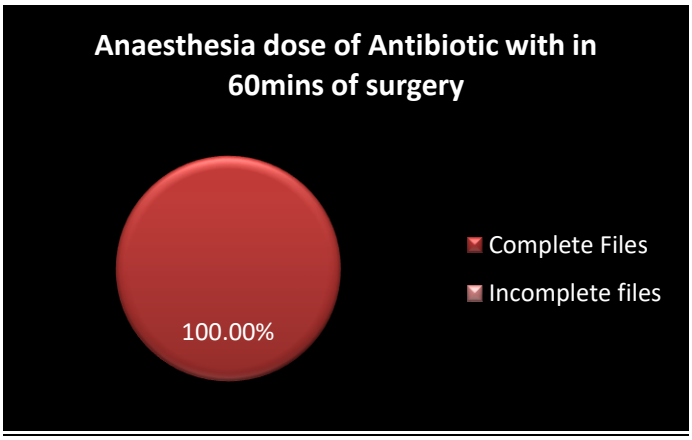
27) Surgery record – Discharge from Recovery area



Interpretation

- The above pie chart depicts that out of 83 files audit, 18 were found to be complete while 1 file were found to be incomplete and 64 was found to be not applicable under above indicator.

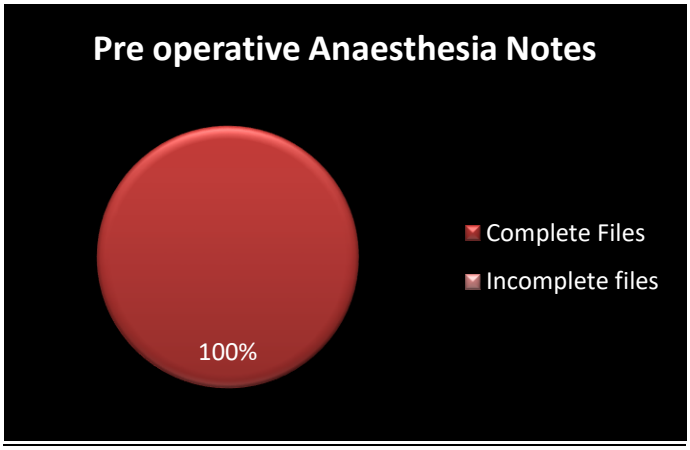
28) Surgery record – Anesthesia dose of Antibiotic within 60mins of surgery



Interpretation

- The above pie chart depicts that all the files which were audited were fully complete.

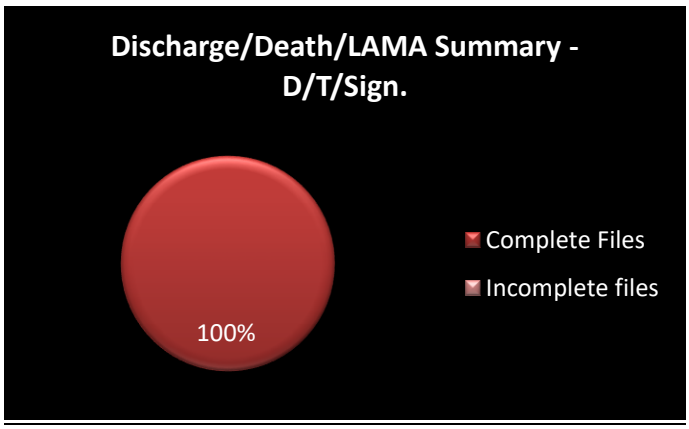
29) Surgery record – Pre operative anesthesia notes



Interpretation

- The above pie chart depicts that out of 83 files audit, 23 were found to be complete while 59 files was found to be not applicable under above indicator.

30) Surgery record – Pre operative anesthesia notes



Interpretation

- The above pie chart depicts that out of 83 files audit, 83 were found to be complete.

Suggestions

- Sensitizing the clinical staff regarding the importance of proper documentation of the medical record.
- Initial Assessment form needs to be properly standardized with respect to initial assessment form on EMR.
- Obstetrics and Gynecology department initial assessment needs to be properly aligned with other initial assessment forms and should include column for Plan of care.
- Admission Consent form needs to be modified and admission counter staff person needs to sign on the same.
- Educating and training the staff to properly fill the record on EMR.
- Monthly audit of the documentation procedure needs to be done.
- Admission Consent needs to be regularly signed by the consultant/MOD.
- MRD Audit Meeting needs to be regularly done on the monthly basics and the results needs to be shared with the concerned stakeholders

Conclusion

Medical records forms a very important and critical part of the hospital working. These records are very vital for legal purpose and for future planning of the hospital services for medical care. Hence all purpose and for future planning of the hospital services for medical care. Hence all possible steps should be taken to ensure that all the hospital medical records are maintained in systemic and orderly manner. The importance of the same should also be communicated to the staff. Periodic audits of the medical record will help to determine the deficiency in keeping records which can be improved and worked upon by the hospital.

Limitations of the Study

Due to COVID-19 Pandemic resulting in nationwide lockdown, Could only worked upon smaller sample size i.e. 10% of the number of discharges of February month.

Ethical Consideration

- Permission was obtained for conducting the File audit from Quality department of the hospital.
- Privacy, Confidentiality, anonymity was guarded during the study.
- Scientific objectivity will be maintained with honesty and integrity.

References

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- B.M Susharkar Principles of Hospital Administration and Planning, Jaypee Brothers Medical publishers (p) Ltd, New Delhi, 2000 Edition.
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