Documentation audit of medical records in a Tertiary care set up

By

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Introduction

- Quality of health care is based upon accurate, consistent and complete documentation of 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.
- 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.

- 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.

- The goal of medical audit is to provide better care delivery and to improve the financial health of the organization.

- Thus medial record audit is the great tool of attaining and maintaining the quality of healthcare delivery.

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

- 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.

Objective

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

Research Methodology

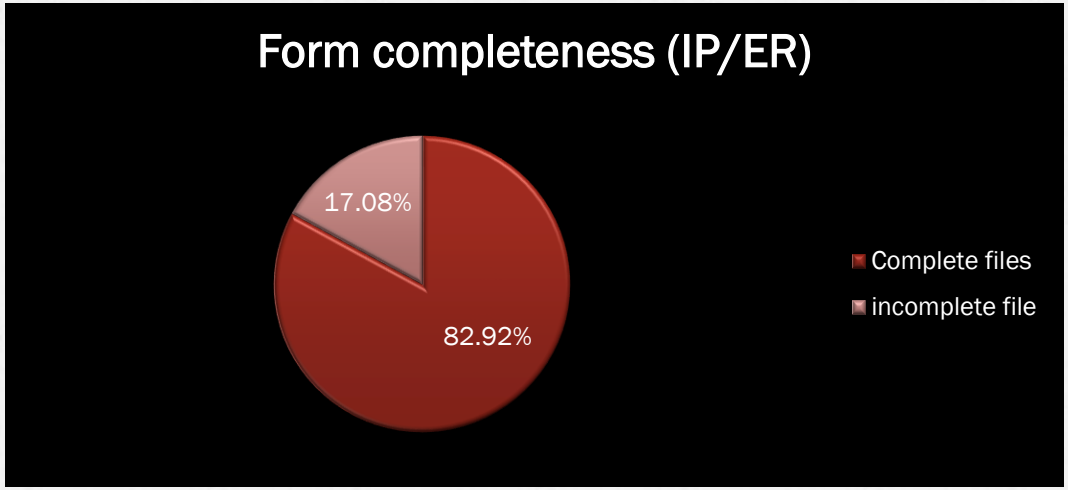
- **Type of Study:** Retrospective, Descriptive, Cross-sectional study
- **Study Approach:** Qualitative study
- **Study time:** 1 Month (24 February- 24 March)
- **Location of Study:** Hospital premises, Nayati Medicity, Mathura
- **Study Population:** Patient from inpatient ward, ICU, ER, Procedural 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.

Findings

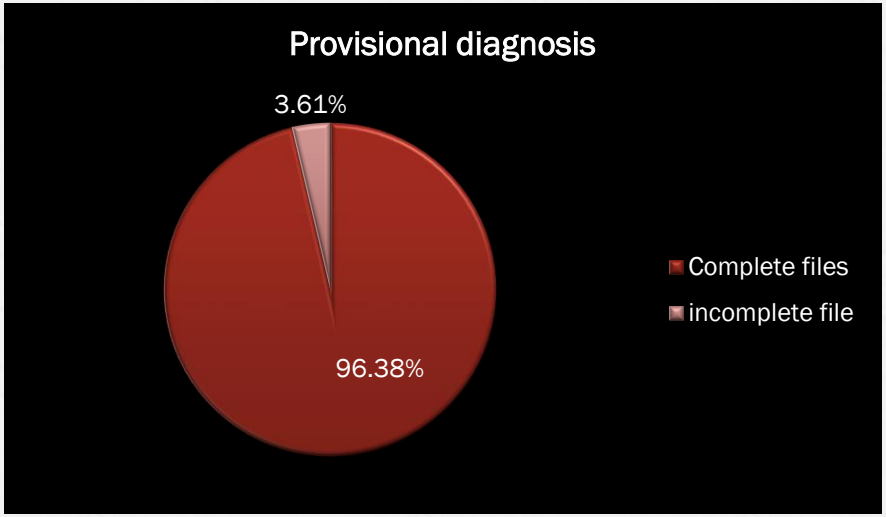
- **Assessment from Emergency and IPD**



Interpretation

- During the audit, it was observed that out of 83 files, 68 files were found to be complete whereas 14 files were incomplete and 1 file were not applicable under above indicator.
- Reason for incompleteness is missing Patient's name, initial assessment time etc.

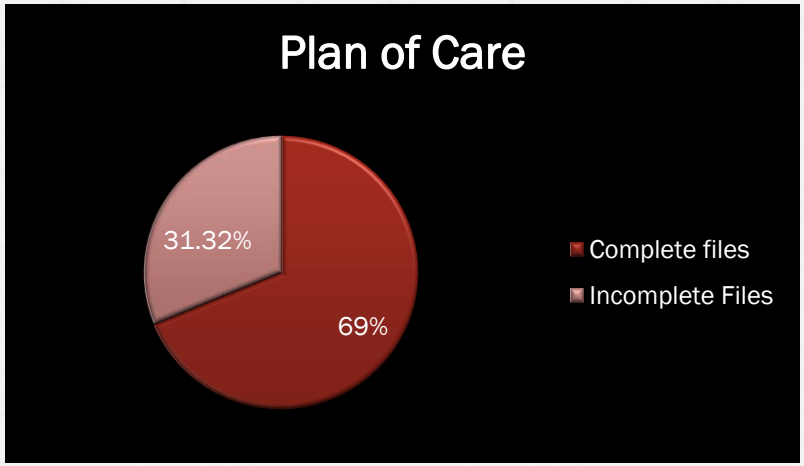
Provisional Diagnosis – IP/ER Assessment Form



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.

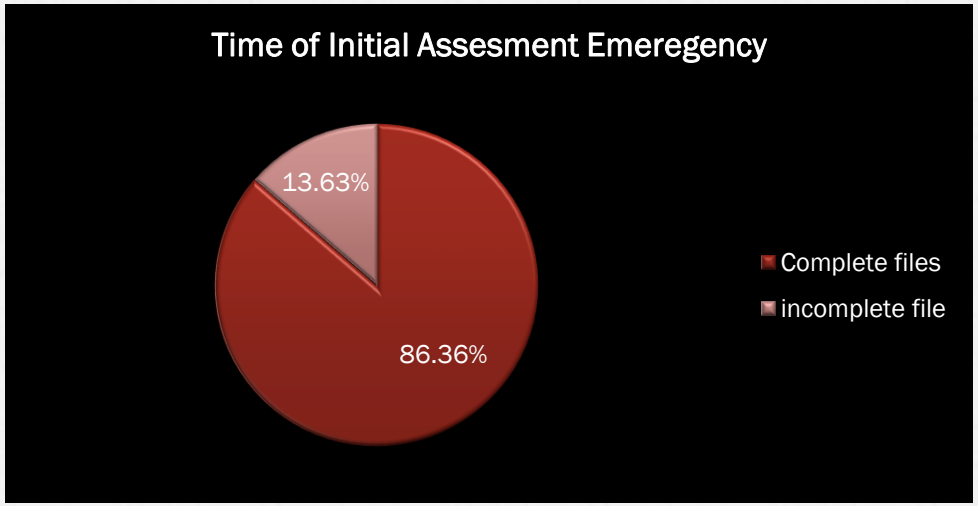
Plan of Care – IP/ER Assessment Form



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.

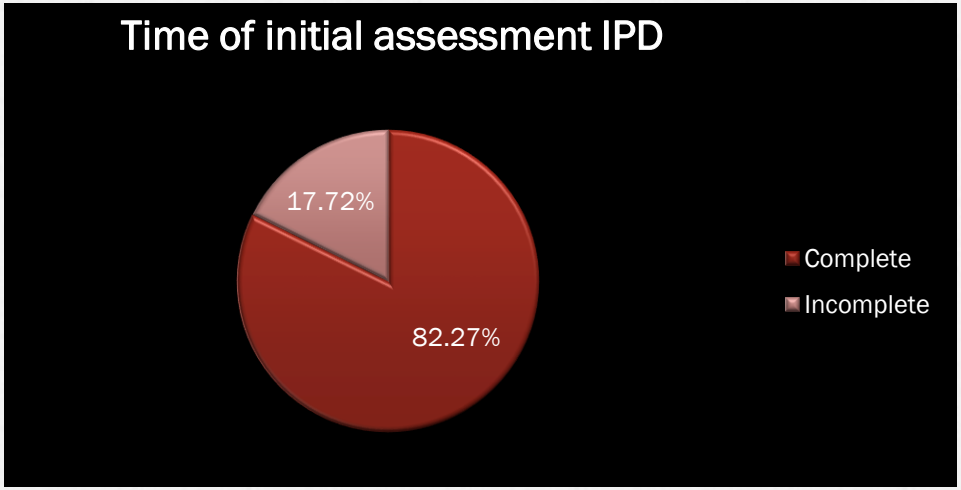
Time of Initial Assessment Emergency



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 missing Emergency Assessment time.

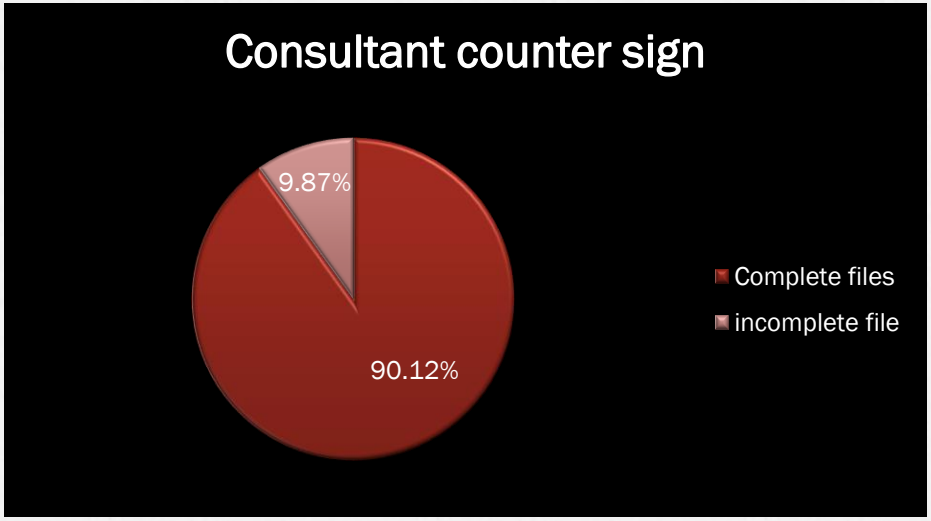
Time of Initial Assessment IP



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 IP assessment form.

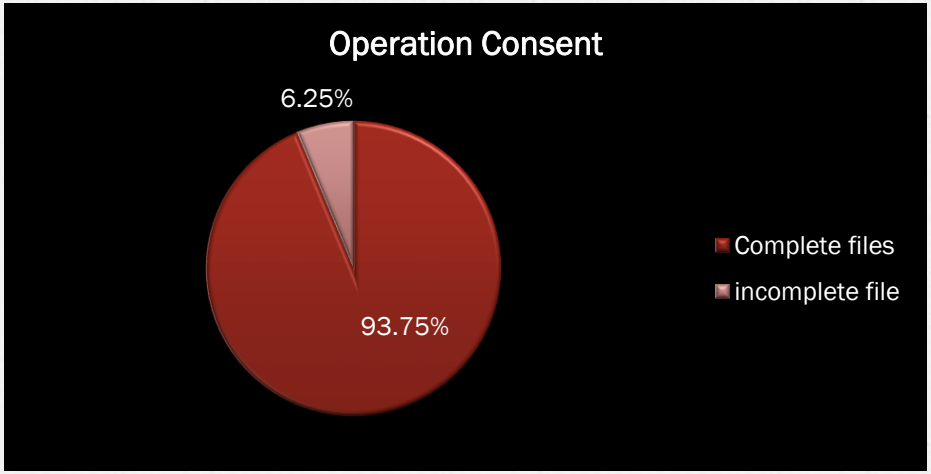
Consultant Counter Sign- Assessment Form



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.

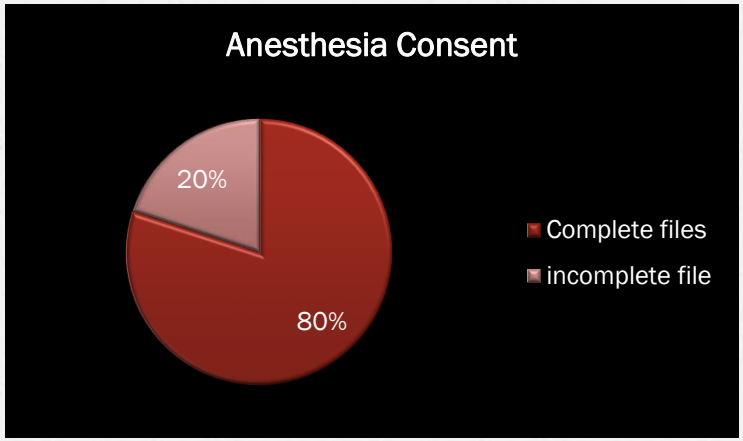
Operation Consent



Interpretation

- The above pie chart depicts that out of 83 files audit, 30 files were found to be complete, 3 files were found to be incomplete while 51 file were not applicable under this parameter.
- Reason for incompleteness was missing patient /attendant signature consultant name on the consent form.

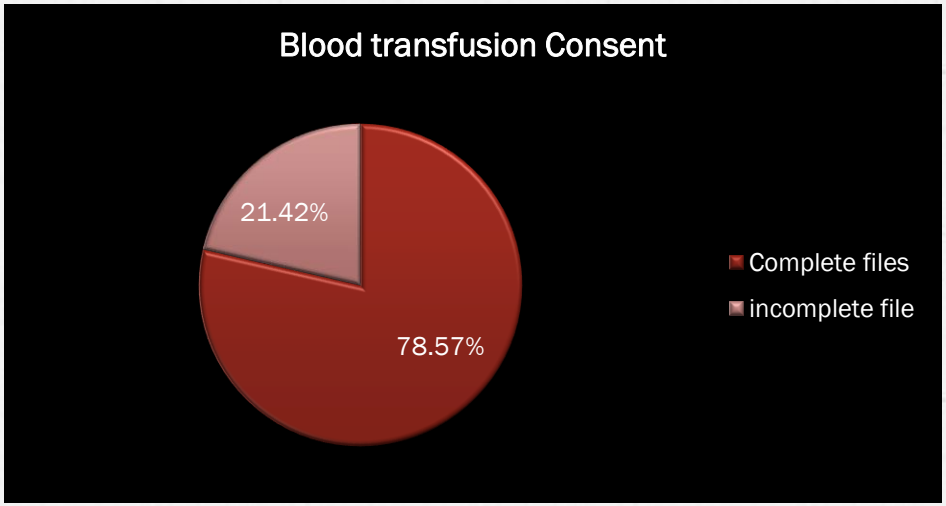
Anaesthesia Consent



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 Signature Anesthetist name on consent form.

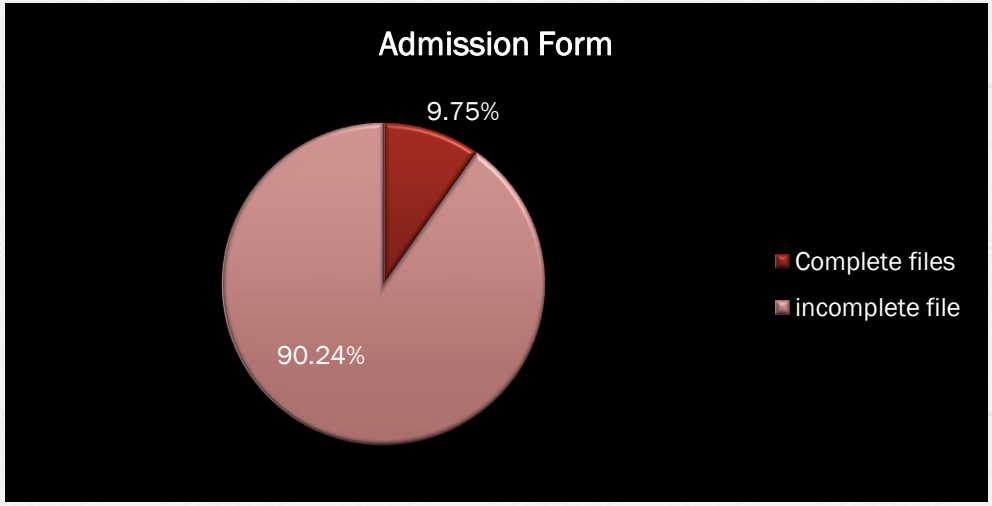
Blood Transfusion Consent



Interpretation

- The reasons of incompleteness were patient/attendant signature Consultant name on consent form.

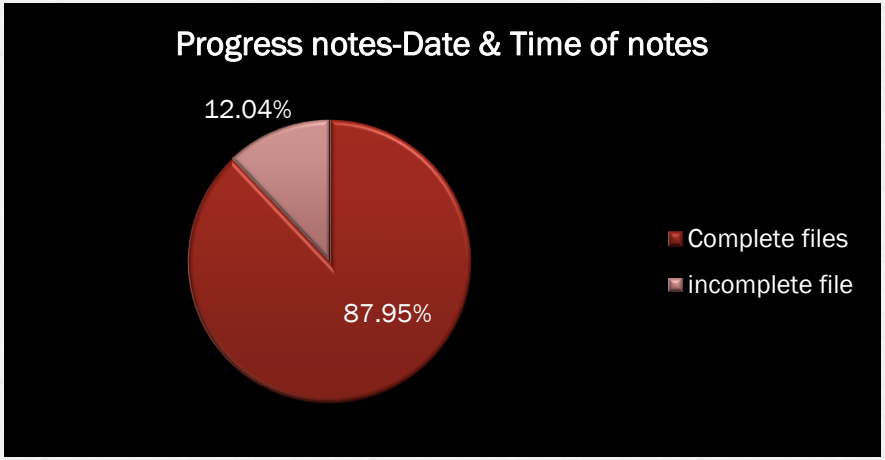
Admission Form Consent



Interpretation

- The above pie chart depicts that out of 83 files audit, 8 were found to be complete while 75 files were found to be incomplete.
- Reason of incompleteness was missing sign of consultant or their representative on Admission Form.

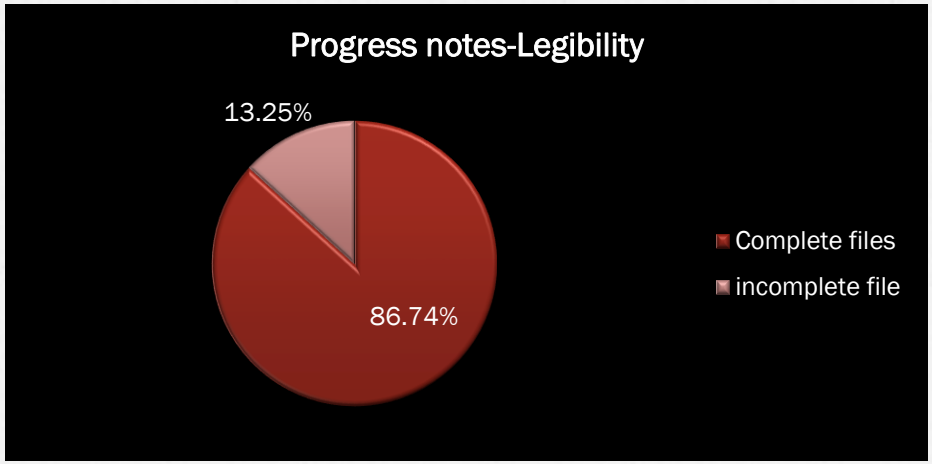
Progress Notes- Date & Time



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.

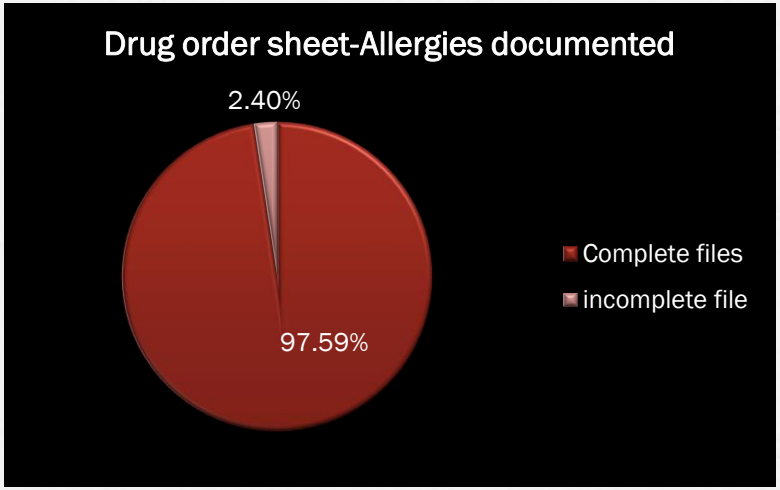
Progress Notes- Legibility



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.

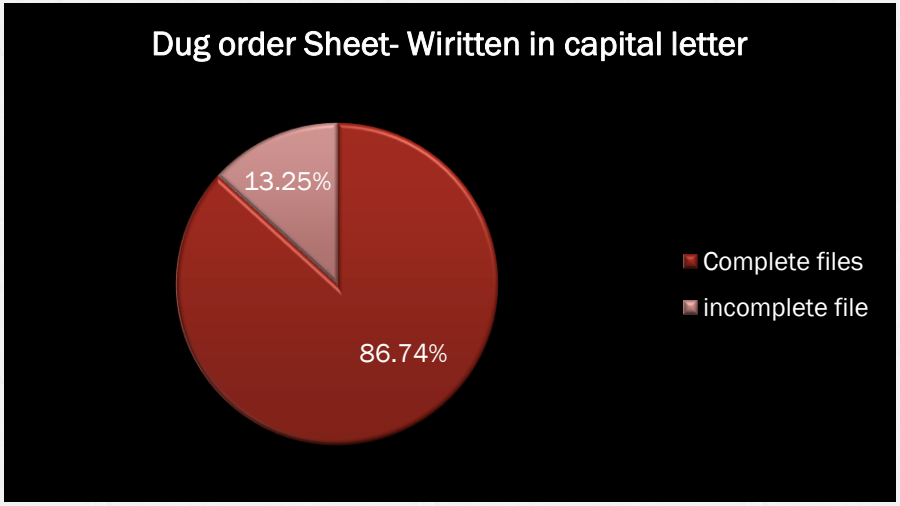
Drug order Sheet- Allergies documented



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.

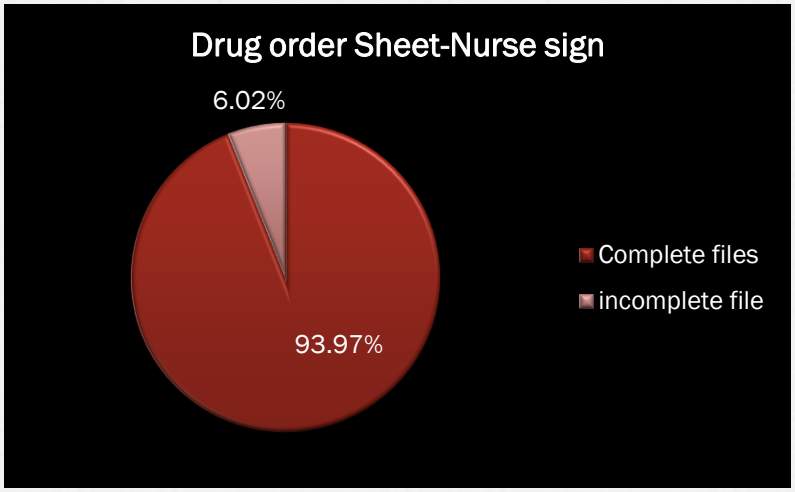
Drug order Sheet- Written in Capital Letter



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.

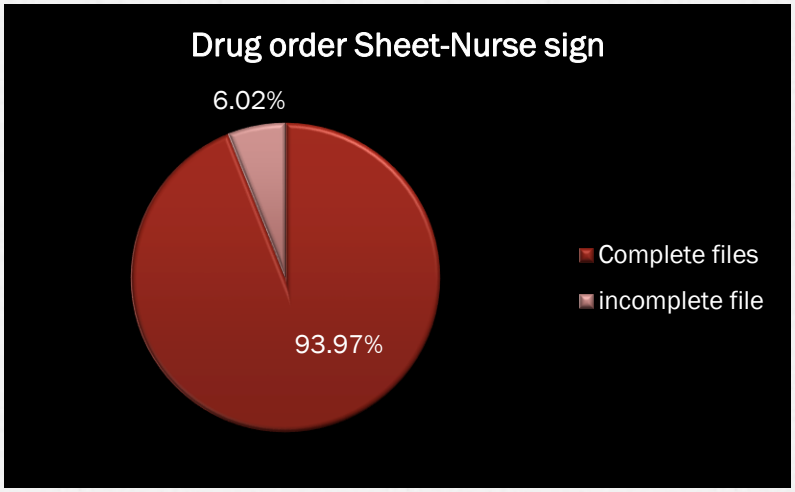
Drug order Sheet- Nurse Signature



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.

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.

Recommendations

- 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.
- Maximum use of EMR should be made in order to maintain the medical record.
- Obstetrics and Gynecology department initial assessment form needs to be properly aligned with other initial assessment forms and should include column for Plan of care.

Suggestions

- 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 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.

Thank You