

CHAPTER: 17

AUDIT OF DOCUMENTATION OF MEDICAL RECORDS AS PER NABH STANDARDS

Ritu Chandel

Student, IIHMR University

Dr. Arindam Das

Professor, IIHMR University

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INTRODUCTION

Medical records play a pivotal role in enabling healthcare professionals to plan and evaluate patient treatments, ensuring a seamless continuum of care across different providers. The precision and lucidity of information in the medical record directly influence the quality of care delivered to a patient. Maintaining comprehensive records is crucial not only to meet requirements for certification and licencing, but also to allow medical professionals to verify that patients have received the right treatment. Clinical audit is a technique that is used in quality improvement to evaluate services against predetermined criteria and facilitate required modifications in order to improve patient outcomes.. Two retrospective assessments of medical record quality were carried out using a random sampling strategy and a 48-item evaluation grid across 9 domains. The evaluation showed a significant improvement in all sections of the medical chart during the second analysis compared to the first. After an initial assessment of 1,460 medical records, a departmental audit program was established. The second evaluation, following internal auditing, was conducted on 1,402 medical records, revealing an increase in all scores above 50% [1].

A uniform, criterion-based questionnaire created within the hospital was used to evaluate routine clerking, evaluation, clinical management, and discharge quality. 1988 (before to the audit's start), 1989 (the active audit year with implicit criteria), and 1990 (the year after explicit note-keeping standards were introduced) were all covered by the audit. There was no discernible improvement in the discharge documentation or notice to general practitioners in spite of the specified criteria. The initial practice improvement was not maintained after a prolonged note-keeping audit, maybe as a result of a coincidental drop in physician performance feedback [2].

To tackle this issue, a documentation review audit tool was developed in accordance with the NABH's objective elements, focusing on essential aspects of health records. Files were evaluated using the audit tool's parameters, and compliance was assessed in three categories: Three options are available: full, partial, and non-compliance. Next, it

was determined what percentage of each health record form had been completed. Following data interpretation and analysis, doctors, nurses, and paramedical staff were informed of instances of substantial non-compliance as well as the reasons behind the non-conformance with NABH criteria. Reductions in the percentage of non-compliance were partly attributed to the following reporting of potential suggestions and recommendations [3].

RESEARCH OBJECTIVES

1. To evaluate the documentation in the inpatient medical records at a gynecology hospital.
2. To evaluate the adherence of medical records to NABH standards.

RESEARCH METHODOLOGY

The research conducted at Cocoon Hospital in Jaipur spanned 45 days and utilized an observational study design. Convenience sampling was employed, involving the study of 80 samples from medical record files in all inpatient department (IPD) wards, focusing on the Medical Record Department. Inclusion criteria covered medical record files from all IPD wards, excluding those from the NICU ward, Emergency ward, and newborns. The study employed quantitative data, utilizing a specially designed audit tool with 21 checklist points aligned with NABH Standards. Data sources included the Medical Record Active Audit Checklist and direct observations. Microsoft Excel was used for data analysis, with parameters expressed as percentages for comparative analysis. Ethical considerations were prioritized, ensuring no intervention in patient care and maintaining confidentiality in handling the collected information.

RESULTS & DISCUSSION

Observations indicated that certain record file categories demonstrated thorough documentation, encompassing a documented provisional diagnosis and care plan, countersigned care plan, documented and signed nursing care plan, and legible handwriting in

the medication chart. In contrast, incomplete documentation was identified in areas such as the history sheet, nutritional assessment, vital monitoring sheet, abbreviation in the medication chart, consent form completion and signature, and records with proper naming, signing, dating, and timing. Lockdown conditions led to communication with Dietitians solely through calls, and some doctors deviated from prescribed guidelines, emphasizing the consistent use of capital letters in prescriptions. Incomplete filling of the history sheet was noted, leaving sections blank. Recommendations include training all staff members across departments on the importance of documentation and attaching a brief audit checklist to each medical record for efficient use by other staff members upon task completion.

CONCLUSION

Medical records accurately and completely described each patient's treatment information and interactions with hospital staff. They were technically legitimate health records. In a hospital, medical records were crucial documents. Legal needs and hospital medical programs mandated the need for these documents. Every effort was made to guarantee the systematic and organized upkeep of all hospital medical records. All staff members were informed of the value of medical records. Frequent evaluation of the medical records assisted in identifying any potential flaws so that the hospital could address and correct them.

REFERENCE

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