ASSESSMENT OF QUALITY CONTROL MEASURES OF PATIENTS MEDICAL RECORDS IN ASIAN HEART HOSPITAL

A dissertation submitted in partial fulfillment of the requirement for the award of

Post graduate programme in hospital & health management

By

Kanak Lata

International Institute Of Health Management Research

New Delhi -110075

02 January to 20April, 2013

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ASIAN HEART INSTITUTE

THE HIGHEST ACCREDITED HOSPITAL IN INDIA

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Certificate of Internship Completion

Date: April 25, 2013

TO WHOM IT MAY CONCERN

This is to certify that **Ms Kanak Lata** has successfully completed her 3 months internship in **Asian Heart Institute & Research Centre, Mumbai** from **January 02, 2013 to April 25, 2013.** During her intern she has worked as Management Trainee in the Medical Records department under the guidance of dedicated team of professionals at Asian Heart Institute, Mumbai. During her tenure she has satisfactorily completed all the tasks assigned to her and has shown complete sincerity and professionalism throughout.

We wish her good luck for her future assignments.

For Asian Heart Institute

.....

Mr Mukul Sharma

Sr. Manager – Human Resources

ASIAN HEART INSTITUTE ***

Every heart deserves the best

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G/N Block, Bandra-Kurla Complex, Bandra (East), Mumbai - 400 051.
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Certificate of Approval

The following dissertation titled "***Assessment of quality control measures of patient medical record***" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post-Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name	Signature
DR. BRIJENDER SINGH DHILLON	2/5/13
Krishan Gopal	
1/5/13.	

Certification from Dissertation Advisory Committee

This is to certify that **Ms Kanak Lata**, a graduate student of Post – Graduate Diploma in Hospital and Health Management, has worked under our guidance and supervision. She is submitting this dissertation titled "**Assessment of quality control measures of patients' Medical Records**" at AHI, Mumbai" in partial fulfillment of the requirements for the award of the Post – Graduate Diploma in Hospital and Health Management.

This dissertation had the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Saumya Pathak

Dr. Dharmesh Lal
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Ms Saumya Pathak
Deputy Manager
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Date:

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FEEDBACK FORM

Name of the Student: Kanakdata

Dissertation Organisation: Asian Heart Institute

Area of Dissertation: Medical Records Department.

Attendance: 100%.

Objectives achieved: Yes.

Deliverables: ① Supervising MRD.
② ~~ISTCC~~ - co-ordinator
③ Compliance to mers. std.

Strengths: ① Hard worker
② Quick learner.
③ Very good at ~~to~~ finding solutions

Suggestions for Improvement: - Needs to increase threshold to handle pressure.

Signature of the Officer-in-Charge/ Organisation Mentor (Dissertation)

Date: 23/4/13.
Place: Mumbai.

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ABSTRACT

Assessment of quality control measures of patients medical records in Asian Heart Hospital

By

Kanak Lata

As a part of a hospital performance improvement activities & to comply with accreditation requirement., hospitals regularly access medical records based on a sample representing the practitioners providing care and the type of care provided for completeness, accuracy and

timeliness of the information they contains required by any JCI accredited hospital.

Methodology – A descriptive study was conducted in Asian heart hospital of, Mumbai for a period of 3 months. A total of 186 medical records were assessed through Simple Random Sampling method from 67 racks &7 close cabinets.7 checklist was prepared as per medical documentation criteria. To assess quality control measure adopted for patient medical record three option were included "yes", "No" and "Not applicable". Data collection took place in January to March, 2013.

Conclusion – Completeness of medical record of Content & doc. ranges from 37.5 % to 96%. Gap of 62.5% is identified which is quite high. Consent form has the highest completion rate (87.5% to 96%) where as minimum is transfer/drug expiry checklist (58.92% to 49%). Highest Completion rate for legal aspects is "all appropriate forms present" (95.69%) followed by "doc. found original "i.e. is 94.62 %.A lowest completion rate aspect is coding and indexing of disease and operation (7.52%). Highest % availability for **special form in MLC, DAMA & Expired is "**death certificate issued by DMC is 88.57% followed by report of medico legal case (received copy by police) is 85.71%.MLC registration form have minimum availability 14% followed by DAMA form 42.85%. In assessment Of Filing And Record Control Function .Highest discrepancy found in labelling of records 83.33% and the lowest is misfiled recorded (22 %). No deficiencies were found in forms design. The compliance rate of receiving patient records within 24 hrs at the time of discharge from wards for **Month of March is having highest compliance rate 99.08 % as compared to, for month of January compliance rate is 97.78 % & for month of February compliance rate is 98.68%.** Month of February & March is having highest delay hours 78 % as compared to January as 64 %. Deficiency rate of patient medical record for month of March is having highest deficiency rate (92.19 %) followed by February (95.67%) & January (87.99%).
Apart from form design assessment all others content, documentation, indicators of patient medical record are not satisfactory.

ACKNOWLEDGEMENT

Completion of any project is like another feather in the cap of an individual. For this consistent hard work, desired to succeed & last but not the least blessings of Lord Almighty are essential ingredients.

It gives me immense pleasure to complete my entire project in quality control of Medical Record Department during my stay of 3 months in Asian Heart Hospital.

For the successful accomplishment of this task I am really grateful to my mentor Dr. Dharmesh Lal sir for his valuable suggestion given to me to complete my summer internship.

I would also like to pay my heartiest thanks to the Medical director (Dr.Vijay D'Silva) Sir & My mentor in the hospital Shruti Chavarkar, for his/her kind support, cooperation & guidance given to me for the successful completion of my project .

Last but not the least I am really thankful to the entire staff of Asian Heart Hospital, nurses & consultants for cooperating in my study & making my study a memorable experience for lifetime.

With regards

Kanak lata

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25.	25.	To estimate deficiency rate of patient medical record on monthly basis.	35

ACRONYMS / ABBREVIATIONS

S.NO	ACRONYMS	FULL FORM
1.	**MRD**	**Medical record department**
2.	**IPD**	**Inpatient department**
3.	**OPD**	**Out Patient Department**
4.	**USAID**	**United state agency for international development**
5.	**MLC**	**Medico legal cases**
6.	**DAMA**	**Discharge Against Medical Advice**

MAIN TEXT

QUALITY CONTROL OF PATIENT MEDICAL RECORD

INTERNSHIP REPORT

1. 1ntroduction to organisation

Asian Heart Institute (AHI) has been set up with an aim to provide world-class cardiac care in India. It is situated at the Bandra-Kurla Complex (BKC), a mere 15-minute drive from the domestic and international airports. The hospital promises to provide quality cardiac care to patients at reasonable costs.[i]

A dream of leading cardiac specialists of Mumbai, Dr. Ramakanta Panda, Dr. Sudhir Vaishnav, and Dr. Tilak Suvarna. AHI was set up with a holistic approach to heart care based on ethics, quality care and professional backed by competitive prices. It prides itself on quality in terms of design, patient care, medical, paramedical and general staff and infrastructure facilities.[ii]

The hospital has a Patient-centric design with stress on safety and comfort of Patients. All Patient areas have been designed to minimize the risk of infection. Internationally accredited with ISO

9001:2000, JCI & NIAHO, AHI reaffirms its commitment towards world class cardiac care by being the India's Highest Accredited Hospital.[iii]

The hospital was started to set a benchmark in quality care, ethical practice, reasonable costs and training for those in the profession. Patients are not charged premium rates for the care they receive. In fact, the charges are reasonable and probably even 10-15 per cent cheaper compared to other hospitals.[iii]

OUR MISSION

- To operate as a world – class heart hospital, incorporating the latest technological advances and ethical practices to provide quality heart care at reasonable cost.

OUR VISION

- Globally preferred centre of excellence

OUR VALUES

- Our Core Values
- Customer Satisfaction
- Highest Quality
- Culture of High Performance
- Integrity & Ethical Practices
- Innovation & Change

PROGRAM

- Asian Heart Health Check - Up Schemes
- Health Check-up Program for International Patients

SPECIALITIES

- Robot-assisted surgery
- Cardiac surgery
- Coronary artery bypass surgery
- Cardiology

- Children's heart centre
- Preventive cardiology and rehabilitation
- Physiotherapy
- Executive health check-up
- Laboratory medicine
- Radiology
- Chest pain

INTRODUCTION OF MEDICAL RECORD DEPARTMENT

A medical record (MR) is the chronological documentation of medical treatment and other health care delivered to a patient by professional members of the health care team. It is an accurate, prompt recording of the team's observations about the patient, the patient's medical progress, and the results of treatment. It is a means of communication among health professionals, a legal document, and a tool for medical research and training. It is also the primary means of evaluating the quality and appropriateness of medical care rendered, as well as a source document for statistical use in research, planning, and budgeting. Finally, it is the original-source document for financial activity involving patient care.[iv]

The medical record department maintains records and documents relating to patient care. Among a host of activities, its main functions are filing, indexing and retrieving of medical records. The primary purpose of the department is to render service to patients, medical staff and hospital administration in support of good patient care. The quality of care rendered depends upon the accuracy of information contained in the medical records, its timely availability to, and the extent of utilization by the professional staff. To achieve economy, accuracy of information, and good communication, which are of vital importance to medical record system, all the information should be concentrated in the original medical record of the patient.[iv]

Three basic principles of the medical record are:

a] They must be accurately and clearly written.

b] Properly indexed and filed.

c] Easily accessible to the relevant clinical personnel.

Medical records are used as primary tools for evaluating the quality of patient care rendered by medical staff and suggest for improvements if need to be. The medical records are widely used for teaching and research purpose.[iv]

In the context of increasing malpractices, liability suits against hospitals and physicians, a good documented medical record is a good protection. The department starts functioning from 9.00 a.m. to 6.00 p.m.[iv]

Department consist of 56 IPD racks, 11 OPD racks & 7 close cabinet. Each rack has 3 shelves. Hospital uses unique no. for MR numbering. The patient has same MR NO. for outpatient, admission & day-care. Hospital uses serial straight filing system.[iv]

Storage period of patient medical record [iv]

IPD files of 5 years are preserved,

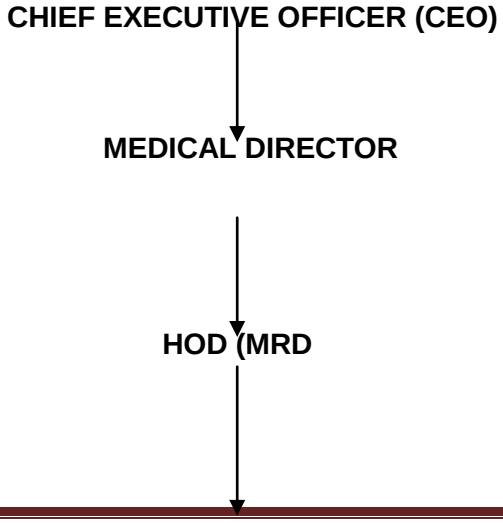
OPD case sheet for 2 years

MLC,LAMA& EXPIRED for 10 years

LIST OF FORMS AND RECORDS [iv]

Sr.No.	List of Forms and Records	Location
1.	OPD File Transaction Registers	Medical Record Department
2.	Mediclaim, certificates and Indoor case papers Register	Medical Record Department
3.	Railway Concession Certificate Form	Medical Record Department
4.	DEATH Files Register	Medical Record Department
5.	Deficiency Checking Form	Medical Record Department
6.	Assembling form	Medical Record Department

ORGANOGRAM [iv]



MEDICAL RECORD SUPERVISOR

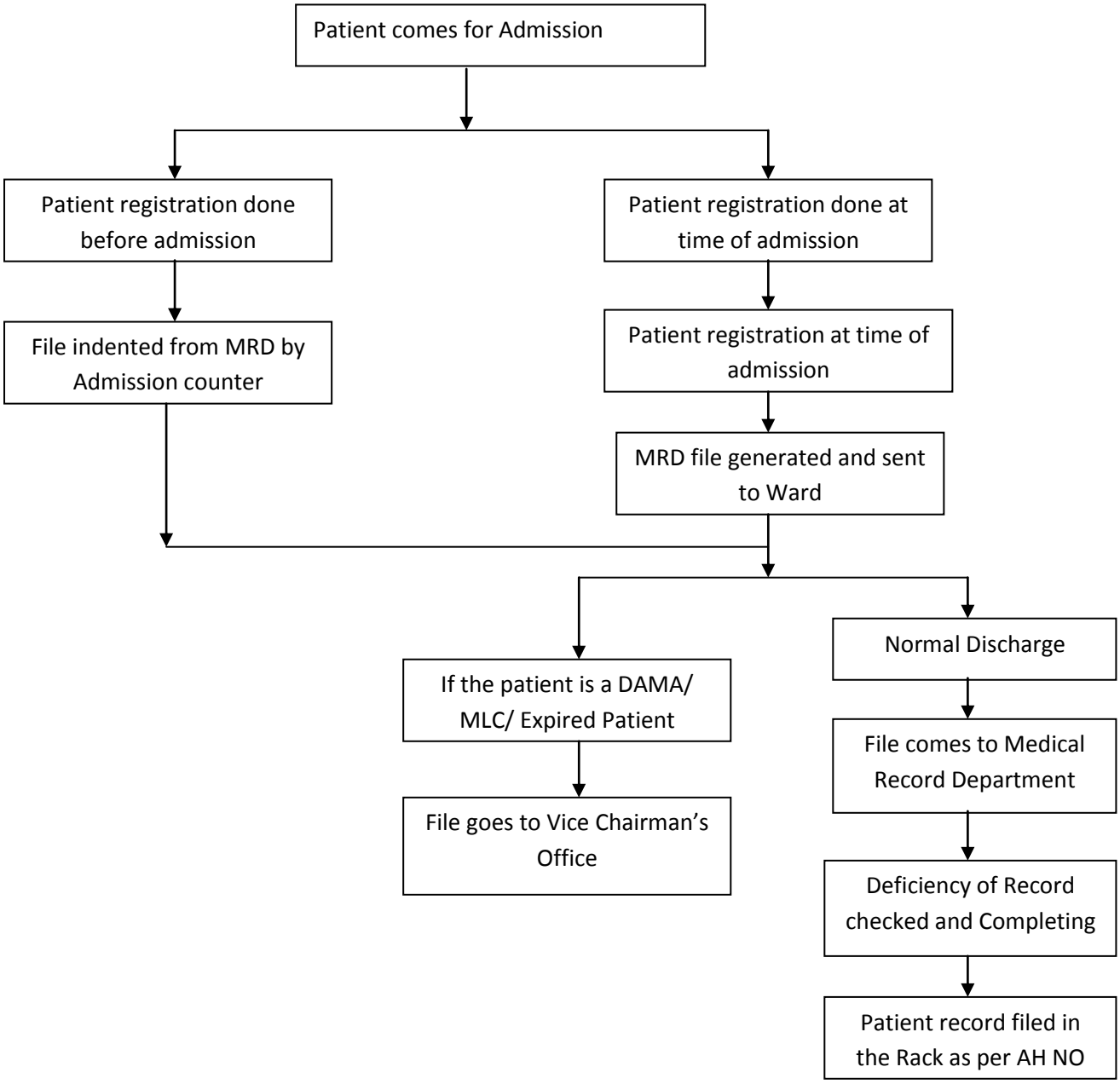
↓

MEDICAL RECORD ASSISTANT

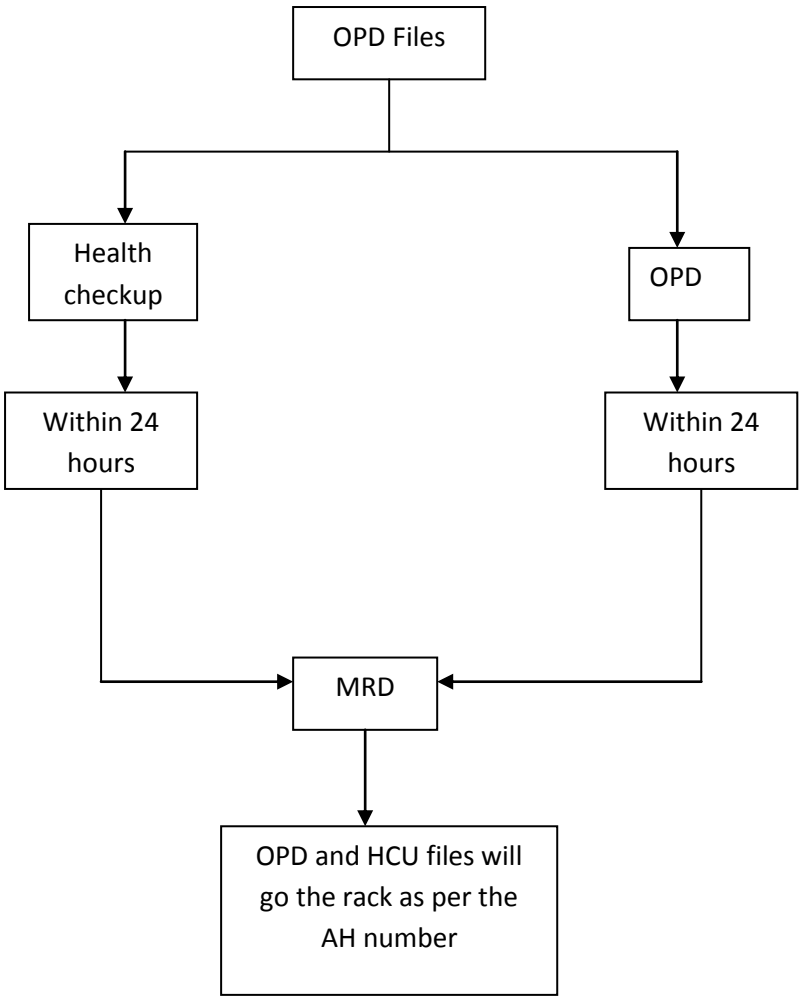
↓

MEDICAL RECORD ATTENDANT

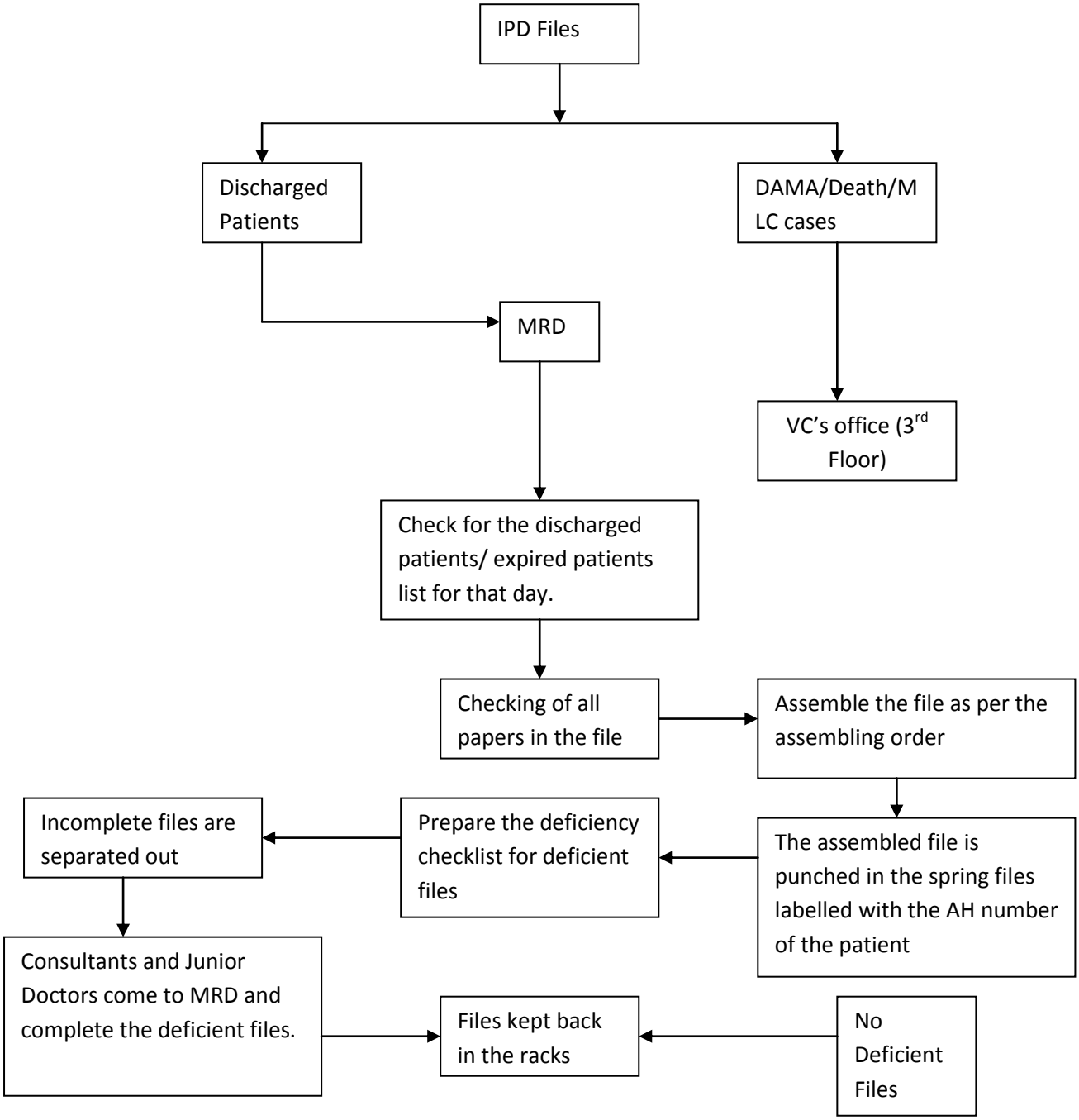
MEDICAL RECORD TRANSACTIONS - IPD [iv]



MEDICAL RECORD TRANSACTIONS – OPD[i] [v]



PROCESS FLOWCHARTS [iv]



QUALITY OBJECTIVES [iv]

- To give quality service to the patients by maintaining his / her records properly.

- To check the different entries and to see that all the relevant papers are in order.

- To facilitate easy and quick retrieval of record whenever needed.

- To part with the information whenever / wherever needed to authorize persons only.

- To complete the files within 24hrs of date of discharge of patient.

- To retrieve the file within 30 minutes maximum from the time of indent.

- To submit the original reports of TPA and credit patients to billing department on same day of papers are received from other department.

DEFICIENCY CHECKING OF INPATIENT FILES [iv]

RESPONSIBILITY : Deficiency checking of files done by MRD supervisor and MRD assistant.

PROCEDURE :

1. Once the files are assembled, punching and filing is done in the spring files. The deficiency checking of files is done to check for the completeness of IPD files.

2. Deficiency Checking is done with respect to the discharge record, discharge summary Operation procedure record, day-care record and history / physical examination.

3. The following important papers are checked for deficiency:

a. **Discharge Record** (status, final diagnosis, secondary diagnosis, operation procedure, and signature of the consultant and junior doctor).
b. **Discharge Summary** (Written and signed by the Junior Doctor).
c. **History / Physical** (Written and signed by the Junior Doctor).
d. **Operation / Procedure Record** (Written by the consultant and signed by the Junior Doctor).
e. **Daycare Record** (Written and signed by the Junior Doctor).

4. Once the files are complete, they are kept back in the racks.

5. With respect to death, DAMA and MLC files, the deficiency checking is done and the incomplete files are then completed with the help of junior doctors and consultants.

CHECKLIST FOR ISSUING OF INDOOR CASE PAPERS [iv]

PROCESS FLOW	
Written application for Indoor Case papers from Patients [self application Or relatives apply] Or Insurance company [NOC is required from the patient	
Applications collection in MRD	
Show file to the treating Consultant and get approval	
Compile papers, photocopy of the Indoor case papers and numbering on each page is done	
Signature of the treating doctor on the documents	
Checked by the MDO	
Documents send to the Admission counter form MRD	
Documents collected by the patient Or patients relatives Or Insurance company agent after collecting charges of photocopy.	
Acknowledgement to be taken form the receiving person on the MRD Application form.	
MRD Application form to be attached to the patients file and photocopy of the same is maintained in a separate Folder.	

ISSUING CASE SUMMARY TO EXPIRED, DAMA AND MLC CASES [iv]

RESPONSIBILITY : Issuing Case Summary to Expired, DAMA and MLC cases

PROCEDURE :

.NO	ACTIVITY	ACTION BY	REF.DOCUMENT
2.1	Written application for case summary from Patients [self application Or relatives apply] Or Insurance company [NOC is required from the patient]	Application received by Admission counter staff	A Mediclaim Register is maintained separately for receiving mediclaim forms at Admission counter.
2.2	Applications collection in MRD	All MRD staff	Mediclaim Register signed by the MRD Staff as received.

2.3	Show file to the treating Consultant and get approval	MRD Officer	Patient Complete file.
2.4	Compile paper, photocopy of the CASE SUMMARY is done	All MRD staff	As per the requirement of the application
2.5	Signature of the treating doctor on the document	Treating Consultant	As per the requirement of the application
2.6	Checked by the MDO	MDO	As per the requirement of the application
NO.	**ACTIVITY**	**ACTION BY**	**REF.DOCUMENT**
2.7	Documents send to the Admission counter form MRD	All MRD staff	As per the requirement of the application
2.8	Documents collected by the patient Or patients relatives Or Insurance company agent after collecting charges of photocopy.	Application given by Admission counter staff	As per the requirement of the application
2.9	Acknowledgement to be taken form the receiving person on the MRD Application form.	Admission counter staff	MRD Application form.
2.10	MRD Application form to be attached to the patients file and photocopy of the same is maintained in a separate Folder.	All MRD staff	MRD Application form.

ISSUING OF MEDICAL CERTIFICATES [iv]

RESPONSIBILITY : Issuing Medical certificate is the responsibility of MRO

PROCEDURE :

.NO	ACTIVITY	ACTION BY	REF.DOCUMENT
2.1	Written application for Medical certificate from Patient [self application Or relatives apply] Or Insurance company [NOC is required from the patient]	Application received by Admission counter staff	A Mediclaim Register is maintained separately for receiving mediclaim forms at Admission counter.
2.2	Applications collection in MRD	All MRD staff	Mediclaim Register signed by the MRD Staff as received.
2.3	Show file to the treating Consultant and get approval	MRD Officer	Patient Complete file.
2.4	Medical Certificate is prepared	MRD Officer	As per the requirement of the application
2.5	Signature of the treating doctor on the document	Treating Consultant	As per the requirement of the application
2.6	Checked by the MDO	MDO	As per the requirement of the application
No.	**ACTIVITY**	**ACTION**	**REF.DOCUMENT**
2.7	Documents send to the Admission counter form MRD	All MRD staff	As per the requirement of the application
BY 2.8	Documents collected by the patient Or patients relatives Or Insurance company agent.	Application given by Admission counter staff	As per the requirement of the application
2.9	Acknowledgement to be taken form the receiving person on the MRD Application form	Admission counter staff	MRD Application form.
2.10	MRD Application form to be attached to the patients file and photocopy of the same is maintained in a separate Folder.	All MRD staff	MRD Application form.

RATIONALE OF THE STUDY

ASIAN HEART HOSPITAL is having highest accreditation with JCI, ISO, NIAHO.

So a medical record (patient medical record as per joint commission international documentation) is a systematic documentation which serves as the business record for a patient encounter for every patient assessed or treated in a health care organization as an inpatient, outpatient or urgent care patient.

JCI accredited standards of accreditation for this hospital require the data be collected in a timely and efficient manner using the degree of accuracy and completeness necessary for the data's required use.

Thus this hospital by laws or policies requires medical staff members to complete patient record within specified time and include checking measures for those who fail to comply. So the hospital should make sure that they are compliance with all standards requirement required of patient medical record.

- ajlouni, musa. may 2006. *assessment of medical records services at ministry of health hospitals in jordan.* bethesda, md: the partners for health reform*plus* project, abt associates inc.: completeness of mr contents is 21□95% in all hospitals; completion rate of operating was the highest (70.95%) of history and physical exam reports the lowest (21.58%).

- Assessment Of Medical Documentation As Per Joint Commission International(R. K. Sinha*, D. Saha**, Prathibha N. R.***A total of 49% non compliance was seen in General consent in respect to the signature of doctors with date, whereas, 18% of anesthesia forms failed to provide any evidence of anesthesia . It was found that the standard documentation of the discharge summary was most dissatisfactory where 44% of discharge summary does not comply with criteria of JCI.

PROBLEM STATEMENT

- With increasing use of medical insurance for insurance for treatment .The insurance co. ask for patient medical record. It was found issuing improper medical record was resulting in not passing mediclaim by insurance company. Thus dissatisfaction of patient was increasing day by day for hospital.

- Doctor asking record for follow-up where having deficient record. Thus in result visiting OPD hrs where delayed.

- Unnumbered, misfiled patient record created confusion & delay in departmental work.

- Many MLC issues where pending because special form related MLC where missing.

- Missing MLC, EXPIRED, DAMA stamp and form created confusion in segregation of these records in medical record department. Patient asking for modification which to be made in case summary because time and date of are not matching with death certificate .

- Request of medical record made by patient was no made within 72 hrs because many records after discharge where not send to MRD within 24 hrs.

- Old patient records of 5 years ago where form design not in standard format. Thus many record papers were projection out from patient medical record.

- On daily basis record received from wards, ICU, day-care having deficiency were increasing day by day which would result in record going back to particular department and thus files receiving within 24 hrs would delayed.

REVIEW OF LITERATURE

1. Assessment of Medical Records Services at Ministry of Health Hospitals in Jordan[v]

FINDINGS

.

MR forms design

Deficiencies were found in admission and discharge records in all hospitals. Some form titles did not match form contents. The weight of paper used is below standard. In eight hospitals, four-page cards of a heavier stock were used for outpatients as substitute for medical records.

MR forms control and management

In all hospitals, the supply department controls the forms' stock room. Production of new forms is decided by the central MOH. Shortage of forms was not reported by any hospital.

In most hospitals, records are kept in the active filing area for one year only. MRs of patients discharged in previous years often were found in remote sites, bundled by year of admission.

Functions

Filing and record control

Eight hospitals lack the one-unit numbering and filing system (i.e., the patient has separate MR for outpatient visits, admission, and emergency). Three hospitals (Princess Basma, Princess Raya, and Princess Rahma) use the National Number for MR numbering.

Filing systems are not standardized. Seven hospitals use the terminal digit filing system, while the remained four hospitals use the serial straight filing system.

Two hospitals (Princess Raya hospital and Princess Rahma hospital) only use the out-card system (records tracing). The percentage of compliance of out-card documentation is 80–95% in both hospitals.

Nine hospitals have overcrowded shelves (more than 80% of storage capacity is used).

For all hospitals, the percentage of misfiled records is 3–5%, the percentage of folders with pages (papers) projecting out is 4–20%, the percentage of folders with illegible names and/ or numbers is 0%–5%, and the percentage of duplicate records (more than one record for the same patient) is 2–6%.

MR content and documentation

No hospitals review MR contents for completeness. The MOH allows patients to keep their cards at home, which raises confidentiality issues.

Basic and special forms were available in all MRs of each hospital. However, the contents of these forms have many deficiencies. Completeness of MR contents is 21–95% in all hospitals; completion rate of operating was the highest (70–95%) of history and physical exam reports the lowest (21–58%).

In all hospitals, some forms do not have the patient name or number; patient name and number are inconsistent; most forms are empty; and accounting copies are filed in the MR.

Coding, indexing and discharge analysis

Only five hospitals (Al-Basheer, Princess Basma, Princess Raya, Princess Rahma, and Al-Karak) have computer applications for patient and diseases indexes. They use the ICD-10 for coding and classification of diseases and operations.

2. ASSESSMENT OF MEDICAL DOCUMENTATION AS PER JOINT COMMISSION INTERNATIONAL [vi]

ABSTRACT

Objective : To evaluate the medical documentationprocess compared to criterion as per Joint Commission International.

Method : A retrospective study was conducted in acancer hospital of Karnataka, India, for a period of 4 months. A total of 600 discharged inpatient records were randomly selected from the records of total patients admitted and discharged during the year 2008. A checklist was then prepared as per the medical documentation criterion laid down by JCI. To measure the compliance three options were included i.e. “Yes”, “No” and “Not Applicable”. The forms considered for the assessment were Admission form, Consent form,Radiation form, Brachytherapy form, Anesthesia consentand management form, Post operative form, Doctor’s record, Nurses record and Discharge Summary.

Results : A total of 49% non compliance was seen inGeneral consent in respect to the signature of doctors with date, whereas, 18% of anesthesia forms failed to provide any evidence of anesthesia used during the surgery. It was found that the standard documentation of the discharge summary was most dissatisfactory, where 44% of discharge summary does not comply with criteria of JCI.

Conclusion : Though overall medical documentation process was satisfactory, the documentation of General consent form and Anesthesia form needs to be enhanced further as per the standards framed by the Joint Commission International. Special attention should be given to the complete and accurate documentation of Discharge summary.

Data was collected by reviewing of the discharged inpatients medical records using the checklist as per the JCI documentation standards. Entries of the admission form such as patient’s details, date of admission, name of the doctor, doctor’s signature, TPAindication, were found to be 100% compliant with the standards, whereas only 95.7% (574) of admission consent forms met the standards in terms of name, signature, and relation of the patient relative in the admission consent (See GRAPH 2- Section. 3)
General consent forms are only taken during certain procedures like X-ray, CT scan, MRI scan etc. The entries made in general consent forms were found to be compliant with the standards where 100% satisfaction had been observed in terms of mentioning the patient name with procedure, in having signature of the patient and the signature of witness. A huge 48.7% non conformity was seen in terms of signature of the doctor with date. This issue needs to be taken care of to avoid any legal implications in future. In cancer care, special consent forms are used for recording treatments such as surgery, Direct laryangoscopy, Palliative treatment, Brachytherapy, radiation therapy. Out of 600 patient records, 317 records were found to have special consent form for the above treatment procedures. Out of the 317 records, in 21 special consent forms were found to be without patient signature which can have legal implications and should be a regular practice to check Out of 600 medical records, 160 records were found to have radiation therapy forms and 173 records with Brachytherapy forms. The documentation of Radiation and Brachytherapy forms were 100% compliant with the criteria mentioned under the JCI standards.

Out of 600, 114 medical records were found to have anesthesia consent forms and all the entries in it were found to be 100% compliant with the standards. The entries of Anesthesia management forms were found to be adquate except for the very crucial entry about the anesthesia used, where 18.4% (21) of the records did not have documentation regarding it. Anesthesiologist should take care in documenting the anesthesia used as in case of complications or even in case of legal litigations, it will be important piece of evidence. It should be brought to the notice of the defaulting doctors and further care should be taken regarding documenting the appropriate anesthesia administered during surgery. (It was also observed that 6.1% records failed to document the physiological changes of the patient during the administration of anesthesia in the form. This also needs to be looke into and measures taken to avoid such omissions in future. Postoperative forms, doctor’s order and nurse’s records were found to be 100% compliant with the standard criteria mentioned under checklist
Out of 600 medical records, only 335 were found to have discharge summary in them. The rest 265 records did not have discharge summary in them. All 335 discharge summaries present were 100% compliant with the laid down JCI standards. But, care should be taken to complete and document the discharge summaries for all the in- patient records of the hospital. This is a major non-compliance and efforts should be taken by the hospital to look into the reasons for incomplete/no discharge summaries in the records.

OBJECTIVE

GENERAL OBJECTIVE

TO ASSESS THE QUALITY CONTROL MEASURES OF PATIENT MEDICAL RECORD

SPECIFIC OBJECTIVE

1. Assessment of medical record content & documentation.

2. Assessment of legal aspects of medical record.

3. Assessment of presence of special forms with content and documentation in MLC, DAMA, DEATH medical record.

4. Assessment Of Filing And Record Control Function

5. Analysis of deficiencies found in forms design.

6. To access the compliance rate of receiving patient records within 24 hrs at the time of discharge from wards.

7. To estimate deficiency rate of patient medical record on monthly basis.

METHOD OF DATA COLLECTION

Study design - Descriptive study

Study area - Asian Heart Institute, Mumbai

Sample size - 186

Sample size calculation - Class level -95 %

Class interval-5

Population-320(Average total no. of admission for month Jan, Feb & March, 2 DAMA cases,2 MLC cases& 5 EXPIRED cases)

Sampling approach - Simple Random Sampling

From 67 racks &7 close cabinets

2 IPD files/ 56 Racks,

1 OPD files/11 Racks

2 DAMA, MLC&5 Death file/ 7 close Cabinets

Data sources - Documents (MR manual & forms)

Existing MRs , hospital forms,

Log book & direct observation

Data collection - Checklist to collect Quantitative Data

Technique & tools

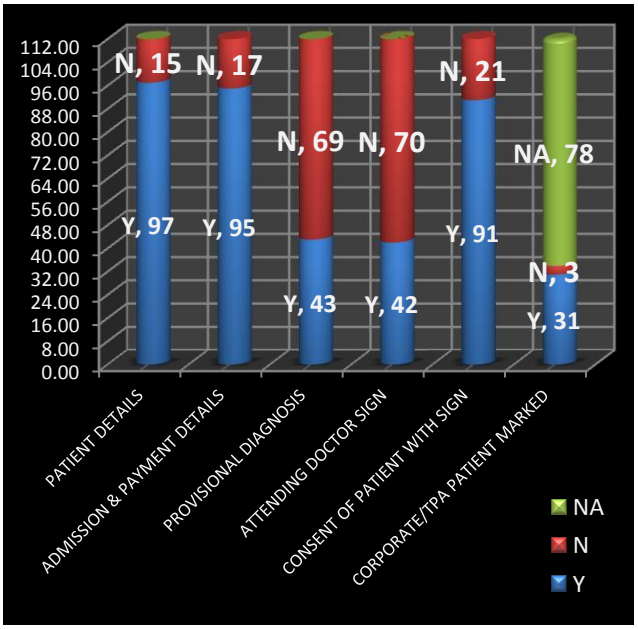
Data collection period – January 2 to March 2, 2013

Statistical process – MS excel 2007

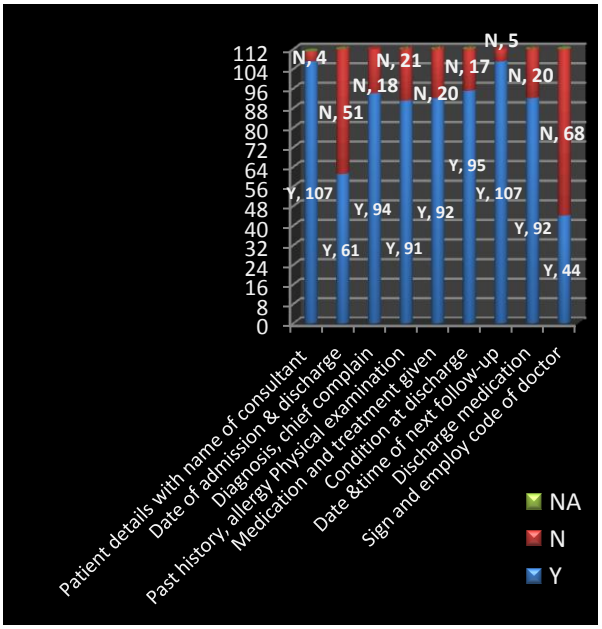
RESULTS & FINDINGS

1. ASSESSMENT OF MEDICAL RECORD CONTENT & DOCUMENTATION.

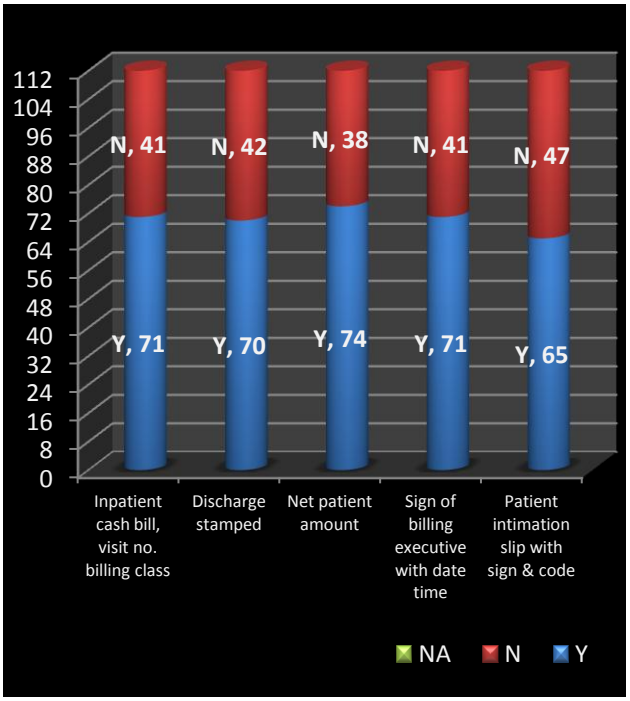
GRAPH 1 . ADMISSION FORMS



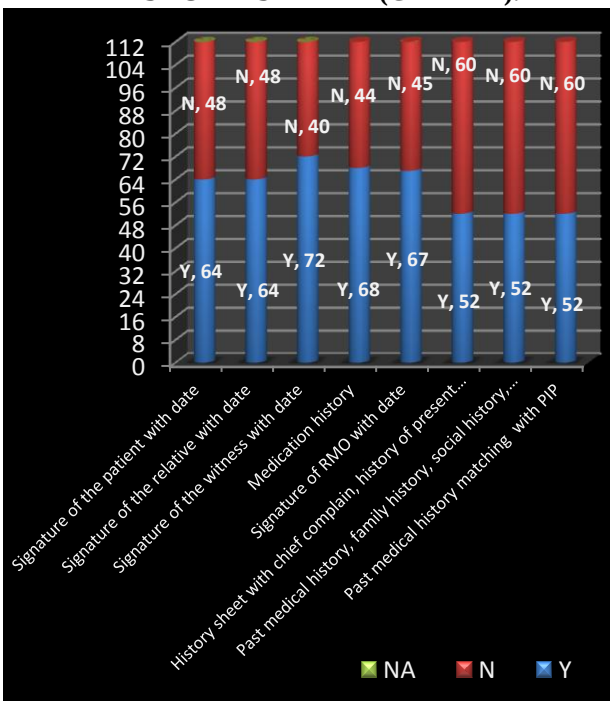
GRAPH 2. DISCHARGE SUMMARY



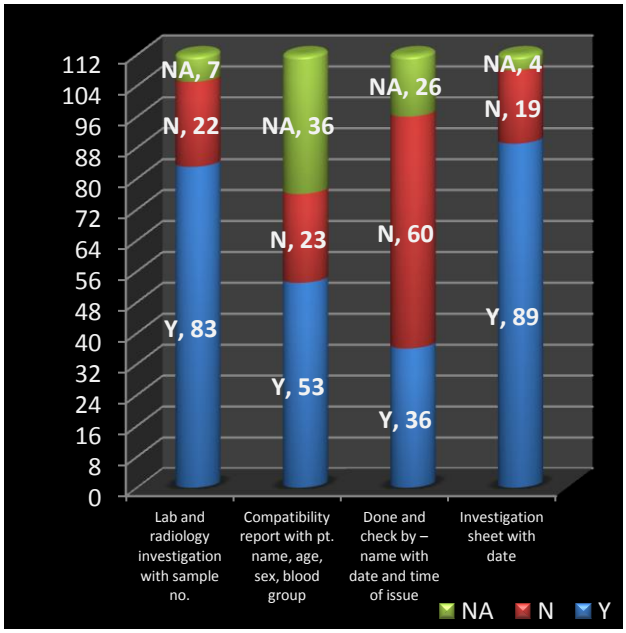
(GRAPH 3.) BILLING



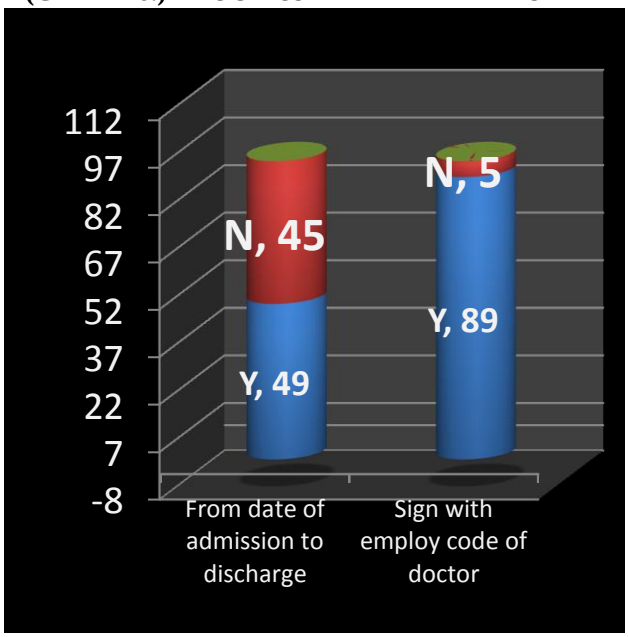
PERSONAL INFORMATION PROFORMA AND HISTORY SHEET **(GRAPH 4).**



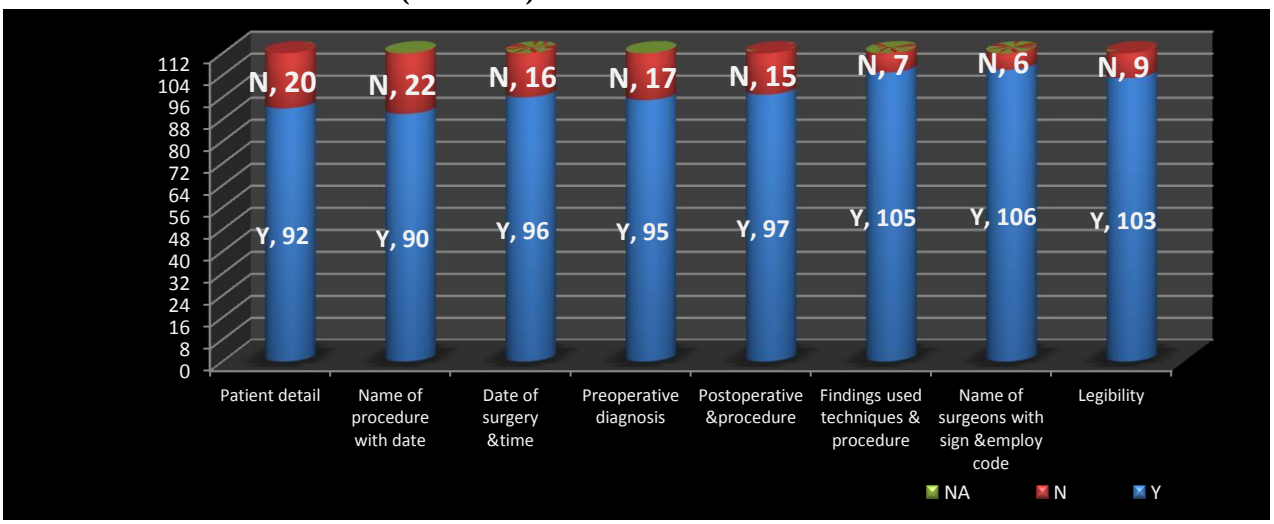
(GRAPH 5.) **INVESTIGATION.**



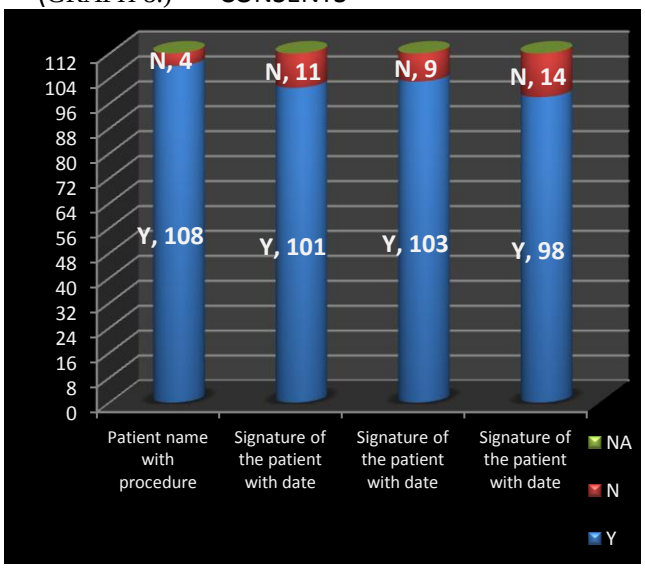
(GRAPH 6.) PROGRESS AND TREATMENT SHEET



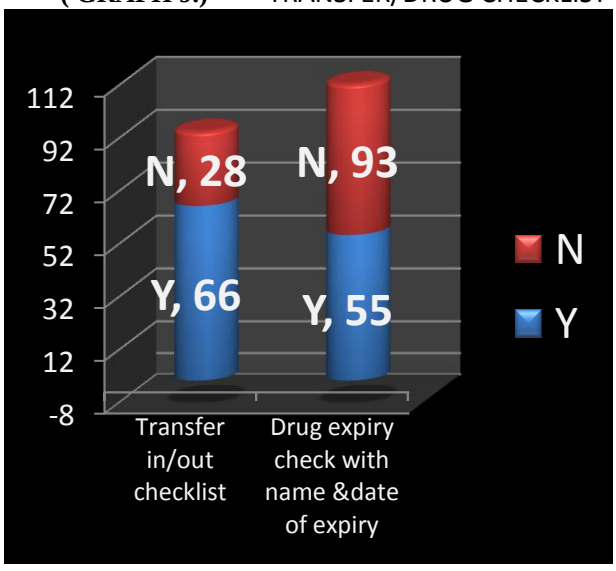
(GRAPH 7). OPERATION RECORD



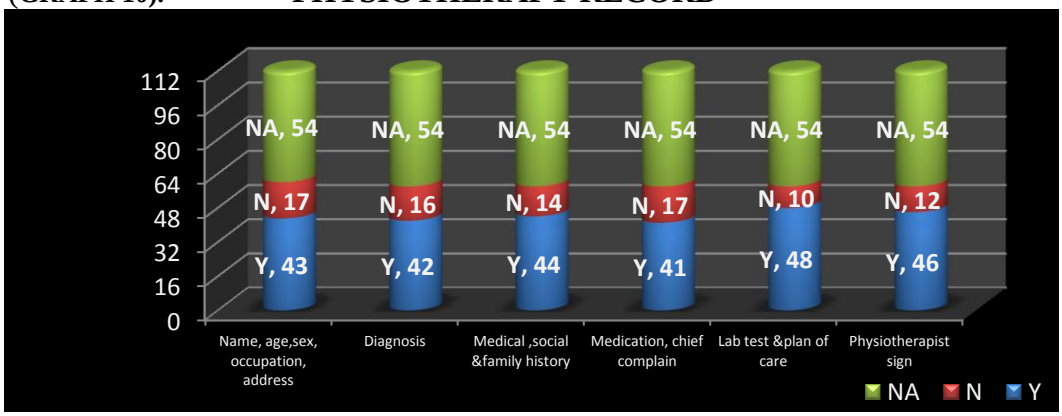
(GRAPH 8.) CONSENTS



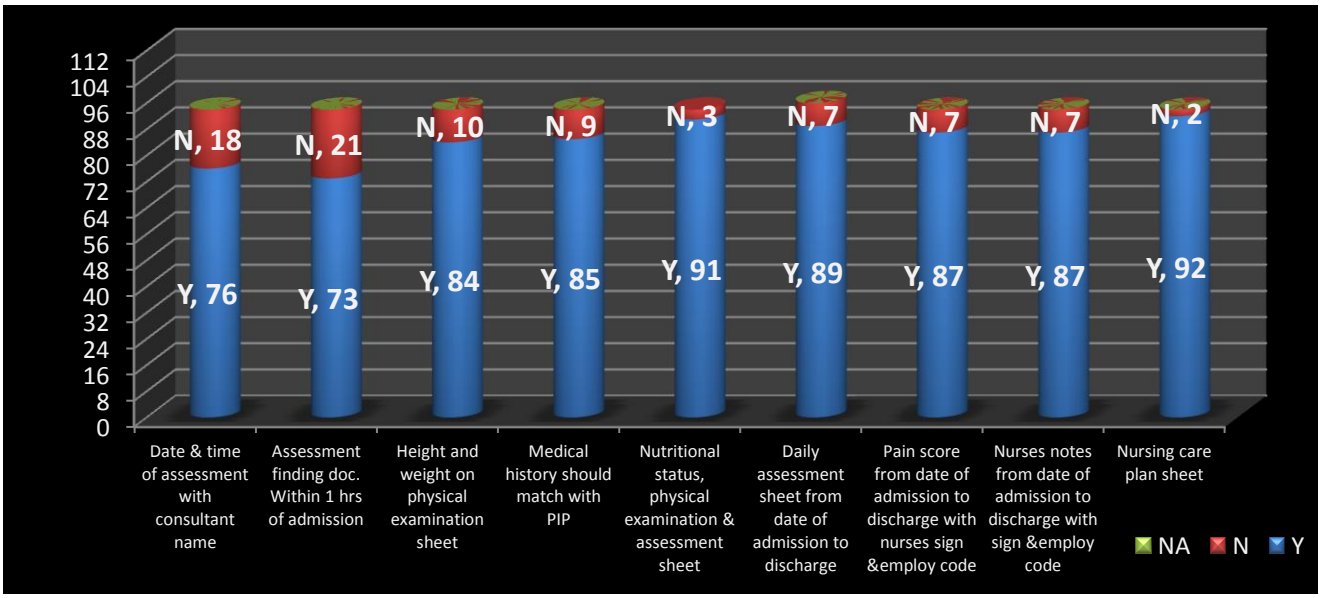
(GRAPH 9.) TRANSFER/DRUG CHECKLIST



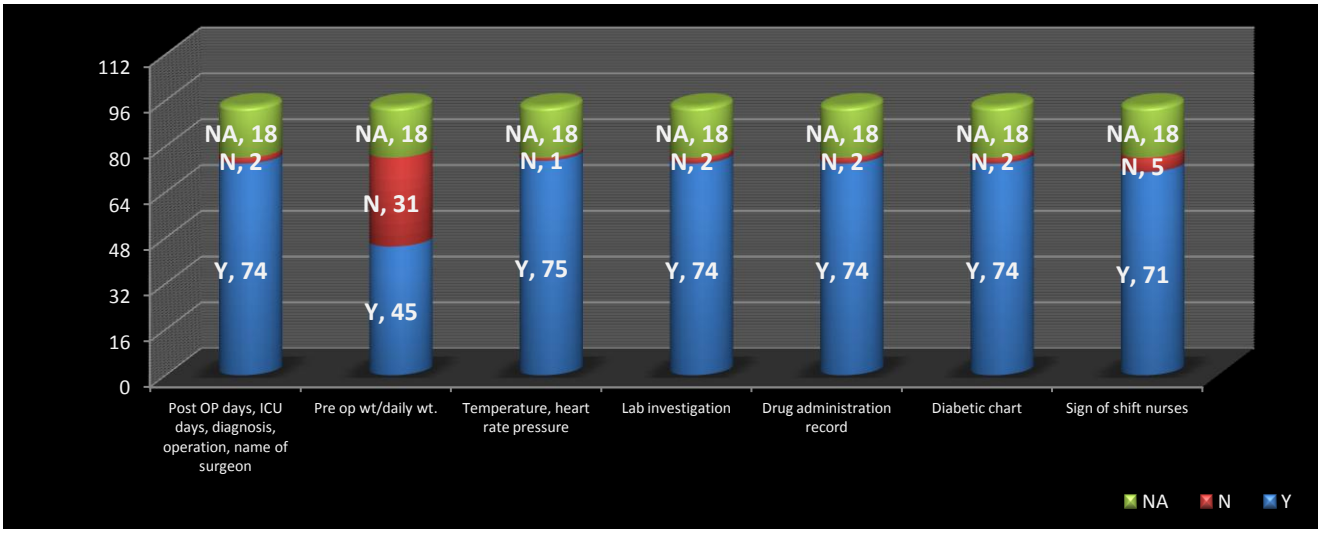
(GRAPH 10). **PHYSIOTHERAPY RECORD**



(GRAPH 11.) **INITIAL NURSING ASSESSMENT**



(GRAPH 12). **CRITICAL CARE FLOW SHEET**



1. Content of all forms have many deficiencies. Completeness % of medical record Content & doc. Ranges from 37.5% to 95.53%.

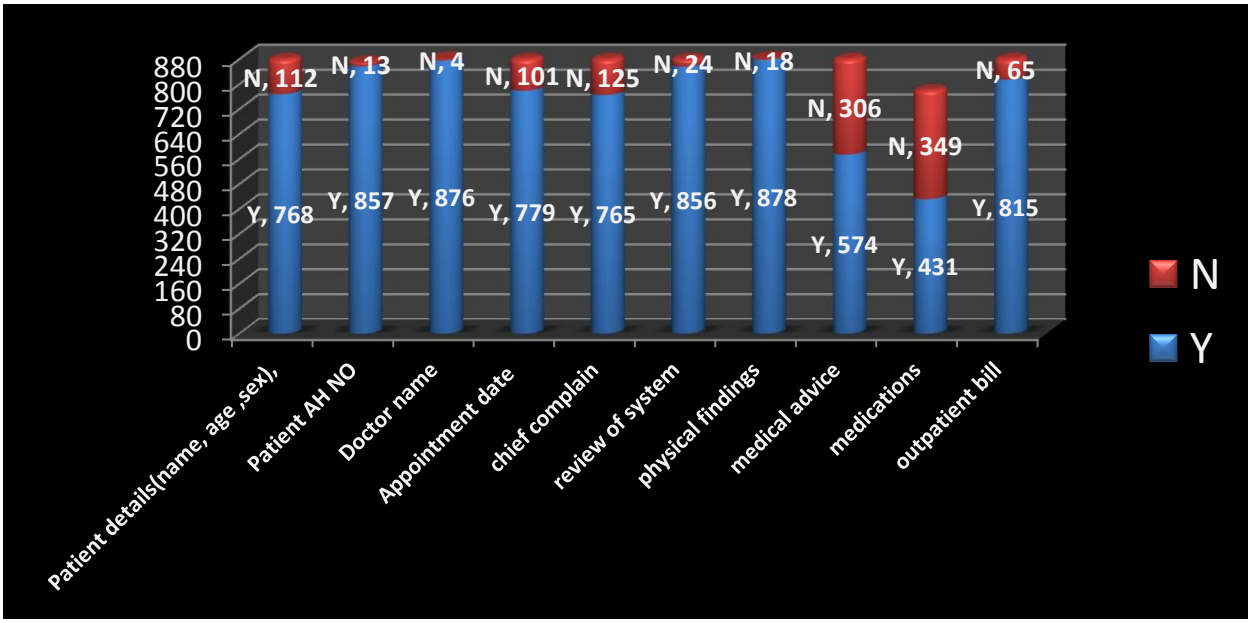
2. Consent form has the highest completion rate (87.5% to 96.42%) where as minimum

is transfer/drug expiry checklist .

3. Highest and lowest completion rate of each form.

FORMS	HIGHEST VALUE COMPLETION RATE OF FORMS		LOWEST VALUE COMPLETION RATE OF FORMS	
Admission forms	87%	patient detail	37.55 %	Attending doctor sign diagnosis. followed by provisional
Discharge summary	100%	date & time of next follow-up	39.28%	Sign and employ code of doctor
billing	66%	Net patient amount	58 %	Patient intimation slip
Personal information proforma and history sheet	64%	Signature of the witness with date	46.4 %	• History sheet with chief complain, history of present illness followed by, • Past medical history should match with PIP & • Past medical history, family history, social history, physical examination
Progress notes and treatment sheet	79%	Sign with employ code of doctor	43.75%	From Date of admission to discharge
Investigation	79.46%	Investigation sheet with date	41.86%	Compatibility report - Done and check by- name with date and time of issue
Operation record	94.64%	Name of surgeons with sign &employ code	80.35%	Name of procedure with date
Consent form	96%	Patient name with procedure	87.5%	Signature of the patient with date
Physiotherapy record	82.75%	Lab test &plan of care	70.68%	Medication, chief complain
Initial nursing assessment	82.14%	Nursing care plan sheet	65%	Assessment findings doc. within 24 hrs of admission
Critical care flow sheet	79.78%	Temperature, heart rate pressure followed by Lab investigation, Drug administration record & Diabetic chart	47.87%	Pre op wt./daily wt.
Transfer/drug expiry checklist	58.92%	Transfer in/out checklist	49%	Drug expiry check form with name & date of expiry

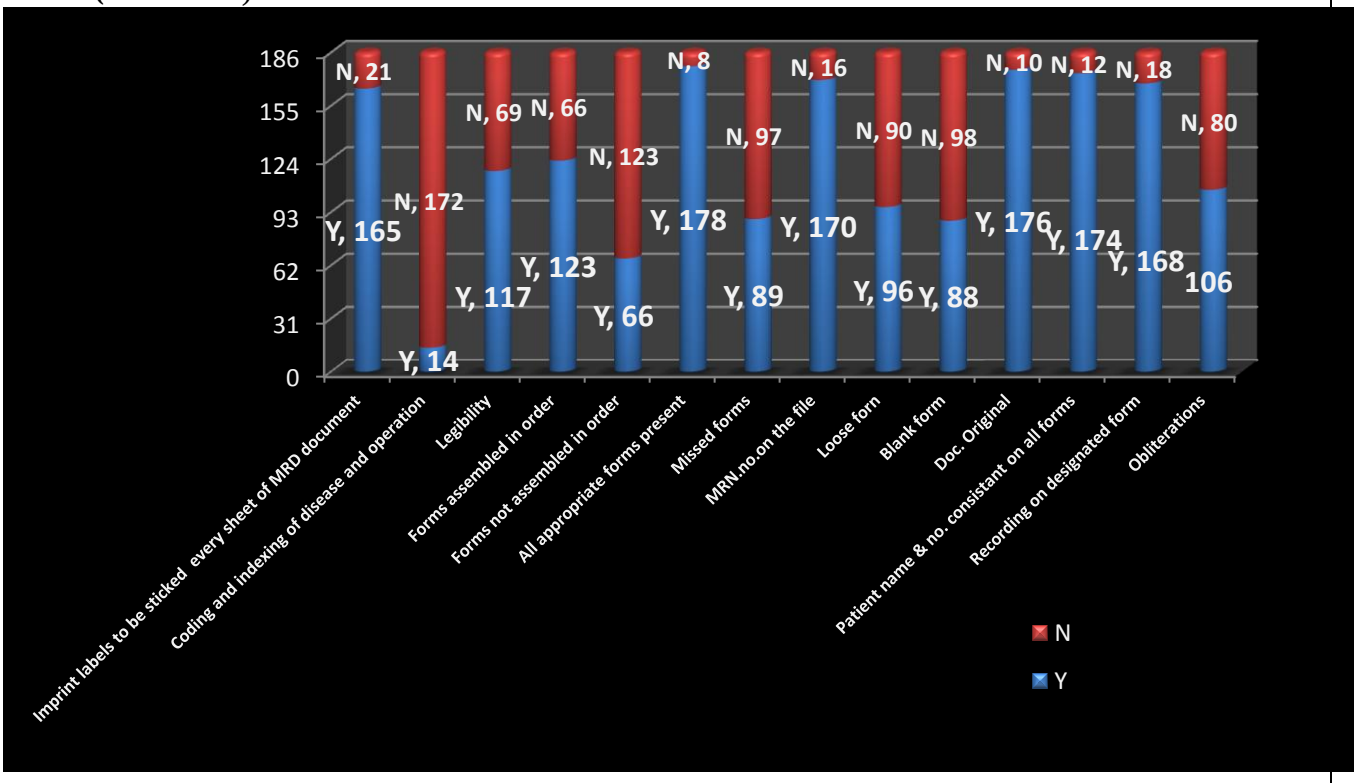
(GRAPH 13.) **ASSESSMENT OF OUTPATIENT BOX FILE**



11 OPD box file, per box containing 80 OPD case where assessed which showed that doctor name is having highest completion rate of 99.54 %where as medication is having 48.97 %completion rate.

2. ASSESSMENT OF LEGAL ASPECTS OF MEDICAL RECORD

(GRAPH 14.)

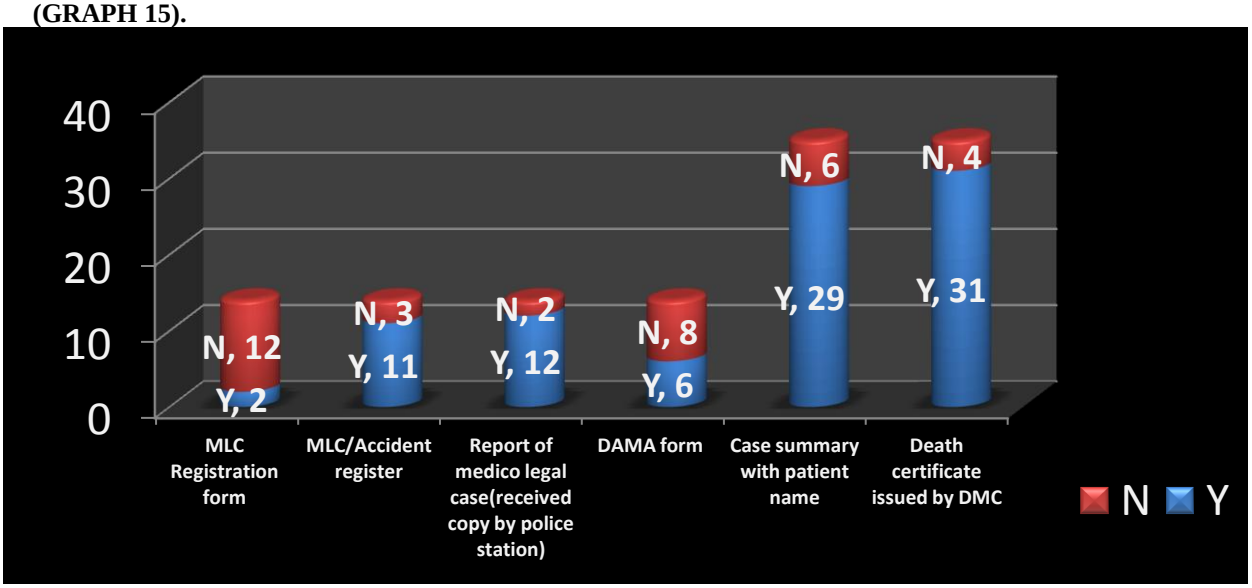


Highest Completion rate for legal aspects is “all appropriate forms present” (95.69%) followed by “doc. found original “i.e. is 94.62 %.

A lowest completion rate aspect is coding and indexing of disease and operation (7.52%) followed by "forms not assembled in order" (35.48%) & "blank form found "is 47%

3. ASSESSMENT OF SPECIAL FORM IN MLC, DAMA &EXPIRED

(GRAPH 15).

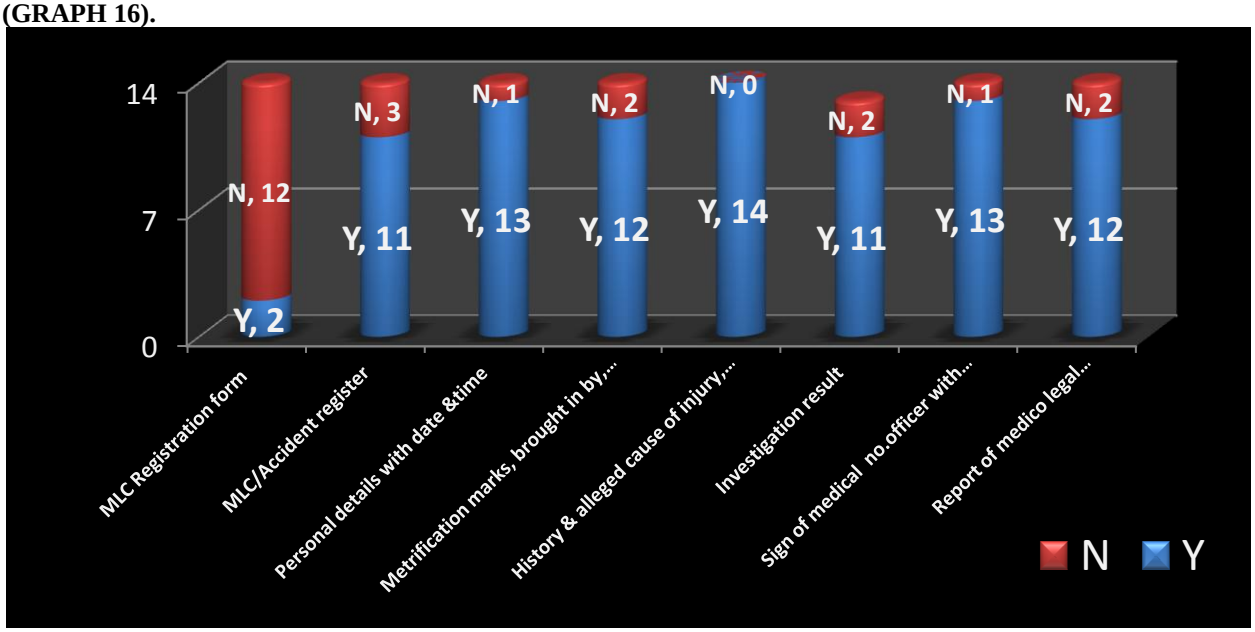


Highest % availability of death certificate issued by DMC is 88.57% followed by report of medico legal case (received copy by police) is 85.71%.

MLC registration form have minimum availability 14% followed by DAMA form 42.85%.

A .**Assessment of presence of special forms in MLC medical record**.

(GRAPH 16).

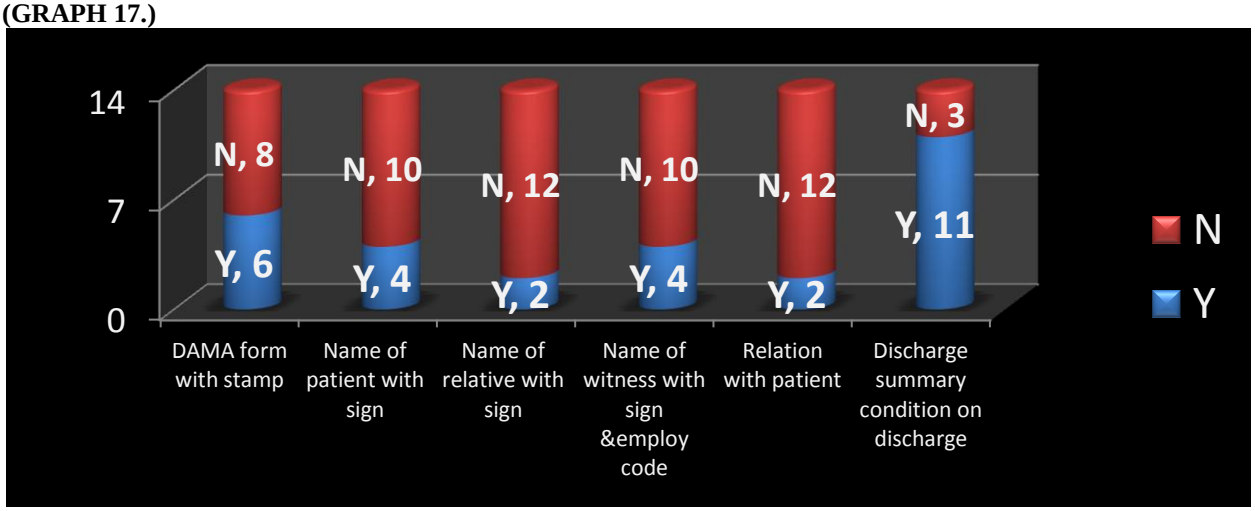


14 MLC medical records, 2 medical record from each 7 close Cabinet viewed that is on average 2 MLC case per month reporting. Assessed medical record of which highest

completion rate 100 % of History & alleged cause of injury, name of injury with description followed by 92.85% of Personal details with date &time & Sign of medical no. Officer with name & registration no. whereas lowest completion rate 14.28 % of MLC Registration form where found.

B. Assessment of presence of special forms in DAMA medical record.

(GRAPH 17.)

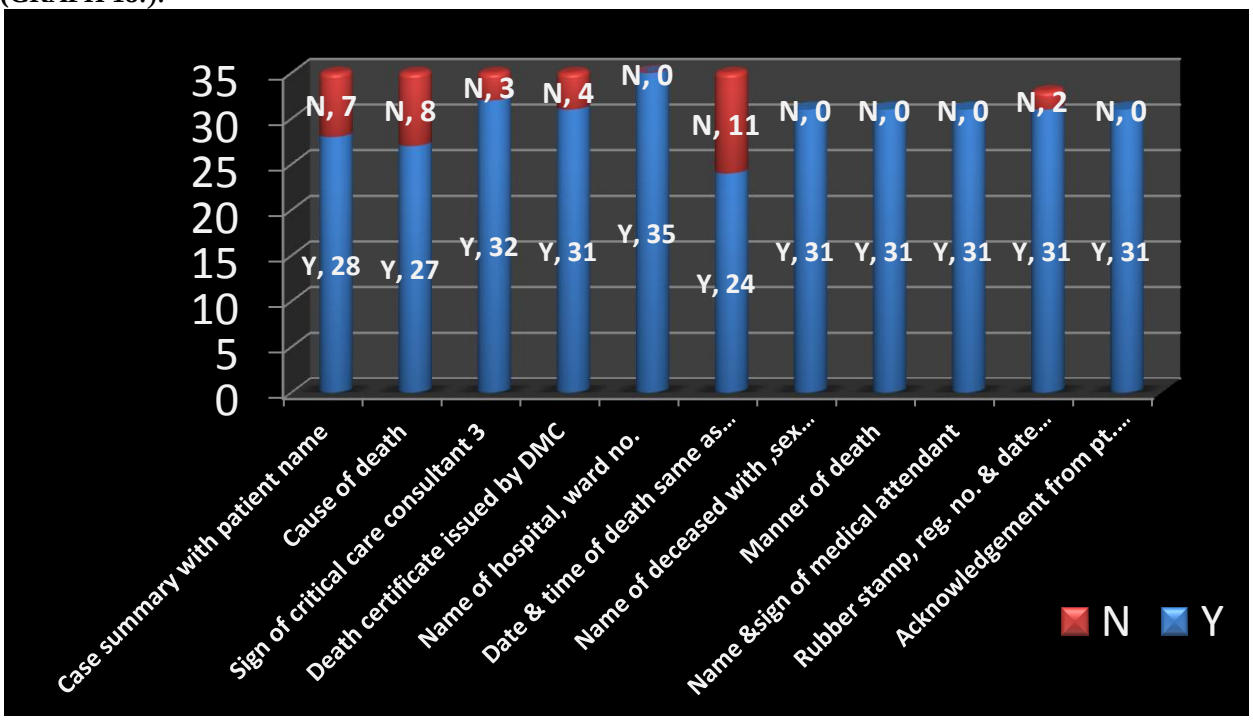


- **Assessment of presence of special forms & content documentation in DAMA medical record**.

14 DAMA medical records, 2 medical records from each 7 close cabinet were viewed that is on average 2 DAMA case per month reporting. Highest completion rate 78.57 % on Discharge summary with condition on discharge i.e. against medical advice and lowest completion rate14 % of Name of relative with sign & Relation with patient.

C. **Assessment of presence of special forms with content documentation in EXPIRED medical record**.

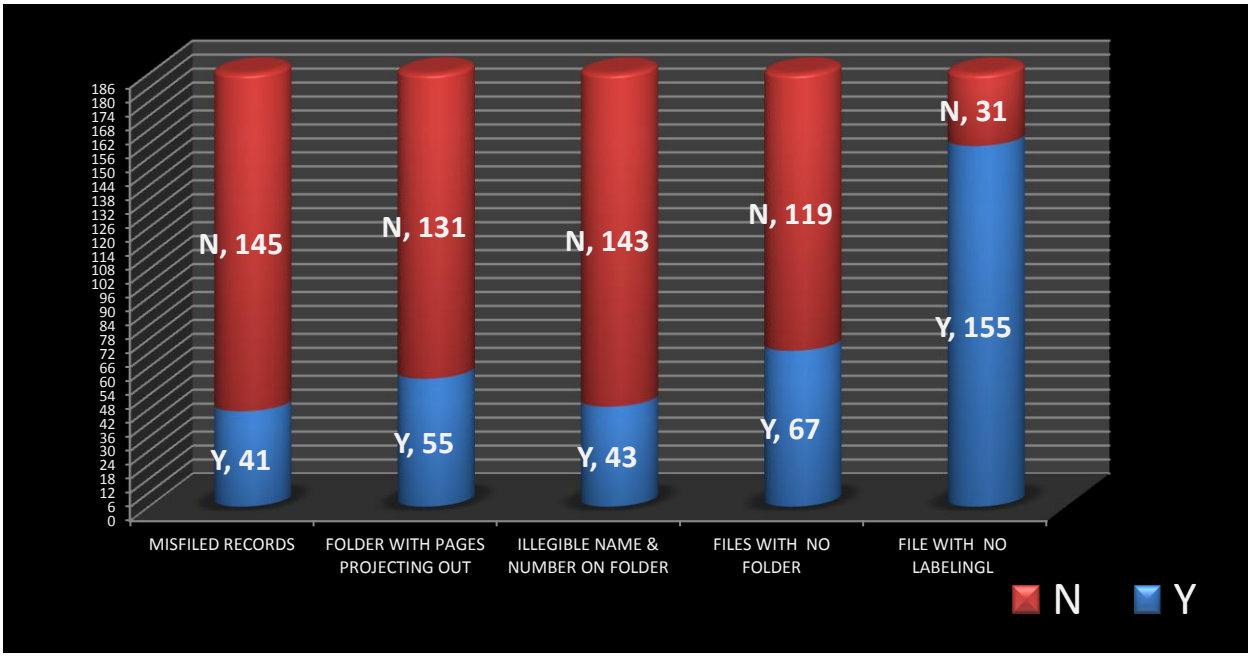
(GRAPH 18.).



35 EXPIRED medical records, 2 medical records from each 7 close cabinet were viewed that is on average 5 expired patients reporting per month.
Highest completion rate 100 % of Name of hospital, ward no. On Death certificate followed by 91 % Sign of critical care consultant. Lowest completion rate 68 % Date & time of death in death certificate same as mentioned in case summary. Followed by causes of death 77 %.

4. ASSESSMENT OF FILING AND RECORD CONTROL FUNCTION

GRAPH 19.



Hospital uses unique no. for MR numbering. The patient has same MR NO. for outpatient, admission &day-care. Hospital uses serial straight filing system. Shelves are overcrowded (more than 95% the storage capacity is used.

Highest discrepancy found in labelling of records 68.18% and the lowest is misfiled recorded.

% of misfiled recorded is 8.18%

% of folder projecting out is 24.54%

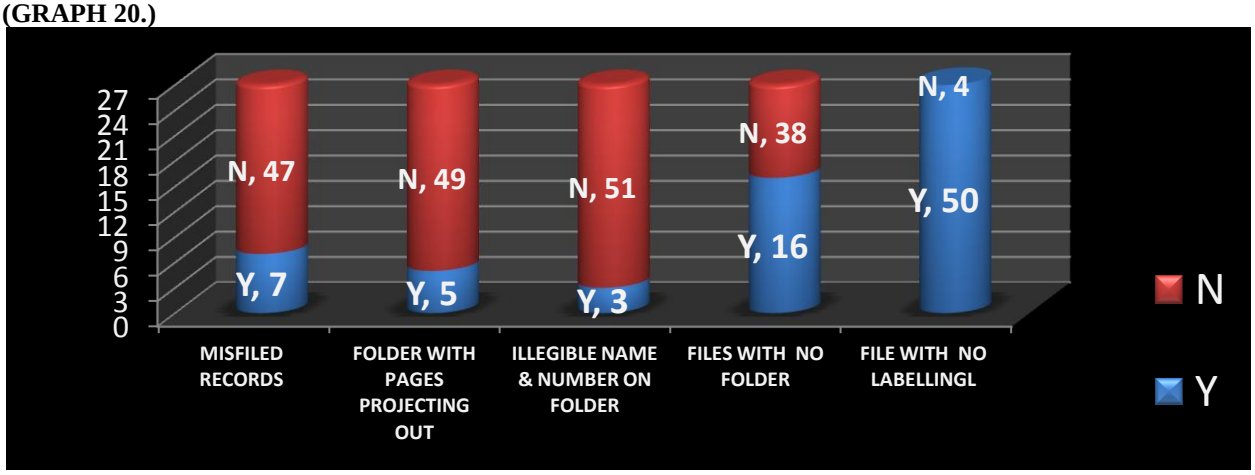
% of illegible name & no. on folder is 10 %

% of files with no folder is 30.90%

% of files with no labelling 68.18%.

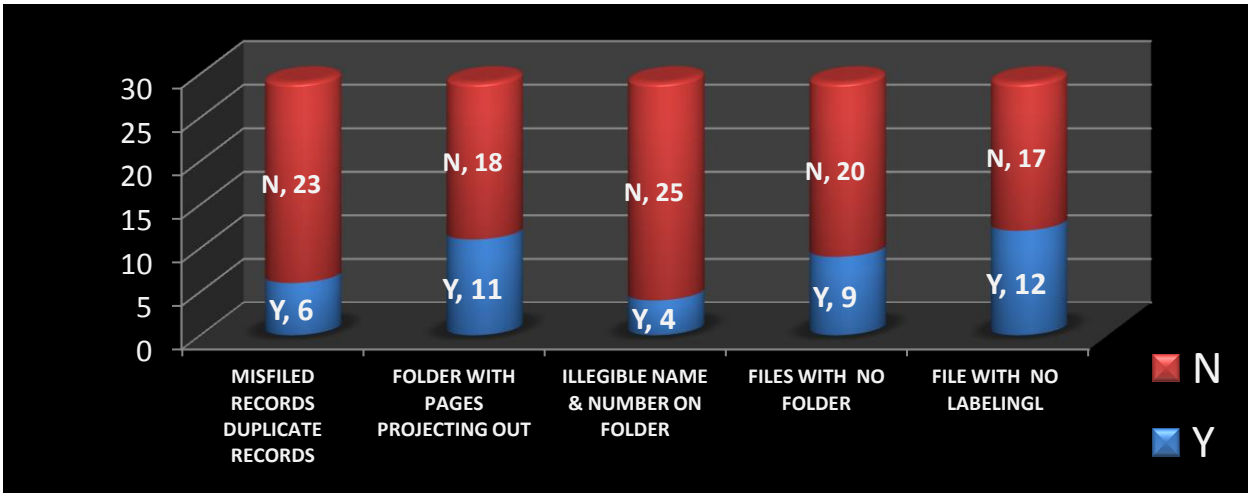
Assessment of filing and record control function of shelves no. 1 to 27

(GRAPH 20.)



Assessment of filing and record control function of shelves no. 28 to 56

GRAPH 21.



Assessment of filing and record control function of shelves no. 1 to 27 & assessment of filing and record control function of shelves no. 28 to 56 has same rate of deficiency in average 30 %.

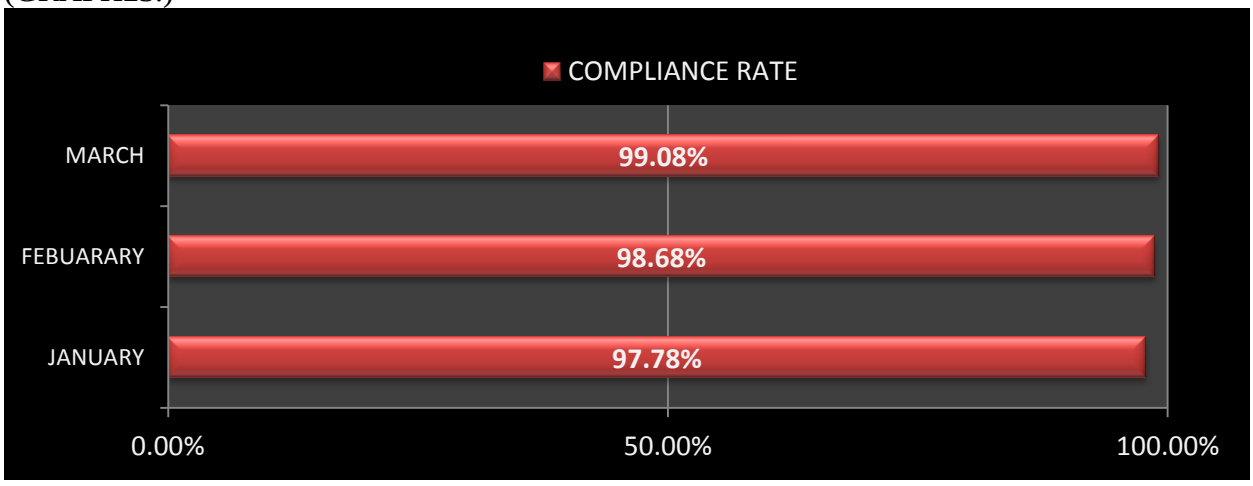
5. ANALYSIS OF DEFICIENCIES FOUND IN FORMS DESIGN

(GRAPH 22.)

No deficiency found in form design in respect to all form appropriate with printed hospital name, code, place for patient name, place for hospital no., uniform margin, uniform binding edge, uniform size(A 4- 21 cm x30 cm)/A5 (21 CM X 15 CM)A6(15CM X10.5 CM), uniform weight(270 GSM).

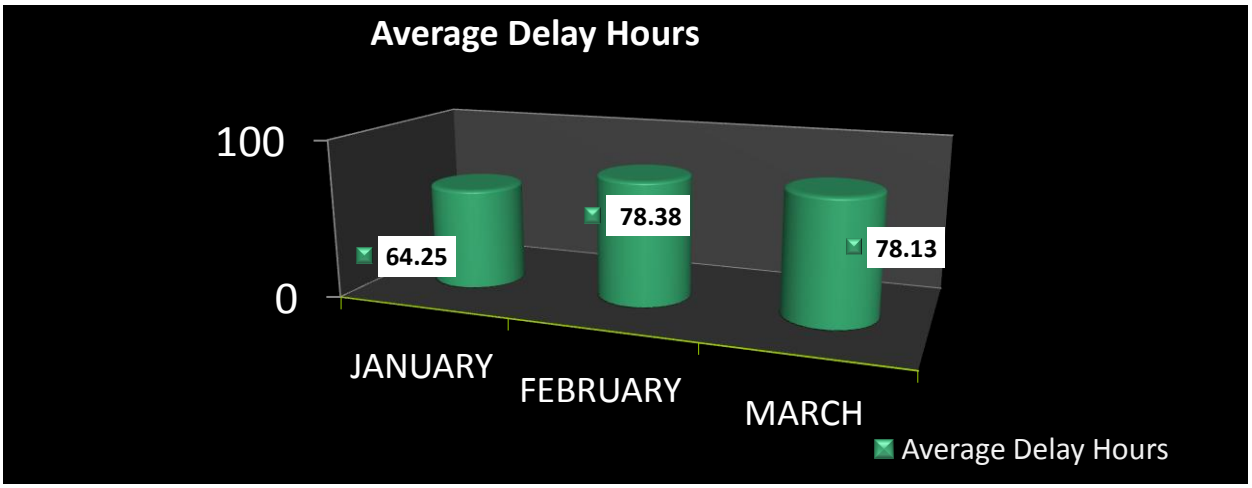
6. TO ACCESS THE COMPLIANCE RATE OF RECEIVING PATIENT RECORDS WITHIN 24 HRS AT THE TIME OF DISCHARGE FROM WARDS.

(GRAPH23.)



Month of March is having highest compliance rate 99.08 % as compared to, for month of January compliance rate is 97.78 % & for month of February compliance rate is 98.68%.

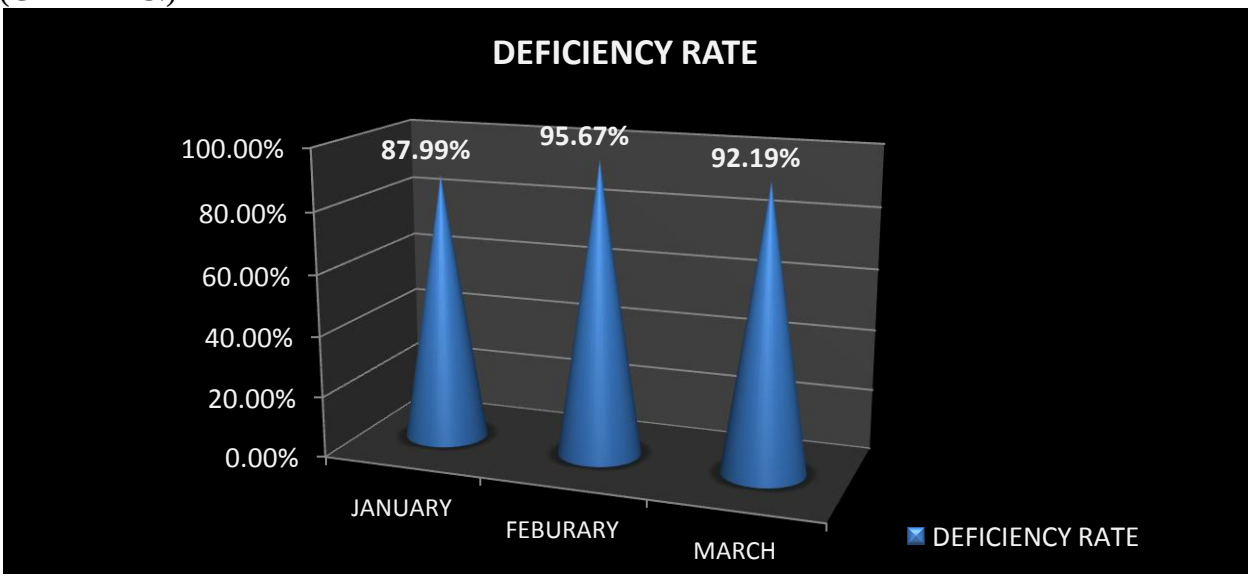
(GRAPH 24).



Month of February is having highest delay hours as compared to March and January.

7. TO ESTIMATE DEFICIENCY RATE OF PATIENT MEDICAL RECORD ON MONTHLY BASIS.

(GRAPH 25.)



Month of March is having highest deficiency rate (92.19) followed by January (87.99%) & February (95.67%).

DISCUSSION

- **ASSESSMENT OF MEDICAL RECORD CONTENT & DOCUMENTATION.**

The medical record is the sole comprehensive source wherein the care and treatment provided to a patient during his/her visit to a health care facility is documented and retained

.The patient file folder and its contents were the focus of the review. The purpose of the review was to verify the completeness, accuracy, and appropriateness of the patient care documentation

Over 112 medical records were randomly selected from each shelf for complete review. Among which Record of bypass surgery 50 %(56), angioplasty or angiography50 %(56) were included for review. The review focused on several administrative and clinical elements that contribute to the overall parameters of record quality. The standard checklist as per JCI medical documentation criteria is used.

The findings are as follows:

1. Content of all forms have many deficiencies. Completeness of medical record Content & doc. ranges from 37.5 % to 96% which is supported by the other study.

   Gap of 62.5% is identified which is quite high and need serious concern by doctor and nurses.

2. Consent form has the highest completion rate (87.5% to 96%) where as minimum is transfer/drug expiry checklist(58.92% to 49%) which contradict with the study of USAID which state operation notes (70 % to 95 %) and history & physical exam reports with (21% to 58 %) .

   Consents form has good indicators because it settles nurses, doctor issues in legal cases. Transfer/drug expiry checklist need to be improved to make sure that there is smooth transfer process of patient from ICU to wards.

3. Admission form- Patient medical record include admission sheet to ensure that accurate and complete information is recorded. The treating physician should document a provisional diagnosis with type of surgery.

   Entries of patient details is found to be 87% completion rate, where as only 37.55 % of attending doctor sign with provisional diagnosis has completion rate which Contradict with other study which state 100% .[vi.]

4. Discharge summary- It ensures that all important variables during patient stay is recorded i.e provisional diagnosis, date and time of admission and discharge, past

history, medication and treatment given, condition at discharge, date and time of next follow-up, discharge medication with sign and employ code of doctor.

Entries of date & time of next follow-up is found to be 96% completion rate followed by

Condition at discharge with 84.82 % while sign and employ code of doctor 39.28 % has lowest completion rate

5. Billing slip – Net patient amount 66 % has highest completion rate followed by sign of billing executive with date and time where as patient intimation slip with sign & employ code 58% has lowest completion rate. Billing executives should take necessary step to make the system more transparent able to the patient party.

6. Pip and history sheet - A complete history describing the chief complain, the details of the present illness, past medical history, social history and family history signature of the witness, patient & relative with date. The content in pip should always match with history sheet. This information could help in treatment procedure.

   64 % has highest completion rate where as History sheet with (chief complain, history of present illness), (Past medical history, family history, social history, physical examination). Past medical history matching with PIP has least completion rate with 46.4%. gap could be lessen if same doctor is going to prepare pip and history sheet for the same patient.

7. Investigation sheet –It should include all pertinent findings resulting from assessment of all the system of body with date and sign.
   Investigation sheet with date 79.64 % has highest completion rate .Where as Compatibility report-done and check by name with date and time of issue has lowest Completion rate. About 32 % of data is not applicable for patient record. Blood bank & Nurses should take a high concern to maintain quality check on date and time of issue with name and date.

8. Progress and treatment sheet – It is included with the scope to indicate the condition of the patient, modality of the treatment given in form of medication on admission in a chronological order from date of admission to discharge.

   Completion rate of sheet with sign of doctor with employ code is 79 & sheet found from date of admission to discharge is very minimum with 43.75 % only which need a serious concern by nurses to assemble all sheets in chronological order from date of admission to discharge.

9. Operation record- all procedure record which include Cathlab checklist, diagram report, timeout policy,ICU transfer note, Anaesthesia record, Operation notes. Procedure detail, preoperative and Postoperative, findings and technique with date sign & legibility. All should be included in the record without fail or incompletion.

   Highest completion rate 94.64% with name of surgeon sign & employ code followed by Findings used techniques & procedure whereas minimum 80.35 % with name of

Procedure with date followed by Patient detail. The finding is supported by study of USAID.[v]

10. Consent form - It assure that informed consent is obtained from patient in compliance with the act. It is very helpful in legal aspects point of view. All consent including procedure, operation procedure, angioplasty, cardiac catherization, high risk catherization, implantation, blood product transfusion, anaesthesia HIV/AIDS test, radial artery harvest,24 hr attendant with patient.

    Highest completion rate with respect to patient name with procedure(96%)followed by sign of relative with date (92 %) and minimum completion rate is signature of the witness with date 87.5%.this finding is contradictory to the other study which state all the findings of consent is 100 % .[vi]

11. Physiotherapy record - To ensure patient has undergone medical management Programme under any procedure during his/her stay in the hospital.

    112 record where viewed of which 54 records were found to be not applicable for medical management. Lab test & plan of care with 82.75 % has highest completion rate whereas medication, chief complain 70.68 % has lowest completion rate.

12. Initial Nursing Assessment- To enable the nurses to provide comprehensive care to the patient following systematic & scientific nursing care. It include following sub content with nursing assessment record, daily nursing assessment, pain score, nurses notes, nursing care plan, flow chart. Precise nursing notes acts as a means of communication between nursing personnel and physician.

    Nursing care plan sheet has highest completion rate with 82.14 % followed by Nutritional status, physical examination & assessment sheet with 81.25 % where as Assessment finding doc. Within 1 hrs of admission has lowest completion rate of 65% followed by Date & time of assessment with consultant name with 67.85%.this finding contradict with the other study which state all the findings of nurses notes is 100 % .[vi]

13. Critical care flow sheet – this chart is initiated in the ward on the admission of the patient and be continued until the critical patient is discharged. include temperature, heart rate pressure ,diabetic, fluid balance flow char and respiration ,drug administration record with written comments on post OP days, ICU days, diagnosis operation ,name of surgeon.pre op wt./ daily wt.

    Of all 112 records 18 records were found to be not applicable. temperature, heart rate pressure with 79.79 % has highest completion rate followed by lab investigation, drug administration record & diabetic chart. With 66 % completion rate.pre op wt.daily wt. is having lowest completion rate 47.87 %.

14. Transfer in-out/drug expiry checklist – to ensure that smooth transfer of patient from one Department to another department and to have stick check on drug expiryadministration. Transfer in/out checklist has very minimum availability with 58.92% and maximum availability of drug expiry checklist with name and date of expiry is 49 %.mainly this document attachment is on the last page of patient file ,which need to take care by Nurses and medical record executive.

Asian heart hospital is having good finding in consent form and poor in admission form, progress noted and treatment sheet, operation record,& nurses notes , with respect to other study.[v]

ASSESSMENT OF CONTENT & DOCUMENTATION IN OPD CASE SHEET

11 OPD box file, per box containing 80 OPD case where assessed which showed that doctor name is having highest completion rate of 99.54 %where as medication is having 48.97 %completion rate. Asian heart hospital having poor finding in terms of medication on OPD case sheet.

- **ASSESSMENT OF LEGAL ASPECTS OF MEDICAL RECORD**

Using a special criteria checklist, the following documentation principles, which have direct legal implications, was to be checked for every form included in the MR: Imprint labels to be sticked every sheet of MRD document, Legibility, Forms assembled in order, Forms not assembled in order, All appropriate forms present (i.e. recording discharge summary on discharge form not on operation record), Missed forms, MRN no. on the file, Loose form, Blank form, Doc. Original, Patient name & no. consistent on all forms, Recording on designated forms (i.e. no recording on Blank form), Blank form, obliterations (spots of ink, spots of blood, ugly marks).

186 medical record where assessed of which highest Completion rate for legal aspects is "all appropriate forms present" (95.69%) followed by "doc. found original "i.e. is 94.62 %. A lowest completion rate aspect is coding and indexing of disease and operation (7.52%) followed by "forms not assembled in order" (35.48%) that where mainly operation record and MLC form & "blank form found "is 47%.

Asian Heart Hospital is having poor finding with respect to coding and indexing of disease and operation, form not assembled than other study.[v]

- **ASSESSMENT OF PRESENCE OF SPECIAL FORMS WITH CONTENT AND DOCUMENTATION IN MLC, DAMA, DEATH MEDICAL RECORD**

Presence of all basic and special forms required to ensure effective and safe patient care and in order to be helpful in legal implication.

14 MLC, 14 DAMA & 35 DEATH medical record where viewed. Highest % availability of death certificate issued by DMC is 88.57% followed by report of medico legal case (received copy by police) is 85.71%.

MLC registration form have minimum availability 7.14% followed by DAMA form 42.85%.

- **Assessment of presence of special forms & content documentation in MLC medical record**.

  14 MLC medical records, 2 medical record from each 7 close cabinet were viewed that is on average 2 MLC case per month reporting. Assessed medical record of which highest completion rate 100 % of History & alleged cause of injury, name of injury with description followed by 92.85% of Personal details with date &time & Sign of medical no. Officer with name & registration no. Were as lowest completion rate 14.28 % of MLC Registration forms where found.

- **Assessment of presence of special forms & content documentation in DAMA medical record**.

  14 DAMA medical records, 2 medical records from each 7 close cabinet were viewed that is on average 2 DAMA case per month reporting. Highest completion rate 78.57 % on Discharge summary with condition on discharge i.e. against medical advice and lowest completion rate14 % of Name of relative with sign & Relation with patient.

- **Assessment of presence of special forms & content documentation in EXPIRED medical record.**

  35 EXPIRED medical records, 2 medical records from each 7 close cabinet were viewed that is on average 5 expired patients reporting per month.
  Highest completion rate 100 % of Name of hospital, ward no. On Death certificate followed by 91 % Sign of critical care consultant. Lowest completion rate 68 % Date & time of death in death certificate same as mentioned in case summary. Followed by causes of death 77 %.

- **<u>ASSESSMENT OF FILING AND RECORD CONTROL FUNCTION</u>**

Hospital uses unique no. for MR numbering. The patient has same MR NO. for outpatient, admission &day-care. Hospital uses serial straight filing system. Shelves are overcrowded (more than 95% the storage capacity is used.

186 medical record were assessed of which 2 record from each 56 racks OF IPD, 1 from each 11 racks of OPD & 9 record from each 7 close cabinet.

Highest discrepancy found in labelling of records 83.33% and the lowest is misfiled recorded (22 %).

% of misfiled recorded is 22 %

% of folder projecting out is 29.56%

% of illegible name & no. on folder is 23 %

% of files with no folder is 36%

% of files with no labelling 83.33%

Assessment of filing and record control function of shelves no. 1 to 27 & assessment of filing and record control function of shelves no. 28 to 56 has same rate of deficiency in average 30 %.

This showed that Asian heart hospital is having poor findings (22 % to 83 %) than any other research study(USAID) which state only 3% to 5 %.

- **ANALYSIS OF DEFICIENCIES FOUND IN FORMS DESIGN**

  30 form where assessed in which No deficiency found in form design in respect to all form appropriate with printed hospital name, place for patient name, place for hospital no., uniform margin, uniform binding edge, uniform size(A 4- 21 cm x30 cm)/A5 (21 CM X 15 CM)A6(15CM X10.5 CM), uniform weight(270 GSM).

  Asian heart hospital have maintained standard to 100 % which is best with respect to other study findings .[vi]

- **TO ACCESS THE COMPLIANCE RATE OF RECEIVING PATIENT RECORDS WITHIN 24 HRS AT THE TIME OF DISCHARGE FROM WARDS.**

  Register for tracking received file within 24 hrs of 3months in medical record department were assessed which showed that

  Month of March is having highest compliance rate 99.08 % as compared to, for month of January compliance rate is 97.78 % & for month of February compliance rate is 98.68%.

  Month of February & March is having highest average delay hours 78 hrs as compared to January 64 hrs.

- **TO ESTIMATE DEFICIENCY RATE OF PATIENT MEDICAL RECORD ON MONTHLY BASIS.**

  Deficiency checklist maintained on monthly in medical record department were assessed which showed that

  Month of March is having highest deficiency rate (92.19) followed by February (95.67%) & January (87.99%).this shows that rate if increasing month by month.

CONCLUSION & RECOMMENDATIONS

1. Content of all forms have many deficiencies. Completeness of medical record Content & doc. ranges from 37.5 % to 96% which is supported by the study conducted by USAID. Gap of 62.5% is identified which is quite high and need serious concern by doctor and nurses. Consent form has the highest completion rate (87.5% to 96%) where as minimum is transfer/drug expiry checklist(58.92% to 49%) which contradict with the other study [vi] which state operation notes (70 % to 95 %) and history & physical exam reports wt (21% to 58 %) . Thus ASIAN HEART HOSPITAL hospital has poor findings in content and documentation with respect to other study ([v,vi]).

    - Qualitative and quantitative analysis of medical record content to done on a regular basis to monitor completeness of information .guidelines for proper documentation principles should be prepared and communicated to doctor and nursing staff.

2. Highest Completion rate for legal aspects is "all appropriate forms present" (95.69%) followed by "doc. found original "i.e. is 94.62 %.A lowest completion rate aspect is coding and indexing of disease and operation (7.52%) followed by "forms not assembled in order" (35.48%) & "blank form found "is 47%.this fig is quite similar to other study.

    - With regard to coding and indexing of disease and operation, the application of computerized system for admission, patient index and disease index. New nursing staff should be made aware about the standard of the medical record. Medical record people should circulate standard guideline list to nurses.

3. Highest % availability for **special form in MLC, DAMA &Expired is "** death certificate issued by DMC is 88.57% followed by report of medico legal case (received copy by police) is 85.71%.MLC registration form have minimum availability 14% followed by DAMA form 42.85%.

    - Medical record personnel should identify records and send them to the concerned professional to complete and then only it should be filed. Senior Nurses should recheck MLC, DAMA and Expired patient record. take serious note that these special content is not missing in the record

4. In assessment Of Filing And Record Control Function .Highest discrepancy found in labelling of records 83.33% and the lowest is misfiled recorded (22 %).Asian heart hospital showing poor finding in filling and record control function in respect to other study. [i]

   - Straight numeric filing should be strictly followed by the medical record staff. On monthly basis shelves to shelves all discrepancy related to file like unlabelled, misfiled record to be identified by medical record attendant and then filled accordingly. To have periodic weekly auditing from shelves to shelves to minimize chances of deficiency/misplacing.

5. No deficiencies were found in forms design. All forms where up to their standard. ASIAN HEART HOSPITAL is having 0 % deficiency rate in form design, which is a very good finding with respect to other study [v].

   - Medical record department should maintain this standard by keeping close eye on main store revised quotation on yearly basis.

6. The compliance rate of receiving patient records within 24 hrs at the time of discharge from wards for **Month of March is having highest compliance rate 99.08 % as compared to, for month of January compliance rate is 97.78 % & for month of February compliance rate is 98.68%.** Month of February & March is having highest delay hours 78 % as compared to January as 64 %. Findings are improving month by month.

   - Files of patient record should be arranged, assembled together at the time intimation of discharge made by doctor. Responsibility of compiling patient record within nursing staff should be divided equally, so that delayed hours could be decreased.

7. Deficiency rate of patient medical record for month of March is having highest deficiency rate (92.19 %) followed by February (95.67%) & January (87.99%) &. The finding is fairly good.

   - MRD department should take responsibility for Periodic training session of nurses & doctors should be organised by management in order to educate the staff about the importance of proper content documentation, to complete fill each entries in all forms, which not only form the basis of documentation of care given and aids in the continuity of care, but also is an important in case of any legal litigations.

REFERENCES

[i] Mr. N. Sohoni MRD procedure manual,asian heart hospital, Document No : DP/MRD/1.0

[ii] Mr. N. Sohoni MRD procedure manual,asian heart hospital, Document No : DP/MRD/2.0

[iii] Mr. N. Sohoni MRD procedure manual,asian heart hospital, Document No : DP/MRD/3.0

[iv] **DR.VIJAY DSILVA** procedure manual **Document No : DP/MRD/1.0 DEPARTMENT PROFILE**

[v] Ajlouni, Musa. May 2006. Assessment of Medical Records Services at Ministry of Health Hospitals in Jordan. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

[vi] R. K. Sinha*, D. Saha**, Prathibha N. R.*** **assessment of medical documentation as per Joint commission international** . Journal of the Academy of Hospital Administration, Volume 21, No. 1 & 2 Jan-June & July-December 2009.

Annexure1 to 7

ASSESSMENT OF MEDICAL RECORD CONTENT AND DOCUMENTATION

Checklist 1

SL NO.	Medical record form and component(IPD)		Medical Record1 MRN NO.		Medical Record 2 MRN NO.	
	Coding	**Y - Yes** **N - No** **NA - Not Applicable**	**Coding**	**COMMENTS**	**Coding**	**COMMENTS**
1.	**Admission forms**					
1.1	Patient details (name, age, sex, marital status, nationality, MRN no., mobile)					
1.2	Admission & payment details					
1.3	Provisional diagnosis					
1.4	Attending doctor sign					
1.5	Consent of patient with sign					

1.6	Corporate /TPA patient marked				
2.	**Discharge summary**				
2.1	Patient details with name of consultant and date of admission & discharge				
2.2	Diagnosis, chief complain				
2.3	Past history, allergy				
2.4	Physical examination,				
2.5	Medication &treatment given				
2.6	Condition at discharge				
2.7	Date &time of next follow-up				
2.8	Discharge medication				
2.9	Sign and employ code of doctor				
3.	**Visits & billing**				
3.1	Inpatient cash bill, visit no., bill no., billing class				
3.2	Discharged stamped				
3.3	Net patient amount				

3.4	Sign of billing executive with date and time				
3.5	Patient intimation slip				
3.6	Doctor visit sheet from adm. to discharge				
4.	**Personal information proforma and history sheet**				
4.2	Signature of the patient with date				
4.3	Signature of the relative with date				
4.4	Signature of the witness with date				
4.5	Medication history				
4.6	Signature of RMO with date				
4.7	History sheet with chief complain, history of present illness				
4.8	Past medical history, family history, social history, physical examination				
4.9	Past medical history should match with PIP				
5	**Progress notes and treatment sheet**				
5.1	From Date of admission to discharge				
5.2	Sign with employ code of doctor				

6.	**Investigation**				
6.1	Lab and Radiology Investigation with Sample No.				
6.2	Compatibility report with pt. name, age ,sex ,blood group				
6.3	Done and check by- name with date and time of issue				
6.4	Investigation sheet with date				
7.	**Operation record**				
7.1	Patient detail				
7.2	Name of procedure with date				
7.3	Date of surgery &time				
7.4	Preoperative diagnosis				
7.5	Postoperative diagnosis				
7.6	Findings Used techniques & procedure				
7.7	Name of surgeons with sign &employ code				

7.8	Legibility				
8.	**Consent form**				
8.1	Patient name with procedure				
8.2	Signature of the patient with date				
8.3	Signature of the relative with date				
8.4	Signature of the witness with date				
9.	**Physiotherapy record**				
9.1	Name, age, sex, occupation, address				
9.2	Diagnosis				
9.3	medical ,social and family history				
9.4	Medication, chief complain				
9.5	Lab test &plan of care				
9.6	Physiotherapist sign				
7.	**Initial nursing assessment**				
7.1	Date &time of assessment with consultant name				

7.2	Assessment findings doc. within 24 hrs of admission				
7.3	Height and weight on physical examination sheet				
7.4	Medical history should match with PIP				
7.5	Nutritional status , physical examination& assessment sheet				
7.6	Daily assessment sheet from date of admission to discharge				
7.7	Pain score from date of admission to discharge with nurses sign &employ code				
7.8	Nurses notes from date of admission to discharge with sign & employ code				
7.9	Nursing care plan sheet				
8.	**Critical care flow sheet**				
8.1	,Post OP days, ICU days, Diagnosis, Operation, Name of surgeon				
8.2	Pre op wt./daily wt.				
8.3	Temperature, heart rate pressure				
8.4	Lab investigation				
8.5	Drug administration record				
8.6	Diabetic chart				
8.7	Sign of shift nurses				
9.	Transfer in/out checklist Drug expiry check form with name & date of expiry				

Assessment of Outpatient box file

Outpatient Box file – 1box file contain 80 OPD sheet

Outpatient sheet content	**AH NO.** **TOTAL**	**AH NO.**	**AH NO.**	**AH NO.**	**AHNO.**
Patient details (name, age ,sex),					
Patient AH NO.					
Doctor name					
Appointment date					
Chief complain					
Review of system					
Physical findings					
Medical advice					
medications					
Outpatient bill					

CHECKLIST 2

ASSESSMENT OF LEGAL ASPECTS OF MEDICAL RECORD

Mrn no.	Imprint labels to be sticked every sheet of MRD document	Coding and indexing of disease and operation	Legibility	Forms assembled in order	Forms not assembled in order	All appropriate forms present	MRN.no.on the file	Loose forn	Blank form	Doc. Original	Patient name & no. consistent on all forms	Recording on designated form	Obliterations	Comments

CHECKLIST 3

ASSESSMENT OF PRESENCE OF BASIC &SPECIAL FORMS IN MLC, DAMA, EXPIRED MEDICAL RECORD

SL NO.	Basic and special form with content and documentation	MRN NO.	MRN NO.	MRN NO.	MRN NO.	MRN NO.
1.	**MLC**					
1.1	Stamped as MLC with red ink					
1.2	MLC Registration form					
1.3	MLC/Accident register					
1.3.1	Personal details with date &time					
1.3.2	Metrification marks, brought in by, police information .PC NO.					
1.3.3	History & alleged cause of injury, name of injury &description					
1.3.4	Investigation result					

1.3.5	Sign of medical officer With name & reg no.					
1.3.6	Report of medico legal case received copy by police station					
1.3.7	Sequence					
2.	**DAMA**					
2.1	DAMA form with stamp					
2.1.2	Name of patient with sign					
2.1.3	Name of relative with					
2.1.4	Name of witness with sign & employ code					
2.1.5	Relationship with patient					
2.1.6	Discharge summary – condition on discharge					
2.1.7	Sequence					
3.	**EXPIRED**					

3.1	Case summary with patient name					
3.1.1	Cause of death					
3.1.2	Sign of critical care consultant					
3.1.3	Death certificate issued by DMC					
3.1.4	Name of hospital, ward no.					
3.1.5	date & time of death same as case summary					
3.1.6	Name of deceased with ,sex ,age cause of death					
3.1.7	Manner of death					
3.1.8	Name &sign of medical attendant					
3.1.9	Rubber stamp, reg. no. & date of verification					
3.1.10	Acknowledgement from pt. relative for receiving original death certificate					
3.1.11	Sequence					

ASSESSMENT OF FILING AND RECORD CONTROL FUNCTION

Checklist 4

CODING - Y-Yes, N- No , NA- Not applicable					
SL NO.	**SHELVES NO.**	**NO. OF PATIENTS RECORD**	**MISFILED RECORDS DUPLICATE RECORDS**	**FOLDER WITH PAGES PROJECTING OUT**	**ILLEGIBLE NAME & NUMBER ON FOLDER**

ASSESSMENT OF FORMS DESIGN

Checklist 5

Sl no.	Forms	Printed form	Printed hospital name	Place for pt. name	Place for hospital no	Uniform margin	Uniform binding	Uniform size	Uniform weight

CHECKLIST 6

TO ESTIMATE DEFICIENCY RATE OF PATIENT MEDICAL RECORD ON MONTHLY BASIS.

DATE	AH NO.	REASON FOR FILE GONE BACK	FLOOR	ISSUES	DEFICIENCY RATE

CHECKLIST 7

Assessment compliance rate of receiving discharged patient file within

MRN NO.	Date of discharge	Date of receiving	Floor	Issues	Delay hrs.