Original article

Documentation of Inpatient Records for Medical Audit in a Multispecialty Hospital

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ABSTRACT

Introduction: Medical audit in the current scenario of increasing medical demands and the increasing trend of medical multispecialty has been a crucial tool to analyse and regulate the service provided to the service receiver or the patient. Medical Records can be defined as the set of documents that provide the clinical, para-clinical, and financial data about the patient.

Materials and Methods: The study was conducted for a period of one year in our own teaching hospital (Teerthanker Mahaveer Medical College, Hospital & Research Centre, Moradabad, Uttar Pradesh, India) which is tertiary care Centre with 900 functional beds, in the urban area of the state to analyse the documentation of medical audit. The data so collected was through brainstorming, observation, interview, and review of workflow during the lean sessions was conducted.

Results: The intensity of difference among the standard of record keeping in various departments was actually surprising. First of all the department of Paediatrics and gynaecology was found to be most satisfactory while general medicine department was not at all in order.

Conclusion: This study showed that in order to achieve patient's satisfaction, the correct measurement of the quality of the services being offered to the patients is the basic quality of the medical service provider.

Keywords: Audit, Para Clinical, Multispecialty

INTRODUCTION

Medical audit in the current scenario of increasing medical demands and the increasing trend of medical multispecialty has been a crucial tool to analyse and regulate the service provided to the service receiver or the patient. Medical Records can be defined as the set of documents that provide the clinical, para-clinical, and financial data about the patient. The Medical Records Department is completely responsible for collecting, and protecting the patient information, and providing it to the people or an organization who are responsible for providing quality treatment to patient.[1] Every medical record department in a hospital comprises of the following four units, each having specialised function; (a) Admission: Registration of the inpatients and the outpatients who are admitted to a Hospital along with the concerned ward. Also the trauma and Emergency Department. (b) Archive: to ensure that a complete discharge summary and all other necessary notes and reports are present in the medical record department. It also involves the assembling and internally organizing the medical records and compiling them in an orderly and timely manner. Later obtaining these records for treatment and the analysis in other capacities. (c) Statistics: to avail statistics for administration use, hospital wards, providing health information for specialist physicians, nurses and students for medical purpose

and discussing history. Also, for research purposes and external agencies including the Ministry of Health. (d) Coding: to evaluate the medical records for all inpatient after discharge and providing them with a set of numeric codes to the diagnostic data, which is based upon the International Classification of Diseases-10 and the International Classification of Procedures in Medicine.[2] Now-a-days the health care expenses continue to increase the budgets of households, governments, and healthcare providers. So, a more reliable method to decrease the cost of treatment is necessary. Such a tool to increase the efficiency and value of treatment is employed known as "Lean thinking".[3] The basic role of Lean management is provide utmost customer satisfaction. Which is achieved by the elimination of waste and by improvement of processes.[4] In the present study documentation record during medical audit was evaluated.

MATERIALS AND METHODS

The study was conducted for a period of one year in our own teaching hospital (Teerthanker Mahaveer Medical College, Hospital & Research Centre, Moradabad, Uttar Pradesh, India) which is tertiary care Centre with 900 functional beds, in the urban area of the state to analyse the documentation of medical audit. A total of hundred entries were made in every department, under the following headings; (a) planned care not according to the protocol, (b) non documentation of food record, (c) entry of records in name/date/sign, (d) leaving without consent of doctor, (e) diseases not classified according to international nomenclature. The data so collected was through brainstorming, observation, interview, and review of workflow during the lean sessions was conducted. To achieve the goals in analysis to analyse and improve medical record department certain steps were followed, such as categorising problems and their solutions. Brainstorming technique was used as to motivate Lean group, collect their ideas, and to come up with creative ideas to counter their problems. We even used interview and discussion methods to know current processes in medical records department worked. We even used of medical record department staff's experience to evaluate and analyse the external clients opinions. The steps followed for lean Management in the Medical Records Department of the hospital during the sessions conducted came forward with their respective suggestions to decrease current wastes. The practicability or non-practicability of the suggestions were later analysed and the final corrections and modifications in the processes were conducted with the consent of the medical record department lean team. To attain this goal the customers were identified and then their expectations and needs were understood.

RESULTS

In total 100 entries were made under 5 various categories each namely; (a) planned care not according to the protocol, (b) non- documentation of food record, (c) entry of records in name/date/sign, (d) leaving without consent of doctor, (e) diseases not classified according to international nomenclature. (table 1)

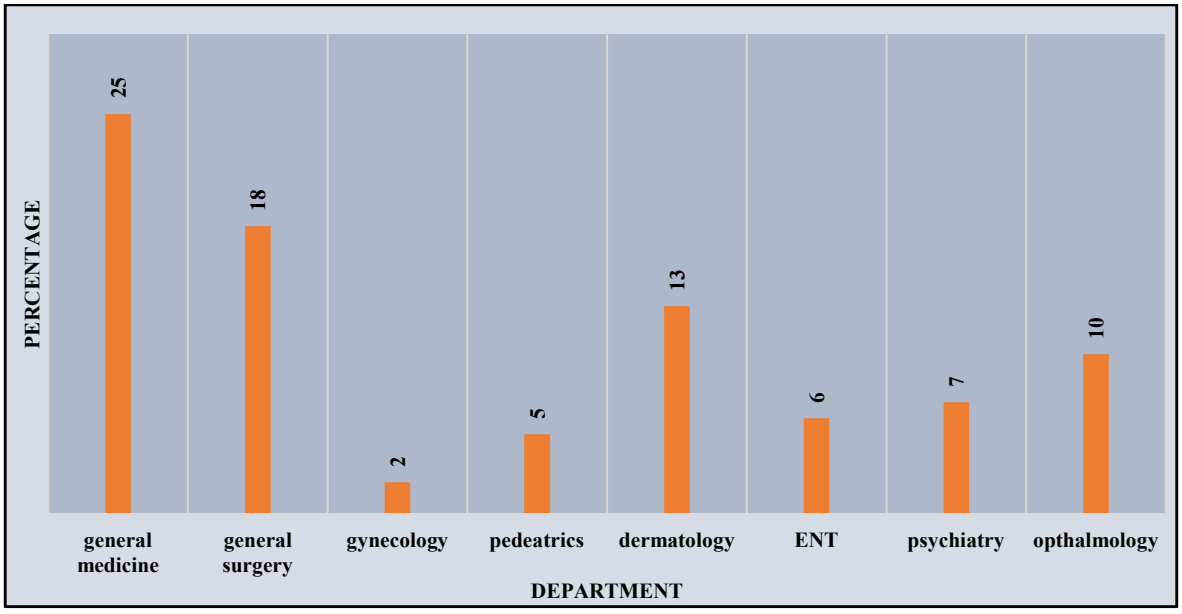
The intensity of difference among the standard of record keeping in various departments was surprising. First of all the department of Paediatrics and gynaecology was found to be most satisfactory while general medicine department was not at all in order. (Graph 1) Also the care provided to the patients was not according to the set protocol in general medicine and general surgical wards. Almost all departments didn't documented the food order in the provided medical records. (graph 2) In the medical record entry the entries for date/name/sign was not present in most of the departments, especially in the general medicine department. (Graph 3) In certain departments

patients were discharge without taking unwillingness for treatment certificate namely as Leaving against medical advice (LAMA). For general medicine and gynaecology department patients. (Graph 4) In terms of international nomenclature department of gynaecology and psychiatry showed maximum number of discrepancies. (Graph 5) Alteration in medical records was found in almost all the departments.

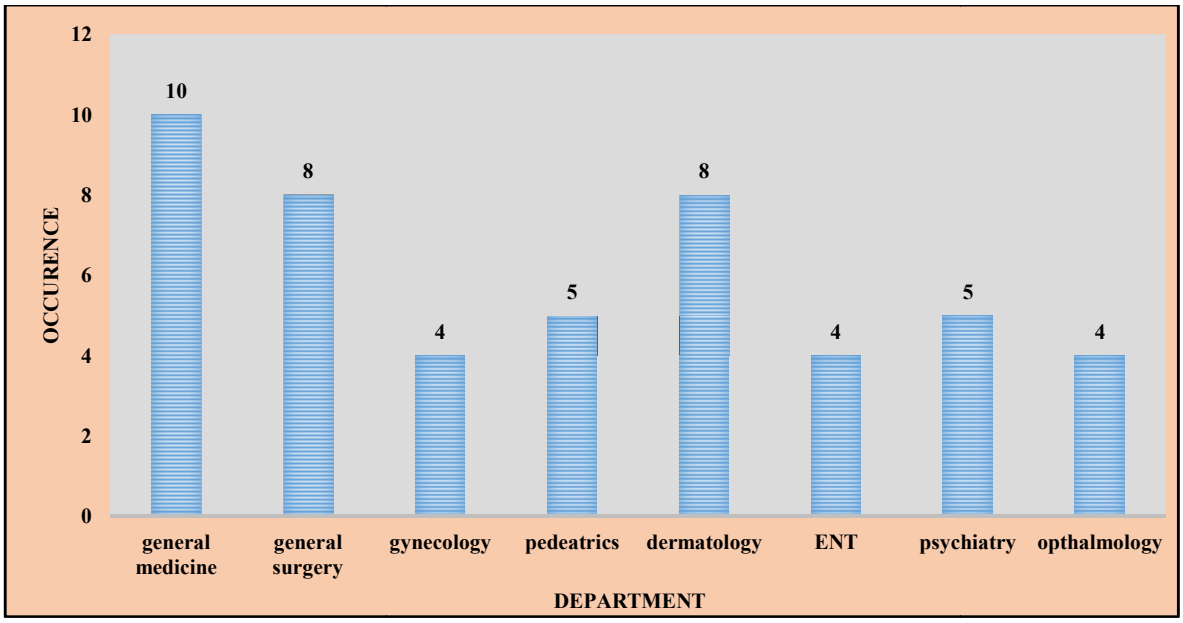
Table 1: The overall criteria's evaluated in the study

	Planned care not as per protocol	Non documentation of food record	Entry record	Leaving without consent of doctor	Diseases not classified according to international nomenclature
General Medicine	25	10	45	8	20
General Surgery	18	8	30	1	18
Paediatrics	2	4	13	9	27
Gynaecology	5	5	31	0	5
Dermatology	13	8	30	0	14
ENT	6	4	21	0	0
Psychiatry	7	5	15	1	28
Ophthalmology	10	4	4	0	16

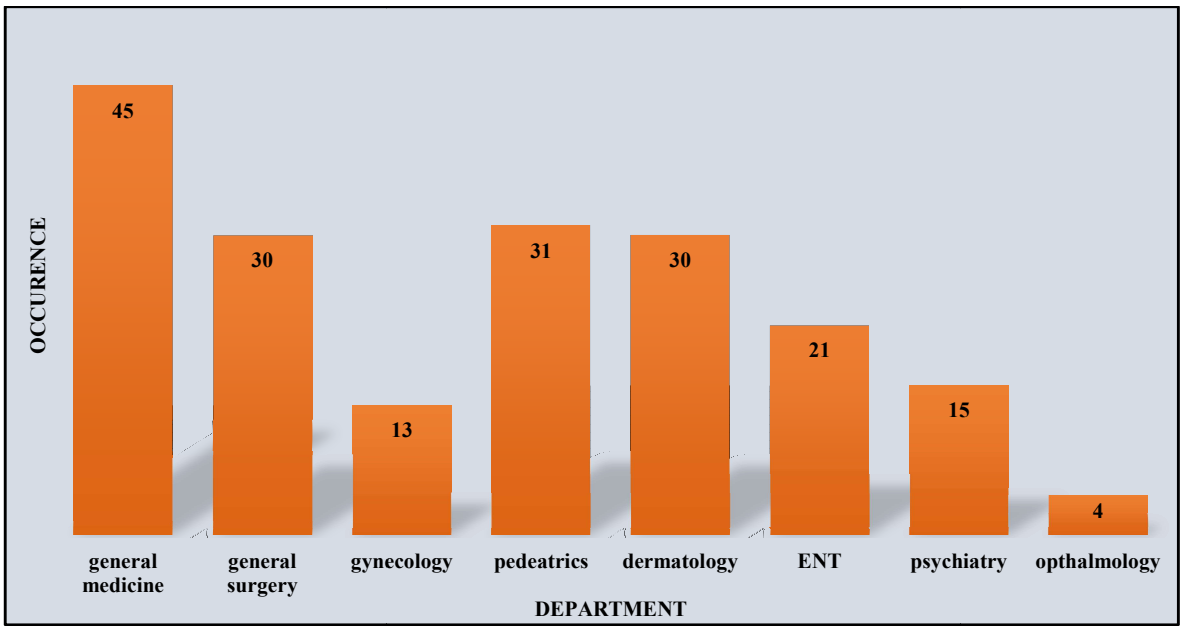
Graph 1: Planned care not provided according to the protocol



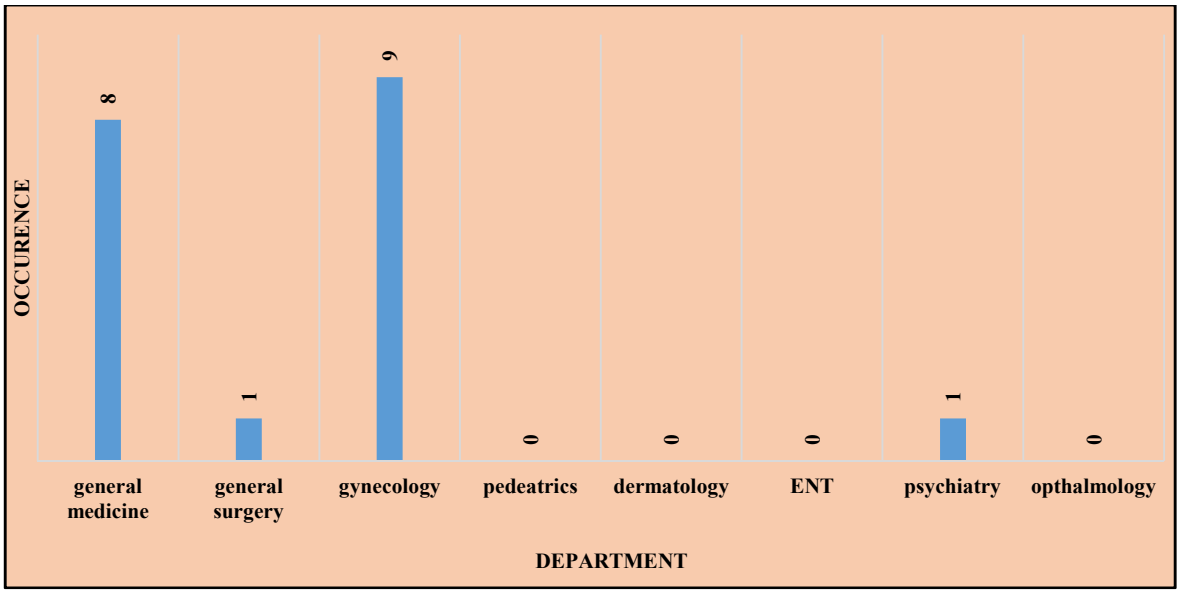
Graph 2: Non documentation of food record



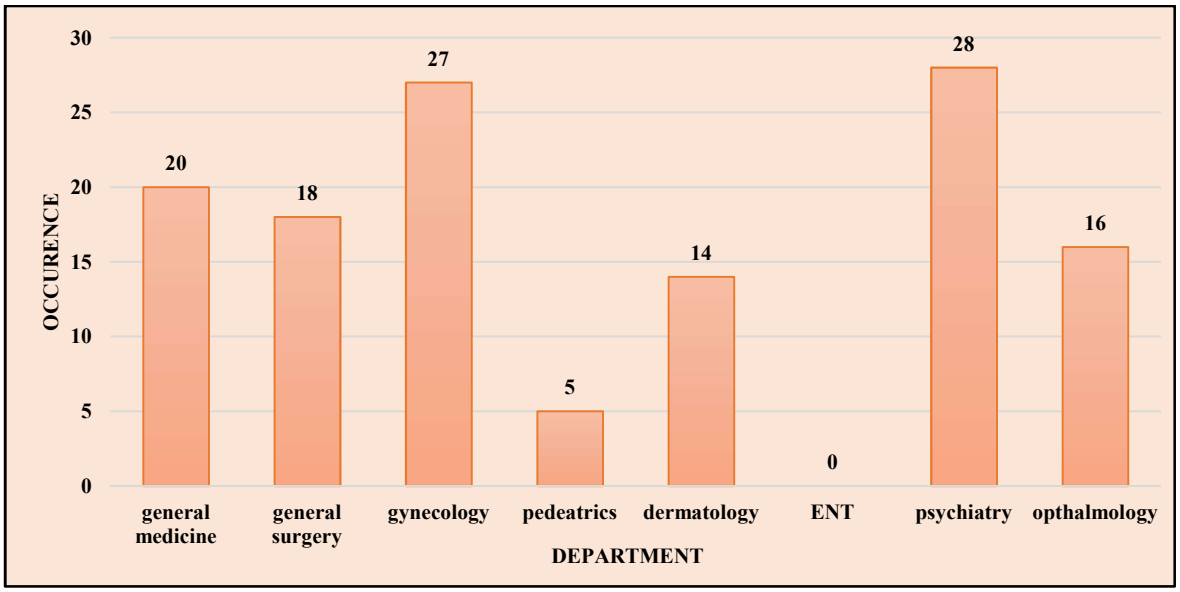
Graph 3: Entry in records for date/sign/time



Graph 4: Leaving without the consent of the doctor



Graph 5: Diseases not classified according to the international nomenclature



DISCUSSION

To keep customer needs in accord to the finances available the lean management has shown necessary efficiency and effectiveness. The lean management is effective only when, it is properly designed and selected.[5] Lean practically reduces the waste by taking out the unnecessary processes and then redirecting human effort towards the value-added procedures.[6,7] Waste in a medical setup can be described as the mistakes that need correction and production of goods without any reasonable demand. The healthcare has its own type of waste including the information, process, and physical environment in a setup. Healthcare is full of information waste. To fulfil the lean management and avoid any waste the correct value stream charting should be conducted. Value stream mapping categorises the waste within a process, helping to plan and construct valuable enterprise. The value stream mapping is defined by the current state, i.e. how the process is being performed presently.[8] The medical department still use paper

as the major medium for medical registrations. This made it hard or let's say nearly impossible to present and share information for referral. The technology absolutely exists to leave behind handwritten prescriptions and move toward the more reliable electronic registration method. Lean integration clearly showed that how this aim can be achieved in a gradual and sustainable method. [9] To execute the Lean steps and improve the performance pertaining to the medical record department, the Healthcare Performance Partners group had discouraged the current processes of the specific department. This was achieved by the means of brainstorming leading to the discovery of the problematic processes in every department of the hospital. In their study one of the crucial stages of doing the job was to discontinue the current processes by the brainstorming sessions of the medical record department lean team.[10] In the current study when the coding processes were being analysed, a number of cases were encountered which lacked correct file documentation causing a great deal of confusion and chaos. Also the patient registration also one of the most tedious work in a medical setup a number of faults and discrepancies were noted. Resulting in the difficulty in receiving medical claims, benefits and insurance money. Poor standard's in registrations in the specific departments led to significant amount of patient complaints. Bills were being sent to incorrect insurance companies who would deny payment, and then the patient was held responsible for the billing of the procedure which was covered in the health insurance. In some cases staff was also seen creating false or multiple accounts for the same patient leading to multiple bills for the same procedure conducted on a patient.[11] Other problems which were more talked about but less discussed in terms of operation improvements were the complete absence of networked Hospital Information Systems, no guidelines were available for authority responsible for the discharge process. The lack of on the visitation hours by physicians for the patients and also aspects like financial inability of the patient to pay their bills on time was also seen as a crucial loophole in the study.[12]

CONCLUSION

This study showed that in order to achieve patient's satisfaction, the correct measurement of the quality of the services being offered to the patients is the basic quality of the medical service provider. It is also the major goal of the lean management. To allow Lean management in the medical registration department is so helpful and highly appreciated, as it is the team work with the presence of the masters of the processes who are involved in the duties and activities of their units and are aware of the minute and correct details of the current activities.

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