CHAPTER 18

A Study on Assessment of Patient Related Documentation in Tertiary Care Hospital

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INTRODUCTION

Documentation serves as a vital communication tool facilitating the exchange of information among healthcare providers. It holds a pivotal role in evaluating the standard of care provided by hospitals, contributing to the enhancement of professional autonomy, critical thinking skills, and the overall development of nursing education. The execution of documentation is paramount for ensuring continuity of care, effective planning, and liability, while also promoting evidence-based practices.

Maintaining good record care not only supports the efficient functioning of a hospital's administration but also provides a tangible record of the institution's accountability for its procedures. Furthermore, these records serve as crucial repositories of data for medical research, statistical reports, and health information systems. Record keeping, viewed as a tool for professional practice, should actively contribute to the care process. Timely and comprehensive documentation, initiated upon a patient's entry to the hospital premises, should continue throughout every stage of the treatment process. It is imperative that accurate and relevant records are promptly created in a patient's profile, encompassing interventions and corresponding responses. This meticulous approach to documentation ensures a holistic and informed approach to patient care, reinforcing the hospital's commitment to quality healthcare practices [2].

Poor documentation practices raise concerns related to the omission of medications, improper or double administration of medicines, and the potential for legal ramifications. Incomplete patient records consistently give rise to uncertainties and legal implications, as only fully documented medical cases are

accepted by legitimate medical groups for verifying and validating medico-legal cases. Statistics from developed countries indicate that 74% of reported cases of errors in healthcare providers are brought to judicial authorities. Thorough documentation of medical records is crucial because deficiencies in this process leave doctors vulnerable in medical negligence cases filed against them. Emphasizing the "Golden Rule" in documentation—i.e., "If it isn't written down, you didn't do it"—underscores the importance of comprehensive record-keeping. One significant reason for incomplete records is the misconception among doctors and surgeons that the documentation of data related to patient care is not an integral part of the treatment process. However, the time spent registering and completing patients' medical records is considered a crucial aspect of the care process [3].

To address this, proper maintenance of Medical and Nursing Records, Consent Forms, Medication and vitals sign observation charts, Handover sheets, and Patient assessment forms is essential. Medical records serve as vital tools in the execution of treatment and prevention activities, reflecting the medical affairs of an institution. The documentation and dissemination of information in medical records are foundational for education, research, and decision-making management in healthcare. Standardized medical record documentation is crucial for good patient care and preventing healthcare providers from negligence suits. Informed consent has become the primary paradigm for protecting patients' legal rights and guiding ethical medical practice. It involves the patient with decision-making capacity freely authorizing a treatment plan, acknowledging the treatment goal. Informed consent is considered complete when the physician discloses and the patient comprehends the

diagnosis, relevant treatment options (including no treatment), and associated risks and benefits. Proper documentation of informed consent, containing all necessary details, is imperative in ensuring ethical and legally sound medical practices [4].

RESEARCH QUESTION

1. What was the extent of adherence to NABH standards in the documentation practices within the examined facility?
2. What were the key factors that significantly contributed to instances of non-compliance in documentation within the considered facility?
3. Did the forms and formats in use align with the corporate or hospital policies that were in place at the facility under examination?

RESEARCH OBJECTIVES

1. To evaluate the adherence to NABH standards in documentation.
2. To enumerate the primary causal factors leading to non-compliance in documentation according to NABH standards.
3. To evaluate and identify any discrepancies in the forms and formats presently utilized within the facility.

RESEARCH METHODOLOGY

The research design employed for this study was a descriptive cross-sectional approach, conducted at Shri Mata Vaishno Devi Narayana Super Speciality Hospital in Katra, Jammu and Kashmir, with collaboration from the Medical Administration and Quality Department. The study duration

spanned from April 1, 2021, to May 31, 2021. The investigation focused on actively and passively admitted patients, observing their files and consent forms to identify and note non-compliances. A comprehensive assessment of forms and formats from various departments, both clinical and non-clinical, was carried out to pinpoint areas of non-compliance and identify the need for updates. The study included a mixed-methods approach, incorporating both quantitative and qualitative assessments. The inclusion criteria comprised files from active and passive patients, specifically admitted individuals. Exclusion criteria involved the omission of MLC and DAMA files, as well as those of COVID and gynaecology patients. The research duration extended over three months, utilizing convenience sampling with a sample size of 200 patient files. The study instrument employed a data collection format for both active and passive files, consent forms, and various forms and registers used within the organization. Microsoft Excel was employed for statistical analysis. Operational definitions were provided for key terms such as medical records, documentation, inpatient, anaesthesia, serology, accreditation, informed consent, and quality.

RESULT AND DISCUSSION

The analysis of consent forms reveals variations in documentation compliance across different parameters and types of consents. In general consent, the SNDT of witness is the least filled parameter, recorded at 1.03%, while the most documented aspect is the explanation of the procedure in the patient's language, boasting a rate of 21.45%. Similarly, anaesthesia consent exhibits minimal documentation in SNDT of witness (0.95%), with the highest compliance found in SNDT of the patient (16.67%). Diagnostic consent illustrates a deficiency in SNDT of witness documentation (1.08%) but excels in procedure

explanation in the patient's language (23.08%). High-risk consent reflects a lack of documentation in SNDT of the patient (2.63%) yet consent within the timeframe is highly documented at 19.74%. Operation/procedure consent and serology consent present their least filled parameters in SNDT of witness (2.74%) and (0.84%) respectively, with the most documented parameters being SNDT of attendant (16.16%) and procedure explanation in the patient's language (18.83%). In transfusion consent, SNDT of witness is the least documented (1.16%), while consent within the timeframe and the name of the procedure are most frequently recorded (17.44%).

Moving on to compliance in patient files, the admission order exhibits a range of 77-78% compliance, with a noteworthy parameter being the name and signature of the admitting consultant (74-76%). Conversely, admission consent attains a perfect compliance rate of 100%, highlighting meticulous recording of the patient's and relative's names and signatures. Initial assessment on admission maintains a compliance rate of 80-85%, with a significant emphasis on correlating allergy history (84-91%). Doctor's progress notes range from 76-84% compliance, emphasizing the importance of daily written progress notes (83-84%).

The consultation cross-referral form achieves an impressive 82-97% compliance rate, particularly excelling in documenting requests for referrals (86-97%). The medicine card for long and short stays records compliance rates of 24-79%, stressing the need for medication orders to be written in capital letters (32-79%). Consent forms (serology, operation, radiology, high risk, blood transfusion, anaesthesia) show varying compliance rates from 12.72-97.67%, with anaesthesia consent's completeness standing out (92.75-97.67%). Operation documents

for surgery demonstrate a compliance range of 20.77-93.05%, highlighting the importance of completing the verification checklist (90.16-93.05%). Narcotic drugs documentation maintains a compliance rate of 29.85-97.67%, with particular attention to filling the narcotic form completely (97.67%). Cath procedure notes exhibit a compliance range of 14.51-91.66%, underscoring the significance of pre-procedure details completeness (91.66%). Nutritional documents showcase compliance rates of 32-92%, emphasizing the need for daily nutritional reassessment (32-92%). Physiotherapy documents, however, present a lower compliance range of 1-21.50%, pinpointing the imperative nature of completing assessments within 24 hours (1-21.50%).

CONCLUSION

In conclusion, the study highlights the imperative need for continuous and progressive educational plans in documentation practices, considering the dynamic nature of patient care. The findings underscore the importance of well-defined, organized documentation instructions and team collaboration, emphasizing the role of continuous monitoring and structured examinations. A meticulously documented medical record is crucial for providing high-quality care, reducing processing inconveniences, and serving as a legal document validating the care provided by the hospital. The study reveals notable deficiencies in the documentation of consent forms and various parameters in patient files, signalling the necessity for targeted training sessions for all staff members. The emphasis should be on achieving full compliance in critical areas and ensuring compulsory documentation in patient health records to enhance completeness and accuracy, aligning with NABH standards. Overall, the study advocates for a

comprehensive approach to documentation improvement, recognizing its pivotal role in patient care, legal validation, and adherence to quality standards.

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