MEDICAL RECORD POLICIES

1) Absconded Patients

Information about absconded patients must be recorded in the patients file with details concerning the date and time the patient was discovered to the missing from the ward. The treating physician should note and sign the record accordingly. The matter must also be communicated to the police.

2) Against Medical Advice

The patient who leaves against medical advice should be considered as discharge. It should be ensured that the signature of the patient or his or her nearest relative is obtained in the prescribed form.

3) Referral of Patient

Patient referred from either outside or within the hospital should receive three referral copies, the first two copies are presented to the hospital by the patient whereas the third copy is retained by the referring health center or clinic. After treatment, the first copy is forwarded to the health center or hospital as feedback information and the second copy is retained in the hospital. All three copies of the referral from patients referred within the hospital become part of math patient file.

4) Patient Having Multiple Records

As a general rule, each patient should have one record and one number, due to improper system or negligence of the MRD staff, the patients may have more than one record. In that situation, it becomes necessary to retain one record by cancelling others. The appropriate procedure is to retain a record as a priority, which is medico legal nature, secondly obstetrics records, thirdly admitted record and fourth priority is oldest records, the remaining records have to be cancelled and given a cross reference numbers and bring all the documents including the investigation reports into the retained record. The cancelled empty folders with the cross reference number should be placed in their respective area.

5) Missing Records

Despite the strenuous measures adopted to have good control of records, and not to lose, some percentage of records, however do not find in the respective place where they are suppose to be.. This could be due to non-receiving, not keeping in appropriate place and wrongly filing. Under this circumstances, when a patient attends either for outpatient or inpatient record. At times, the physicians insist on original record for rendering care. The MRO might be able to retrieve them later, but at that stage the only option left for him to create a duplicate record with a similar number andwith all previous ID data. The duplicate record should be retained by the MRO without filing andimmediately should trace out the original records and incorporated all this forms of duplicate recordinto the original record and then the record should be filled.

Medical Audit

Definition

Medical Audit is a planned programme

- which objectively monitors and evaluates the clinical performance of all practitioners
- which identifies opportunities for improvement
- provides mechanism through which action is taken to make and sustain those improvements.

Medical Audit vs. Clinical Audit

- Medical audit is defined as the review of the clinical care of patients provided by the medical staff only.
- Clinical audit is the review of the activity of all aspects of the clinical care of patients by medical and paramedical staff.
- By 1994, the term 'clinical audit' appeared to have largely replaced the earlier term 'medical audit

History of Medical Audit

History

- 1750 BC: the 6th king of Babylon, Hammurabi instigated audits for the clinicians.
- Modern medicine (1853-1855): Florence Nightingale conducted first clinical audit during the Crimean War. She applied strict sanitary routine & hygiene standards that decreased the mortality rates from 40% to 2%.
- 1869-1940: Ernest Codman became known as the first true medical auditor following his work in 1912 on monitoring surgical outcomes. Codman's "end result idea" was to follow every patient's case history after surgery to identify errors made by individual surgeons on specific patients

Need of Medical Audit

1. To plan future course of action
   - it is necessary to obtain baseline information through evaluation of achievements for comparison purpose with a view to improve the services.
2. Regulatory in nature
   - ensures full & effective utilisation of staff and facilities available.
3. Assess the effectiveness of efficiency of health programmes & services put into practice

Purpose of Medical Audit

1. Professional motives- Health care providers can identify their lacunae & deficiencies and make necessary corrections.
2. Social motives- To ensure safety of public and protect them from care that is inappropriate, suboptimal & harmful.
3. Pragmative motives- To reduce patient sufferings and avoid the possibility of denial to the patients of available services; or injury by excessive or inappropriate service

Prerequisites

1. Hospital Operational Statistics.

a. Hospital Resources: Bed compliment, diagnostic & treatment facilities, Staff available

b. Hospital Utilization Rates: Days of care, operations, deliveries, deaths, OPD investigations, Laboratory investigations etc.

c. Admission Data: Information on patients, i.e. hospital morbidity statistics, avg length of stay [ALS], post operative morbidity, operation outcome etc.

Prerequisites

2. Standardized hospital statistics collection and tabulation.
3. Medical Record should be accurate and complete.
4. Medical record librarian.
5. Medical audit committee.
6. Hospital Planning and Research cell at State level

Principles

1. Health authorities and medical staff should define explicitly their respective responsibilities for the quality of patient care.
2. Medical staff should organise themselves in order to fulfil responsibilities for audit and for taking action to improve clinical performance.
3. Each hospital and specialty should agree a regular programme of audit in which doctors in all grades participate.

Principles

4. The process of audit should be relevant, objective, quantified, repeatable, and able to effect appropriate change in organisation of the service and clinical practice.

5. Clinicians should be provided with the resources for medical audit.

6. The process and outcome of medical audit should be documented.

7. Medical audit should be subject to evaluation

Types of Medical Audit

Statistical Audit

i. Data on different indicators set by audit committee are prepared unit wise on monthly basis
ii. A standard norm is evolved taking into consideration of available facilities, services, resources by an expert committee
iii. The data so obtained is critically examined & compared against the standard norm
iv. Deviation from standard norm dictates investigation to find out possible causes & remedial actions
v. The data are generated, compiled & presented by the MRD

Types of Medical Audit

MORBIDITY AUDIT

- A simple method of doing medical audit of a group of cases suffering from a disease category.
- Findings are matched with predetermined norms and standards of care laid down by medical staff for this disease category.
- It is done ward/unit wise.

Types of Medical Audit

POST OPERATIVE AUDIT

i. Patients are grouped based on similar surgical procedures done on them.

ii. A group of experts study:-Diagnosis confirmed by surgery, pre anaesthetic check up, post op complications, anaesthetic complications, safety checks, antibiotics used etc.

iii. the shortcomings are noted and intimidated for future precaution & rectification.

Types of Medical Audit

OBSTETRIC AUDIT

The indicators are similar to surgical cases but also includes

- No of CS done with indications
- No of forceps or vacuum application & indications
- No of maternal complications
- No of maternal & neonatal deaths

Types of Medical Audit

AUDIT OF DEATH CASES IN THE HOSPITAL (MORTALITY REVIEW)

- All the deaths which takes place after 48 hrs. of admission to the hospital are normally subjected to a review by a committee
- also useful to review the deaths within 48 hrs (especially death in emergency department)
- Case sheets are examined for quantitative as well as qualitative adequacies

Types of Medical Audit

NURSING AUDIT

- Review of the nursing care based on standard criteria
- Seeks to identify areas of service improvement, develop & carry out actions to rectify or improve the service.
- Special care, Input Output charts, O2 inhalation, daily nursing note etc. are studied.
- The can be retrospective or introspective.

Medical Audit in Hospital

Medical audit is far more important to a hospital than financial audit. Financial deficits can be met eventually but medical deficiencies can cost lives, or loss of health thereby resulting in unwanted agony.

THANK YOU