Medical Record Review

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Objective Medical Record Review

Medical records are critical documents

Completeness, timeliness & legibility

Facilitate continuity of care and communication among all those providing patient care services as well as allowing quality improvement activities to be performed

Identify opportunities for improvement

Type of Record Review

- **Open Record Review**
  - Prospective review
  - Usually done by staff
  - Allows for immediate feedback to staff

- **Closed Record Review**
  - Retrospective Review
  - Usually done by a multi-disciplinary team
  - Data discussed in committees

Review Process

- Review and evaluation includes records of active patients as well as records of discharged patients.
- Scope: inpatient areas, outpatient clinics and emergency room
- A representative sample of records is included in the review process
- Sample Size :

    a. Open File Audit (Inpatients) – Atleast 5-10 % of total admissions (after 48 hours of admission).

    b. Closed Audit – 100% of all inpatient discharges.

- Monthly/Quarterly data monitoring and review of data.

Team Members

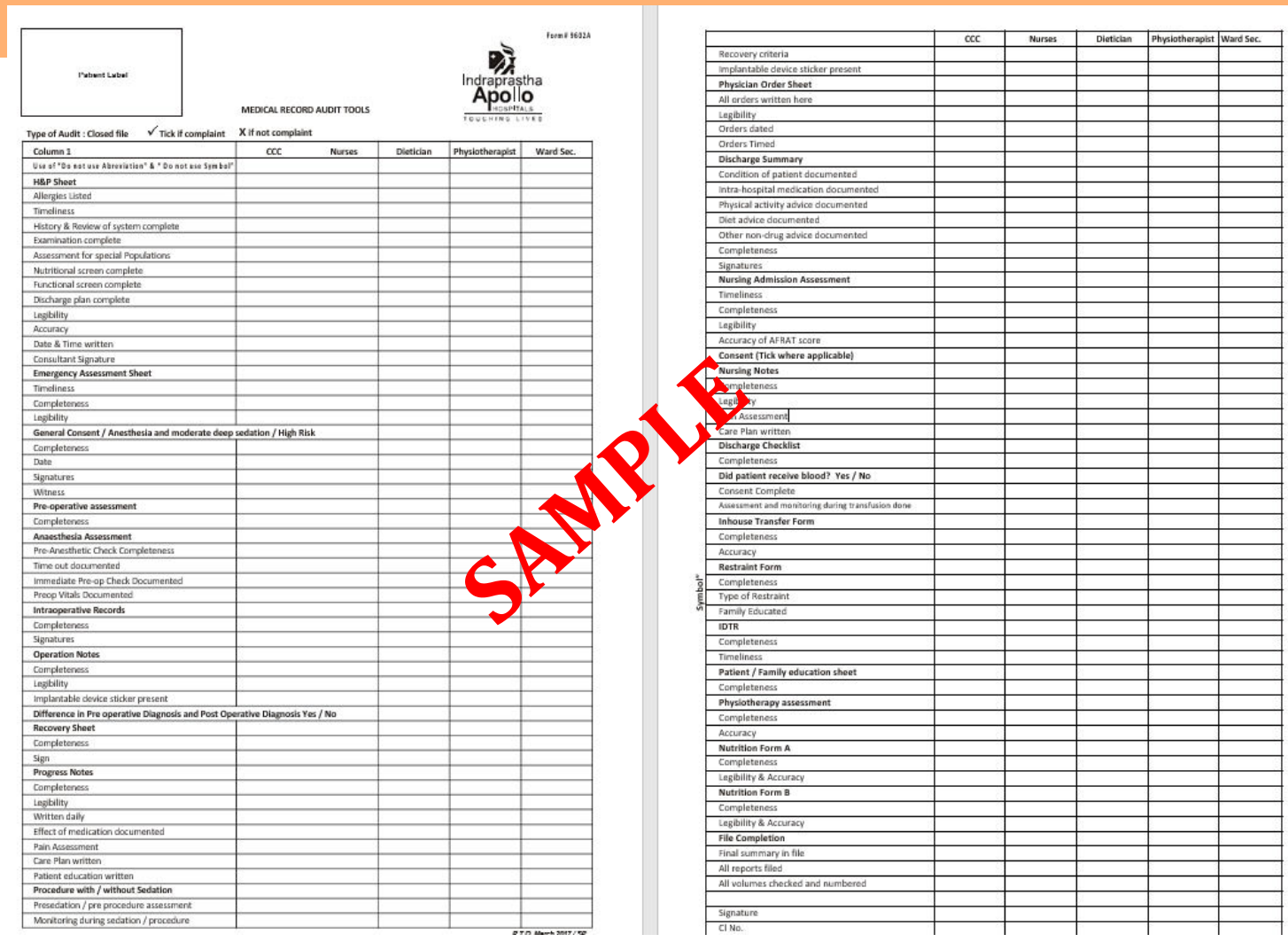
Medical Record Review is carried out by conducted by the medical staff, nursing staff, and other relevant clinical professionals who are authorized to make entries in the medical record or to manage medical records.

- Doctor
- Nurse
- Physiotherapist
- Dietician

Medical Record Review Tool

- Standard Patient Medical Record Review Tool based on policies
- The form is intended to be used on an ongoing basis.
- Identify potential discrepancies in documentation and areas for improvement.
- Continuity of care delivery
- To assure completeness, timeliness, legibility, use of abbreviations and symbols
- Appropriateness of orders, tests, and treatments
- Variance and outcome monitoring based on clinical paths or practice, guidelines
- Adequacy of the medical record as a clinical, communicative record

MEDICAL RECORD REVIEW TOOL



Patient Label

Form # 9632A

Indraprastha Apollo HOSPITALS TOUCHING LIVES

MEDICAL RECORD AUDIT TOOLS

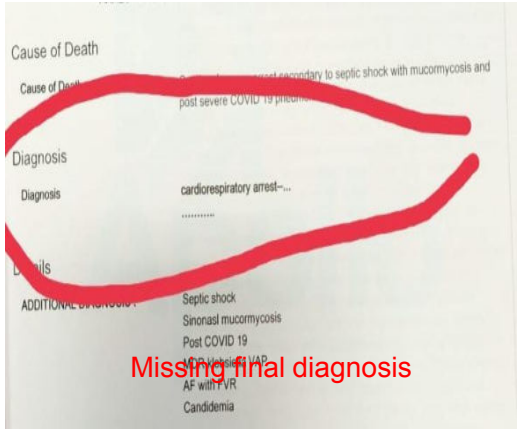
Type of Audit : Closed file ✓ Tick if complaint X if not complaint

Column 1	CCC	Nurses	Dietician	Physiotherapist	Ward Sec.
Use of "Do not use Abbreviation" & " Do not use Symbol"					
H&P Sheet					
Allergies Listed					
Timeliness					
History & Review of system complete					
Examination complete					
Assessment for special Populations					
Nutritional screen complete					
Functional screen complete					
Discharge plan complete					
Legibility					
Accuracy					
Date & Time written					
Consultant Signature					
Emergency Assessment Sheet					
Timeliness					
Completeness					
Legibility					
General Consent / Anesthesia and moderate deep sedation / High Risk					
Completeness					
Date					
Signatures					
Witness					
Pre-operative assessment					
Completeness					
Anaesthesia Assessment					
Pre-Anesthetic Check Completeness					
Time out documented					
Immediate Pre-op Check Documented					
Preop Vitals Documented					
Intraoperative Records					
Completeness					
Signatures					
Operation Notes					
Completeness					
Legibility					
Implantable device sticker present					
Difference in Pre operative Diagnosis and Post Operative Diagnosis Yes / No					
Recovery Sheet					
Completeness					
Sign					
Progress Notes					
Completeness					
Legibility					
Written daily					
Effect of medication documented					
Pain Assessment					
Care Plan written					
Patient education written					
Procedure with / without Sedation					
Presedation / pre procedure assessment					
Monitoring during sedation / procedure					

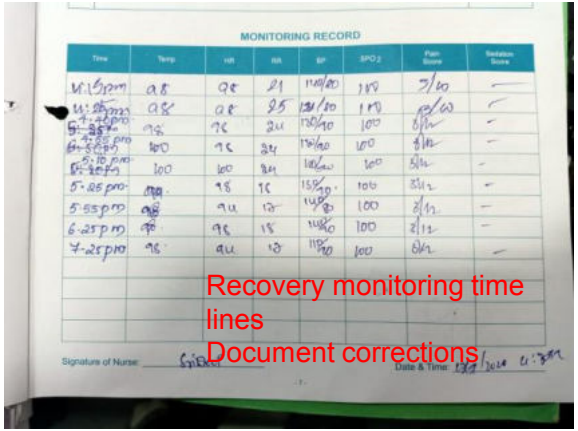
	CCC	Nurses	Dietician	Physiotherapist	Ward Sec.
Recovery criteria					
Implantable device sticker present					
Physician Order Sheet					
All orders written here					
Legibility					
Orders dated					
Orders Timed					
Discharge Summary					
Condition of patient documented					
Intra-hospital medication documented					
Physical activity advice documented					
Diet advice documented					
Other non-drug advice documented					
Completeness					
Signatures					
Nursing Admission Assessment					
Timeliness					
Completeness					
Legibility					
Accuracy of AFRAT score					
Consent (Tick where applicable)					
Nursing Notes					
Completeness					
Legibility					
Pain Assessment					
Care Plan written					
Discharge Checklist					
Completeness					
Did patient receive blood? Yes / No					
Consent Complete					
Assessment and monitoring during transfusion done					
Inhouse Transfer Form					
Completeness					
Accuracy					
Restraint Form					
Completeness					
Type of Restraint					
Family Educated					
IDTR					
Completeness					
Timeliness					
Patient / Family education sheet					
Completeness					
Physiotherapy assessment					
Completeness					
Accuracy					
Nutrition Form A					
Completeness					
Legibility & Accuracy					
Nutrition Form B					
Completeness					
Legibility & Accuracy					
File Completion					
Final summary in file					
All reports filed					
All volumes checked and numbered					
Signature					
CI No.					

Symbol"

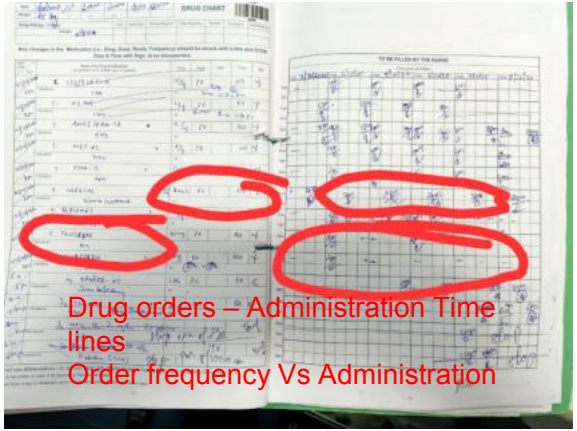
SAMPLE



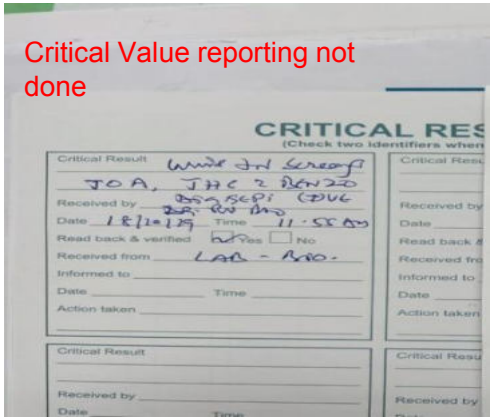
Missing final diagnosis



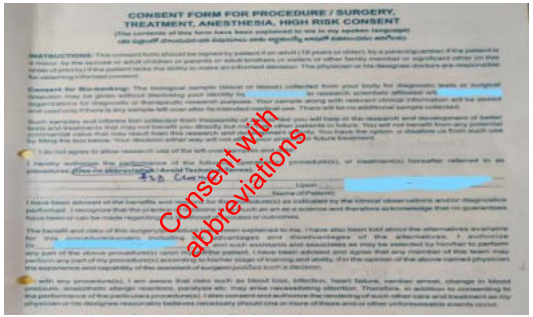
Recovery monitoring time lines
Document corrections



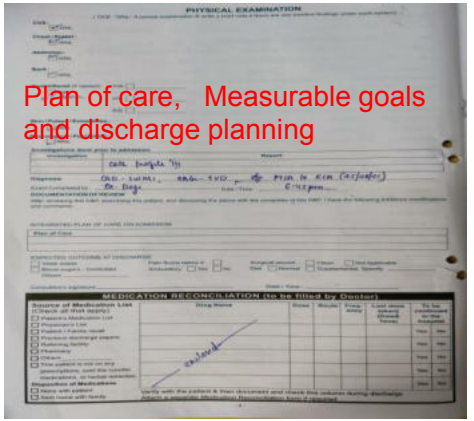
Drug orders – Administration Time lines
Order frequency Vs Administration



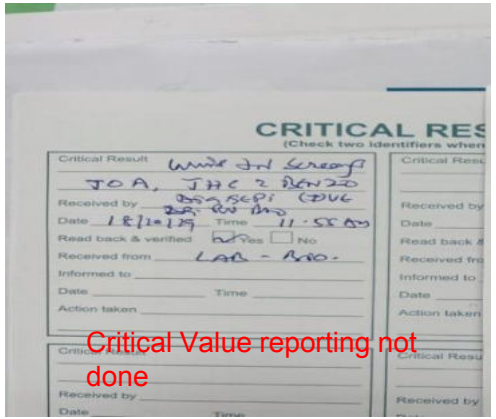
Critical Value reporting not done

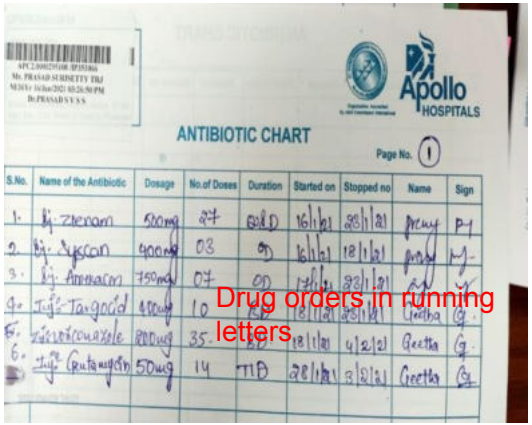


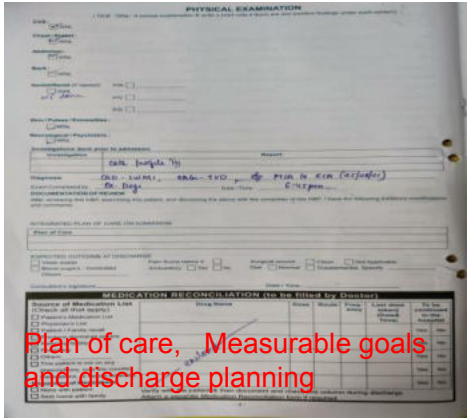
Consent with abbreviations

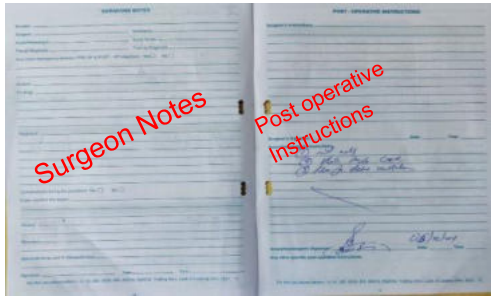


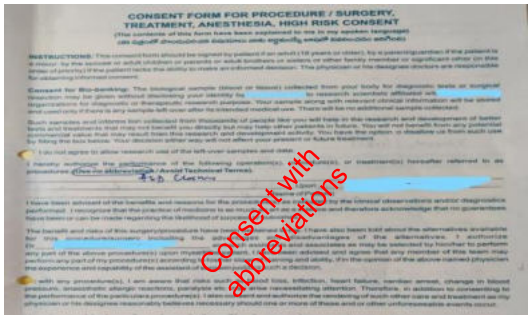
Plan of care, Measurable goals and discharge planning


CRITICAL RES
(Check two identifiers when
Critical Result
Received by
Date
Time
Read back & verified
Yes
No
Received from
LAB - ABG.
Informed to
Date
Time
Action taken
Critical Value reporting not done


Apollo HOSPITALS
ANTIBIOTIC CHART
Page No. 1
S.No.
Name of the Antibiotic
Dosage
No.of Doses
Duration
Started on
Stopped no
Name
Sign
Drug orders in running letters


PHYSICAL EXAMINATION
MEDICATION RECONCILIATION (to be filled by Doctor)
Plan of care, Measurable goals and discharge planning

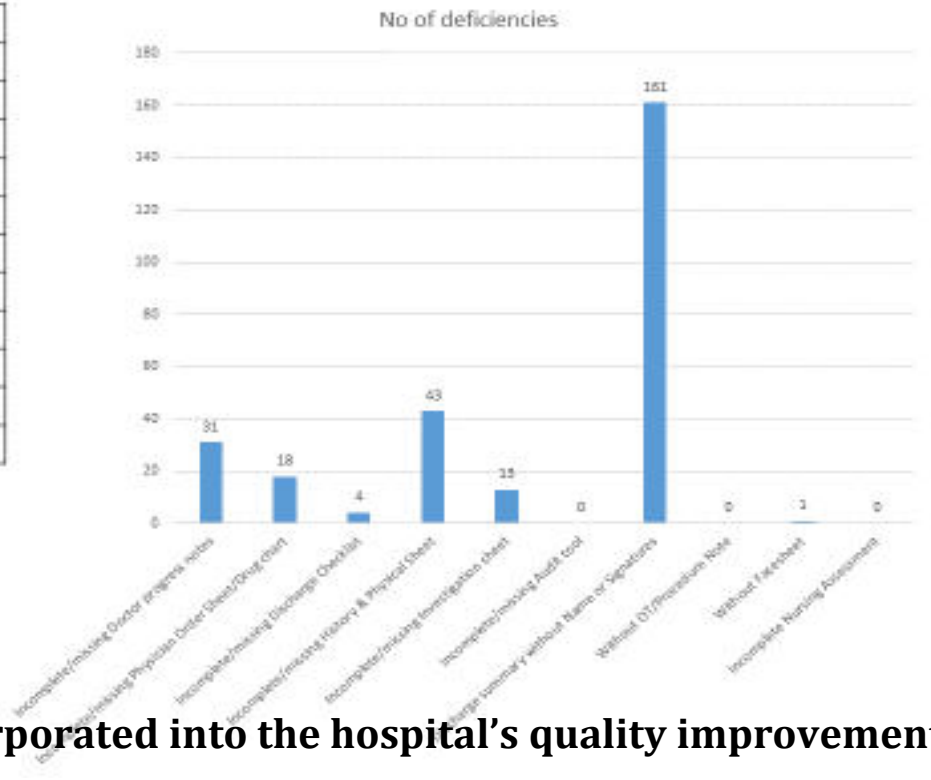

Surgeon Notes
Post operative Instructions


CONSENT FORM FOR PROCEDURE / SURGERY,
TREATMENT, ANESTHESIA, HIGH RISK CONSENT
Consent with abbreviations

Sample Data Analysis

STATISTICS

22.07.21 TO 10.08.21 (FILES 1246)	
Type of Deficiencies in documentation	**No of deficiencies**
Incomplete/missing Doctor progress notes	31
Incomplete/missing Physician Order Sheet/Drug chart	18
Incomplete/missing Discharge Checklist	4
Incomplete/missing History & Physical Sheet	43
Incomplete/missing Investigation sheet	13
Incomplete/missing Audit tool	0
Discharge summary without Name or Signatures	161
Without OT/Procedure Note	0
Without Facesheet	1
Incomplete Nursing Assessment	0

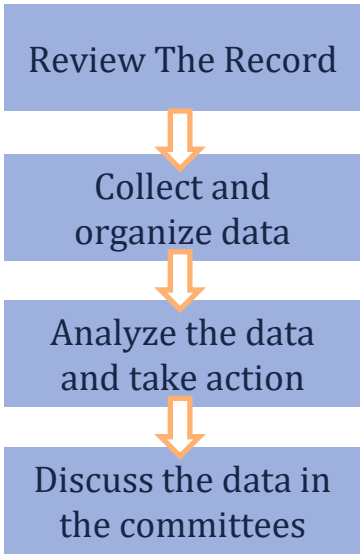


Results of the review process to be incorporated into the hospital's quality improvement program

Results of the review process to be incorporated into the hospital's quality improvement program

How is this data disseminated?

Is the data used to evaluate the staff?



IF IT IS NOT DOCUMENTED, IT HASN’T BEEN DONE!!