Improving Medical Record Documentation of Physicians-
A Retrospective Study at a tertiary care hospital at Karachi Pakistan

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Team Members

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ORGANIZATION PROFILE

The Aga Khan University Hospital, (AKUH) Karachi started operations in 1985. It is a philanthropic, not-for-profit, private teaching institution committed to providing the best possible option for diagnosis of disease and team management of patient care. AKUH’s multidisciplinary approach to diagnosis and care ensures a continuum of safe and high-quality care for patients – all services under one roof.

The University Hospital provides high quality of patient care in a broad range of secondary and tertiary services to over 50,000 hospitalized patients and to approximately 600,000 outpatients annually. In September 2006, AKUH became the first hospital in Pakistan and one of the select few teaching hospitals in the world to be awarded Joint Commission International (JCI) accreditation for achieving and maintaining highest international quality standards in healthcare.

AKUH is also the first hospital in Pakistan and among the first few teaching hospitals in the world to receive ISO 9001: 2008 certification. AKUH remains a differentiated provider in the field of healthcare. It has continued to excel because it provides quality services and is keen to innovate.
QPSD Scope of Services

The aim of QPSD is to improve quality, patient safety activities in all the divisions, departments and Service lines of AKUH including secondary hospitals. The role of the QPSD is to provide leadership and direction in providing high quality and safe services to internal and external customers through defined systems and processes for quality and patient safety. QPSD caters areas of all disciplines, in addition also work with other multidisciplinary committees to meet the standards of care in organization.

We offer following services:
- Internal and External Audits (JCIA and ISO 9001:2008)
- IPSG Audit
- Code blue Audit (Actual)
- Crash Cart Audit
- JCIA Library of measures:
  - Hospital acquired Pressure Ulcers/Skin Break Down
QPSD Scope of Services

Compliance to medical record reviews:
- Open
- Closed
- Ambulatory
- Emergency
- Medication reconciliation
- Supervision Data
Background

At AKUH (Aga Khan University Hospital), Karachi while preparing for the JCIA accreditation survey in 2006 we developed few institutional policies and procedures related to medical record documentation and similar expectations were also laid down in the medical bylaws. In addition we also formally started the process of medical record review for both active patients and discharged patients and later we included the review of ambulatory medical record review.
Definition of The Patient Medical Record!

Record providing a chronicle of a patient's medical history and care. Physicians, nurse practitioners, nurses and other members of the health care team may make entries in the medical record. The medical record includes a variety of types of "notes" entered over time by health care professionals, recording observations and administration of drugs and therapies, orders for the administration of drugs and therapies, test results, x-rays, reports, etc.
Significance: JCIA Requirement

Standard **MOI 10**

The hospital initiates and maintains a standardized clinical record for every patient assessed or treated and determines the record’s content, format, and location of entries.
Vital Components of Medical Record

- Initial Assessment
- Periodic Re Assessment i.e. Progress Notes
- Procedure Notes
- Event Notes
- Physician's Order
- Discharge Summary
- Consultations
- Informed Consent
- Discussions during consultations and outcomes of such discussions
Continuity of Care
Rationale for Selection

In the initial months of year 2015 Medical records were screened by a dedicated quality coordinator to perform a gap analysis in order to identify the critical elements and areas of noncompliance in clinical documentation. The selection was based on physicians documentation’s where majority of noncompliance were seen in the standards of medical records documentation below the target set by the institution.
Problem Statement

Six significant problems identified through gap analysis:

- Discharge summary was not countersigned by senior resident.
- Initial physician assessment and plan of care was not countersigned by attending physician (Attending comments).
- Progress notes were not countersigned by attending physician on daily basis.
- Informed consent was not obtained by resident or medical officers instead internes obtained the consent from patient/family.
- Pre anesthesia assessment was not done by senior resident.
- Postoperative plan of care was not countersigned by operating surgeon.
Mission Statement

To improve the Clinical documentation compliance in medical record documentation by 94% and ensure continuity of care
Methodology
## Project Plan

<table>
<thead>
<tr>
<th>Project Plan</th>
<th>Dec 2014</th>
<th>Q1 2015</th>
<th>Q2 2015</th>
<th>Q3 2015</th>
<th>Q4 2015</th>
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<tbody>
<tr>
<td>Brain Storming</td>
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<td>Audit tool development</td>
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<td>Audit plan development</td>
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<td>Initiation of regular monitoring through audits</td>
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<td>On time observations sharing with the stakeholders</td>
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<td>Result sharing with relevant stakeholders</td>
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<td>Reinforcement to attending physicians and residents</td>
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<td>Observations shared at different forums</td>
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<tr>
<td>Analysis of improvement</td>
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<td>Sustainability</td>
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Project Plan

- Each month approximately 260 medical record were reviewed.

- Overall compliance to medical record documentation was assessed through standardized tool.

- On spot sharing of non compliance with the staff, residents and monthly basis formal reports were relaxed to leadership.

- Results were discussed in different quality forum.

- Awareness was done in department quality improvements committees.
### Medical Record Audit Tool

**The Aga Khan University Hospital**  
**Quality & Patient Safety Department**  
**Medical record review Audit Tool**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Name of the Auditor</th>
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<tbody>
<tr>
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</table>

**Key:**  
M = Met  
PM = Partially Met  
NM = Not Met  
NA = Not Applicable

<table>
<thead>
<tr>
<th>Patient Name and MR #</th>
<th>Physician name</th>
<th>Diagnosis</th>
<th>Date of Admission</th>
<th>Date of discharge</th>
</tr>
</thead>
<tbody>
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<table>
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<tr>
<th>P</th>
<th>PM</th>
<th>NM</th>
<th>NA</th>
<th>P</th>
<th>PM</th>
<th>NM</th>
<th>NA</th>
<th>P</th>
<th>PM</th>
<th>NM</th>
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</tr>
</thead>
</table>

**Standard**  
**Criteria**

**MPE.4**  
Medical Professional Educational

- Discharge summary is countersigned by senior resident.
- Initial physician assessment and plan of care is countersigned by attending physician *(Attending comments)*
- Progress notes are countersigned by attending surgeon.
- Informed consent can be obtained by resident or medical officers (not interns).
- Pre anesthesia assessment is done by R1 and above.
- Postoperative plan of care is countersigned by operating surgeon.
CAUSE AND EFFECT

MAN
- Lack of team approach
- Lack of accountability
- Human error: Forgetting to countersign or placing the notes
- Tools for monitoring
- Audit Plans

MATERIAL
- Non availability of medical record folder
- Lack of policies and protocol
- No system in place for check and balance
- Lack of refresher Courses for staff and doctors
- Non availability of audit tools to observe correct practices

MEASUREMENT

Non compliance in medical record documentation

Audit Plans

Lack of Leadership involvement

Non availability of audit tools to observe correct practices

Tools for monitoring

Lack of refresher Courses for staff and doctors

No system in place for check and balance

Non availability of medical record folder

Lack of policies and protocol

Lack of Leadership involvement
Check: Analysis of The Project

All six elements were reviewed after the intervention and it was observed:

- Discharge summary countersigned by senior resident was improvement by 15% i.e. from 55% to 70%.

- Initial physician assessment and plan of care was countersigned by attending physician (Attending comments) was improvement by 65% to 75%.

- Progress notes were countersigned by attending surgeon was improvement by 60% to 75%.

- Informed consent was obtained by resident/medical officers (not interns) was improvement by 60% to 75%.

- Pre anesthæsia assessment was done by R1 and above was improved by 70% to 85%.

- Postoperative plan of care was countersigned by operating surgeon was improvement 65% to 75%.
Check: Compliance to Medical Record

OVERALL COMPLIANCE RATE MEDICAL RECORD REVIEWS BEFORE AND AFTER INTERVENTION

<table>
<thead>
<tr>
<th>Category</th>
<th>Before Intervention</th>
<th>After Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Summary Countersign</td>
<td>55%</td>
<td>70%</td>
</tr>
<tr>
<td>Attending Comments</td>
<td>65%</td>
<td>75%</td>
</tr>
<tr>
<td>Daily Progress Notes</td>
<td>60%</td>
<td>75%</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>60%</td>
<td>75%</td>
</tr>
<tr>
<td>Pre anesthesia assessment</td>
<td>70%</td>
<td>85%</td>
</tr>
<tr>
<td>post operative Plan of care</td>
<td>65%</td>
<td>75%</td>
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</table>
Act: Holding the Gains

- Improvement was evident the data analysis and it was decided that as part of the continuous quality improvement this will be continued.
- Institutional indicator and monitoring will be on quarterly basis.
- Quality improvement and patient safety committee QIPSC was directly involved and all the data were shared with the committee on quarterly basis and interventions were initiated and observations were shared with the relevant teams.
### Institutional Indicator

#### Quality Indicator - Clinical Indicator

**Measure:**
- Overall Compliance in Medical Record Documentation

**Target / Benchmark (Source):**
- >94% (Ascertainment from previous trends)

**Reporting schedule:**
- Monthly

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>Q1-2015</th>
<th>Q2-2015</th>
<th>Q3-2015</th>
<th>Q4-2015</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target goal</strong></td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>70746</td>
<td>21770</td>
<td>24030</td>
<td>26002.5</td>
<td>30608</td>
<td>103316.5</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>76660</td>
<td>23618</td>
<td>26701</td>
<td>28029</td>
<td>33340</td>
<td>111688</td>
</tr>
<tr>
<td><strong>Rate in percentage</strong></td>
<td>92.29%</td>
<td>92.18%</td>
<td>93.39%</td>
<td>92.77%</td>
<td>91.81%</td>
<td>92.50%</td>
</tr>
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</table>

#### Analysis and Actions:

In Q4, 2015 the average overall compliance is 91.81%, which is slightly decreased as compared to Q3-2015. The further analysis of the data indicates that the major non-compliance was in Surgery department documentation. The specific non-compliance in Surgery includes: Countersigning of Progress Notes by the responsible physician, documentation of patient’s issues and needs, Countersigning of Post-Surgical Management Plan by operating surgeon and documentation of Post-Operative Counseling. Other non-compliance includes; Review of discharge summary by senior resident / fellows and nursing care plan was not updated.

**Action(s):**
- Conducted session on medical record documentation of Surgery department. Reinforcement has been done in all service line and departmental QIC. Clinical Leadership should define measures to improve the compliance including disciplinary actions for actions/departments / primary physicians for usual non-compliance. Clinical Leadership should also define Key Performance Indicators for Medical Record Documentation.

#### Data Provider / Responsible:
- Quality and Patient Safety Department
Holding the Gains

Reminder stickers are developed and will be introduced for physicians to complete the file which shows noncompliance and re audit those files after reminder stickers will be introduced for physicians to complete the file which shows noncompliance and re audit those files after given time period.

Following Documentation was found incomplete:

- [ ] Discharge Summary Countersigned by Senior Resident
- [ ] Attending Comments on initial assessment form
- [ ] Countersign of daily Progress notes by attending
- [ ] Informed consent obtained by Resident
- [ ] Preanesthesia assessment complete by R1 before surgery
- [ ] Postoperative plan of care is countersigned by operating surgeon before patient leave OR

Once completed: Sign: --------- Date: ------------
Holding the Gains

Reminder flyer were also developed and will be introduced for residents, nurse and physicians to remind them to complete the file which shows noncompliance.
Conclusion

This study proved that complete and accurate clinical documentation enhances the quality of patient care and facilitates the reporting of the pertinent health information that is critical for optimal management of health care system. Physicians are the key building blocks to creating and maintaining health data of the highest quality.
References

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THANK YOU