

# Srishti D

*by* Srishti Gupta

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**Submission date:** 06-Jun-2019 12:36PM (UTC+0530)

**Submission ID:** 1140576675

**File name:** 375100.docx (366.91K)

**Word count:** 1512

**Character count:** 8873

# **DISSERTATION**

**At**

**MEDANTA, THE MEDICITY HOSPITAL, GURGAON**

**A Study of the Effect of Educational Intervention on Proper  
Documentation of Cross Consultation Forms Among Hepatology Team at  
Medanta Hospital, Gurgaon**

**A Report**

**By**

**Dr Srishti Gupta**

**5**

**Post Graduate Diploma in Hospital and Health Management**

**2017-19**



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## Acknowledgement

Every successful story is a result of an effective team work, a team which comprises of a good coach and good team players I want to take this opportunity to thank each and every one who supported to make this report .

To start with, I take immense pleasure to thank **Dr. Sanjiv Kumar** (Director- International Institute of Health Management Research, New Delhi) and **Dr. Pradeep Panda** (Dean, International Institute of Health Management Research- Delhi) for placing me in such an esteemed organization (Medanta The Medicity) to perform my dissertation and start my career with; and my mentor, **Dr. Pradeep Panda** (Dean, International Institute of Health Management Research- Delhi) for his timely advice and encouragement for the successful conduction of my project .

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I am highly indebted to **Dr. Shaveta Dewan**, (AVP and Head, Quality and Medical services) providing me with the opportunity of working on this Quality Improvement Project.

Lastly, I thank **all the employees** of Medanta, the Medicity for being highly co-operative and for helping me in every phase.

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## **Introduction:**

Medical records are the reflection mirrors of the progress of treatment of a patient during his stay in the IPD, hence documentation is an integral part of quality in the hospital. Cross consultation forms are the forms filled when the primary team gives a cross referral of the patient to some other speciality within the hospital. The primary team needs to document in the cross-referral form about the required necessary details related to the patient so that it becomes easy and convenient for the referred team to know the purpose of consult.

**The following details have to be documented by the primary team:**

- Date and time of referral
- Request to which speciality
- Type of Referral (whether routine, for opinion, urgent, review after reports, continuous care, stat)
- Purpose of consult
- Name of requesting physician

The doctors of the primary team have to adhere to the protocol of documentation as per the process, as improper documentation reflect improper care and can even lead to medico legal consequences.

## **Literature Review:**

<sup>2</sup> Medical records are the important tools to perform the affair of treatment and prevention and are known as the reflecting mirror of the medical affairs in an institute. Medical records documentation and dissemination of information, which are used as the foundation of the programming and decision-making management in education, research and health, are the most valuable criteria of hospital staff professional assessment . The most important reason of incomplete records is that the doctors and surgeons believed that the medical or surgical care required for patients are vital, but documentation of the data concerning to care is not considered as a part of treatment process by them, while the time spent to register and complete the patients' medical records must be considered as part of care process .

Medical records contain valuable information about a patient's medical history and treatment. Completing the process of documentation is necessary to continue patient care and continuous quality improvement of basic services. Common errors include incomplete or incorrect information.<sup>8</sup> Recording errors can create legal problems in subsequent years in problematic cases. Accurate and comprehensive records are valuable, especially when the required data can be achieved as soon as possible .

<sup>1</sup> Making referrals to other hospital specialties is one of the key duties of the Primary doctor, which can be difficult and time consuming. Two of the reasons given was their own lack of information and potentially extensive workload <sup>1</sup> then to sub-optimal patient care. <sup>3</sup> Cross referral between consultants during an in-patient stay may be in the patient's best interest and the general

practitioner should be kept informed. When inter-specialities referrals are made, primary care physicians must coordinate service delivery across settings, multiple providers, and time to maintain a seamless continuum of care. Optimal coordination involves the documentation of patient care activities, inter-provider communication, and the integration of service delivery into a single medical home .

## **Rationale:**

4 Inaccurate and incomplete documentation can lead to poor treatment and medico-legal consequences. Improper documentation of medical records remains to be a worldwide problem.

A systematic review showed that many countries have been complaining for incompleteness, inappropriateness and illegibility of records. The high prevalence of medical errors and recording errors increases public concern about the health services provided to them and thus the subject has been a priority in medical research. Two of the reasons given was their own lack of information and potentially extensive workload then to sub-optimal patient care .

Studies indicate that teaching programs, training sessions can help to improve the documentation of medical records. Instructive interventions have been shown to improve the documentation entered into medical records significantly. The study aimed to evaluate the effect of an educational intervention on the Hepatology team doctors .

### **Research Question:**

- What is compliance of documentation of cross referral forms before intervention?
- Did improvement occur after interventional training and by how much percent?

### **Objectives:**

- To ensure compliance in accuracy, timely completeness of patients medical record
- To provide educational intervention to the hepatology team and analyse the change and improvement after intervention
- To provide other solution if no improvement is observed



## **Methodology:**

**Study Type:** Descriptive Cross-sectional Interventional study

**Duration of Study:** January 2019 to May 2019

**Data Collection:** <sup>9</sup> The study included three parts:

1. A retrospective review about cross consultation forms documentation in which a checklist was employed to collect information about medical record documentation .
2. In intervention phase, education interventional training was done and then daily reminders were given to duty doctors
3. Post interventional phase, same checklist tool as in retrospective tool was used to collect information to analyse the change and improvement

<sup>7</sup> **Sampling Technique:** Simple Random Sampling

**Sample Size:** Sample of 50 cross referral was collected every month from January to May.

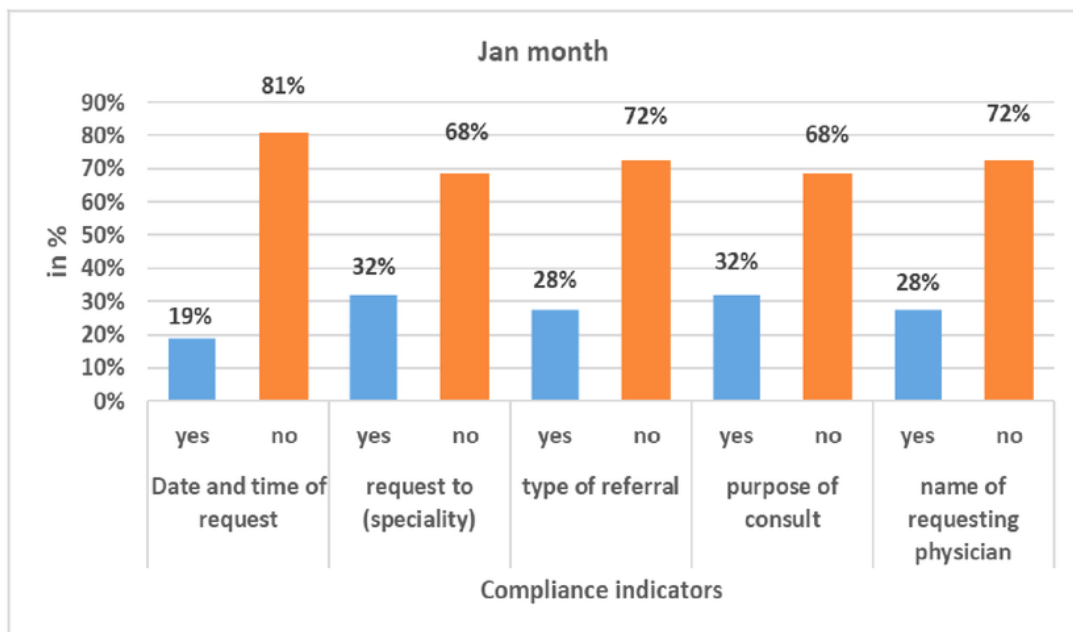
So, the total sample size is 250.

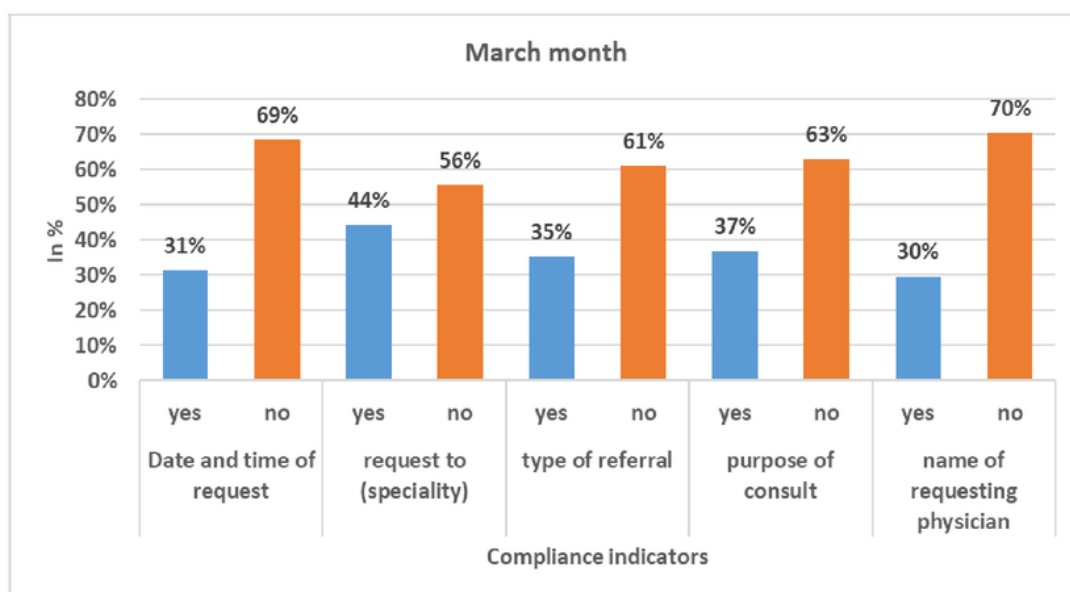
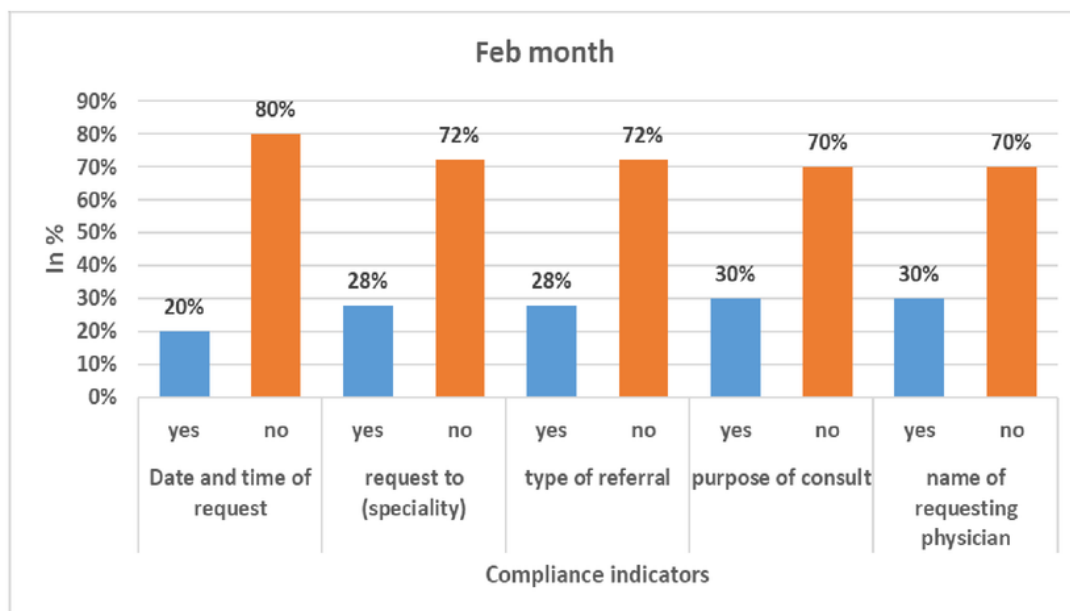
## **Result and Findings:**

### **Before Intervention:**

#### **1) For january, February and March:**

Reterospective data was collected to analyse the compliance of the parameters.

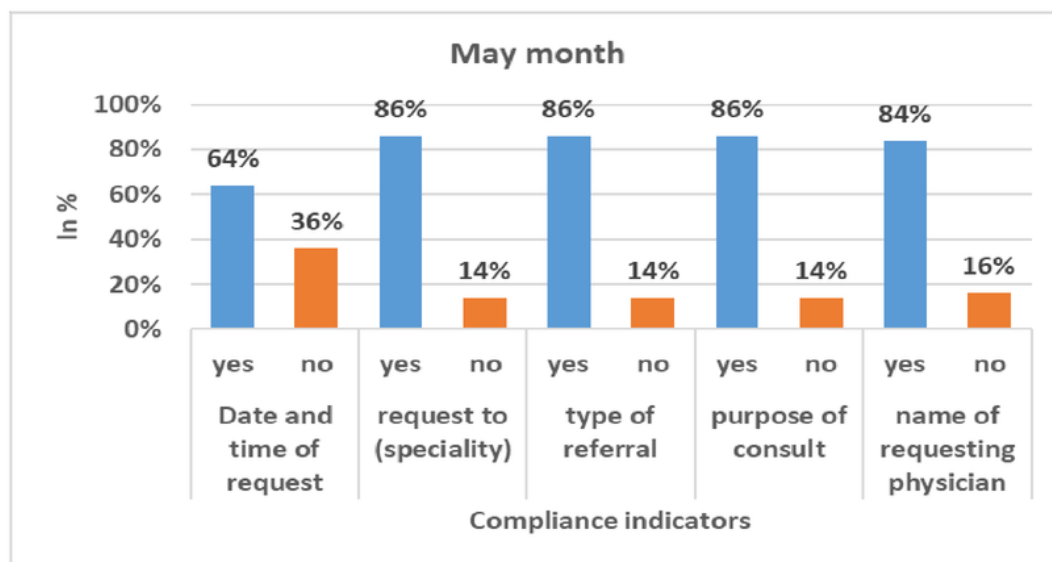
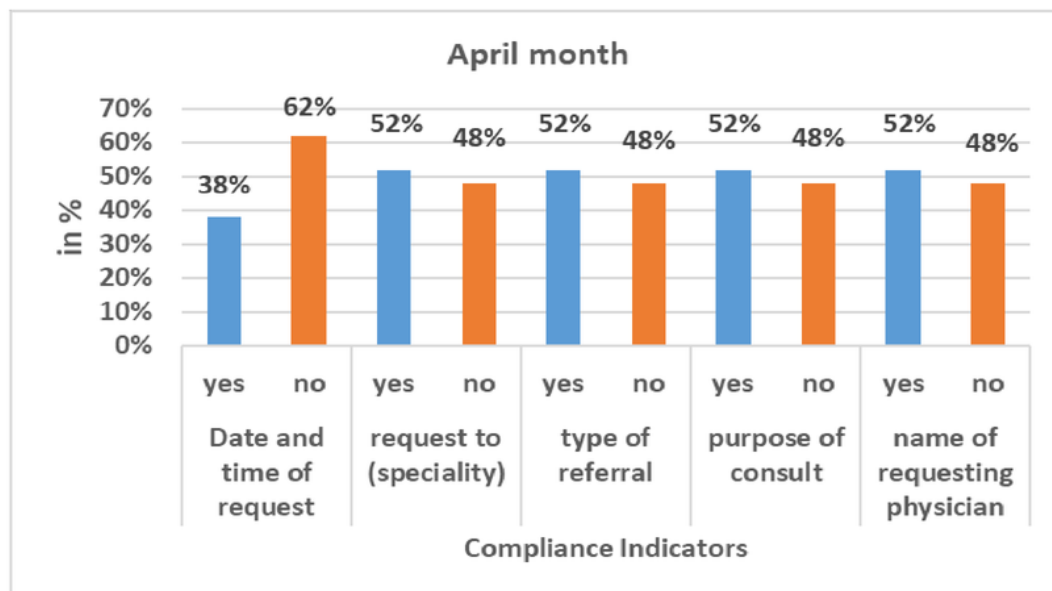




## 2) After Intervention:

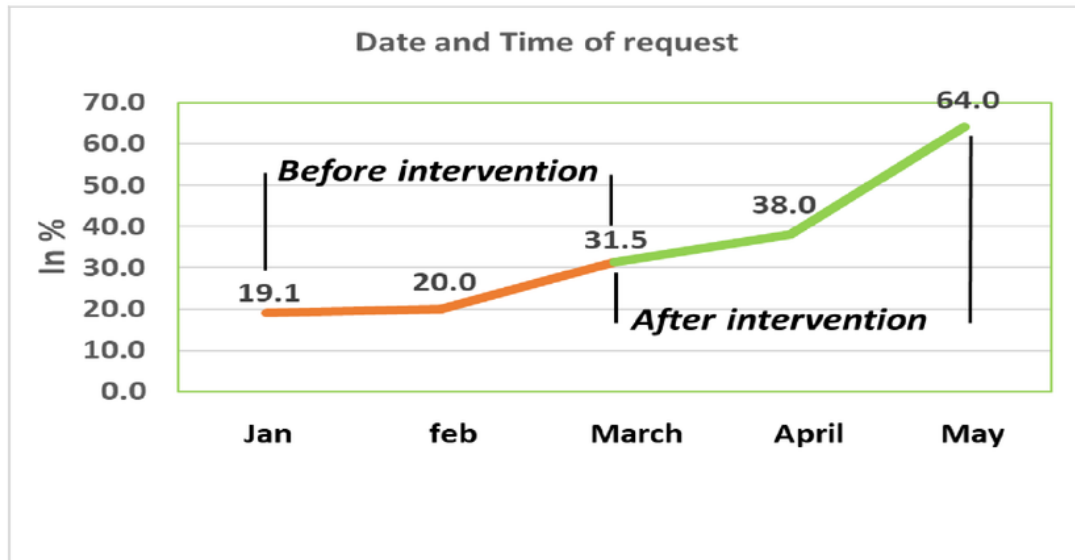
### For April and May :

Prospective data was collected and analysed based on the parameters selected.

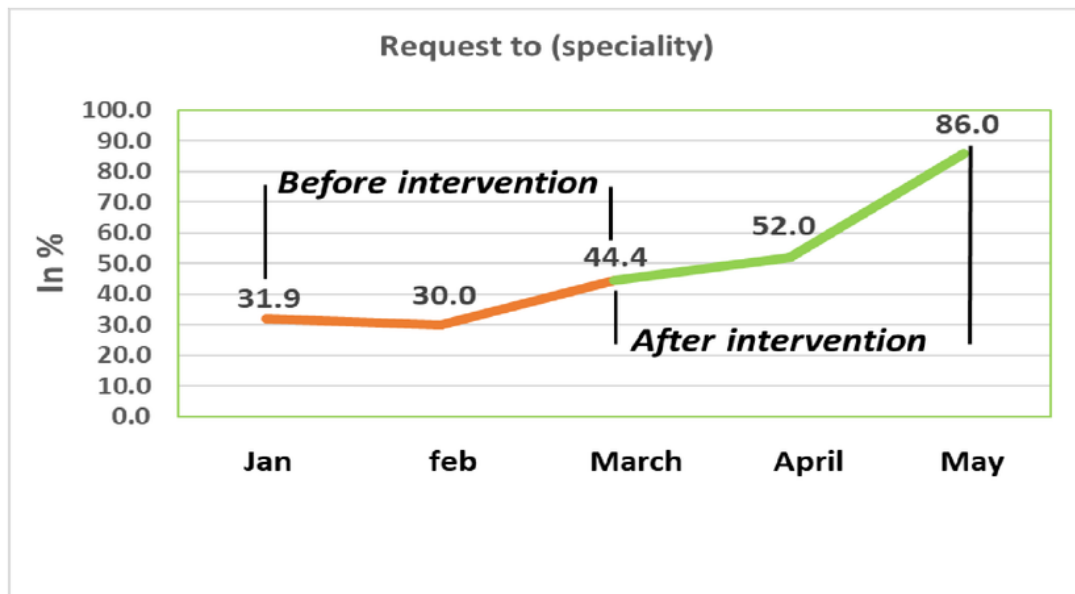


### Trend Analysis of individual parameter:

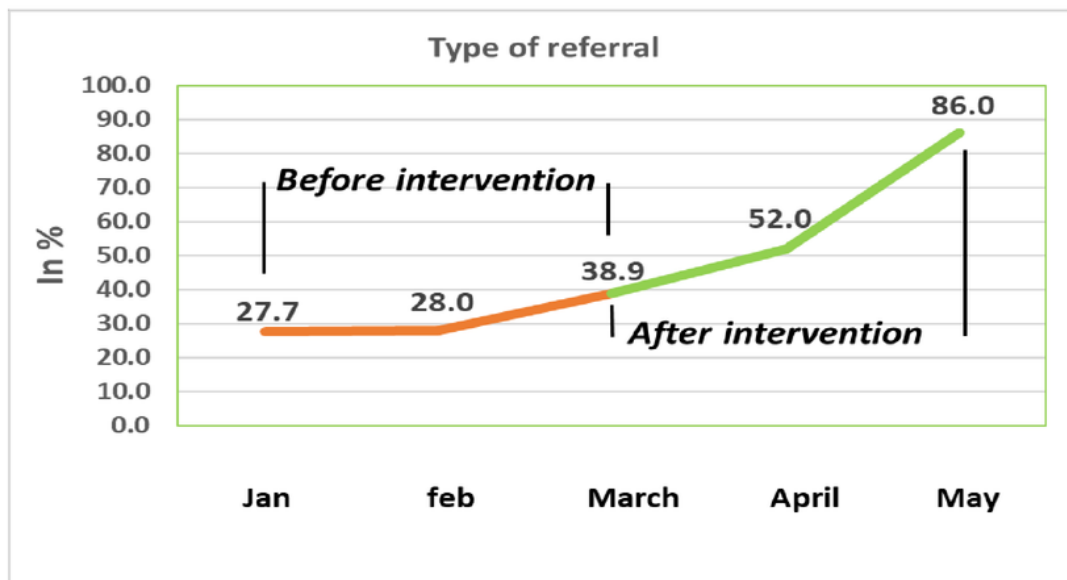
#### 1) Date and Time of Request:



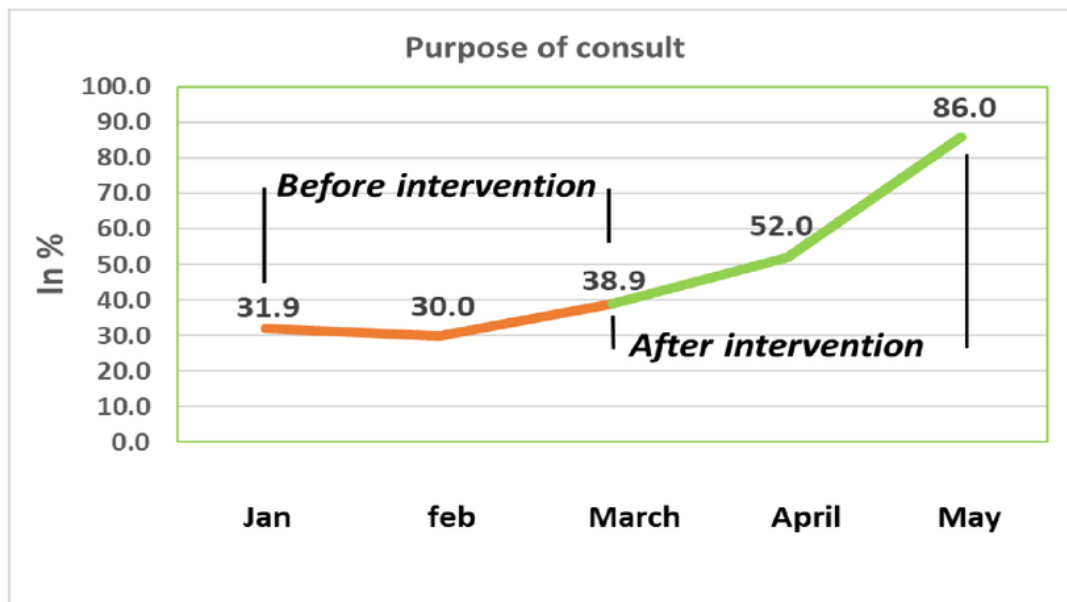
#### 2) Request to (Speciality):



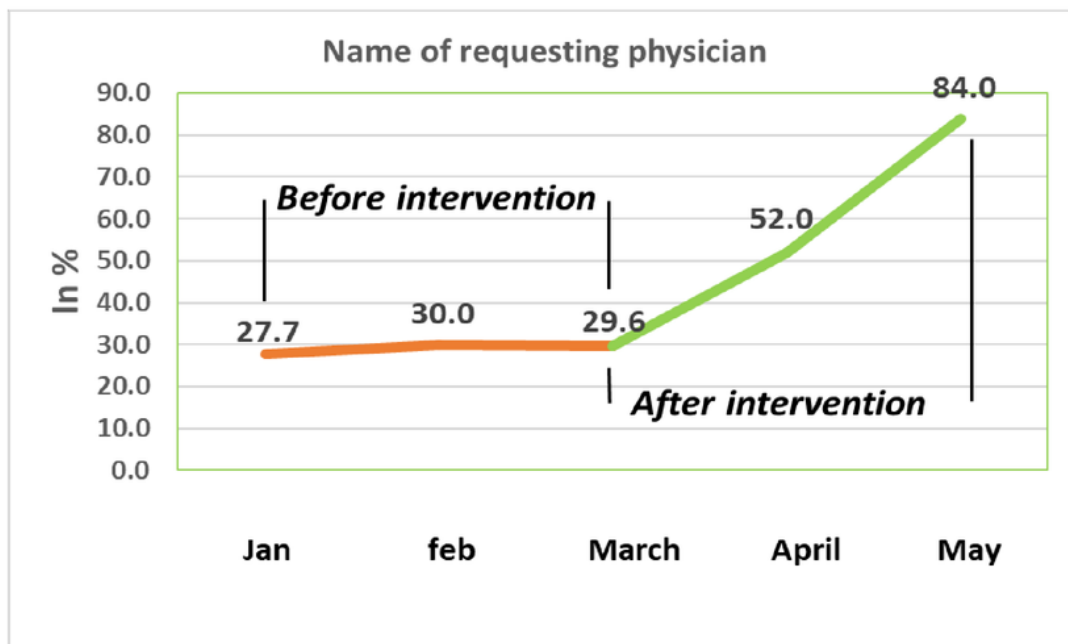
### 3) Type of Referral:



### 4) Purpose of Consult:



5) Name of Requesting Physician:



**Conclusion:**

- Quality of documentation differs based on physician workload
- The educational intervention and continuous focus have proved to be effective
- The study has helped in improving the cross-referral process
- This quality improvement project has helped in providing better interdisciplinary care to the patients

**Conflict of Interest:**

None



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