

A Report

2018

Webinar on Medical Documentation



VISION 2020 INDIA
Knowledge Hub
Presents
Webinar

Date: 6 December, 2018

Time: 16:00 – 17: 00 hrs

Medical Documentation

CONTEXT: Medical/health records form an essential part of a patient's present and future health care. As a written collection of information about a patient's health and treatment, documents are used essentially for the present and continuing care. A careful detailed recording of patient's medical information ensures quality care for during patient repeat visits. A negligence of this protocol can result in a wrong treatment. Also, negative legal repercussions can be avoided in proper documentation and appropriate communication of patient information is adhered to.

In addition, medical records are used in the management and planning of health care facilities and services, for medical research and the production of health care statistics.

NABH standards also cover pertinent points on medical documentation which are mandatorily followed by NABH accredited hospitals or hospitals planning to achieve NABH accreditation.

Keeping the importance of a vital aspect in patient care, VISION 2020 INDIA plans to conduct a one hour webinar session.

OBJECTIVES

- Build member hospitals' capacity by offering correct and comprehensive knowledge regarding importance of medical documentation.
- Orienting member hospitals on - documentation and its types
- Creating awareness amongst the member hospitals about the medico-legal cases management and legal repercussions of improper documentation.



WHO CAN ATTEND



This programme is intended for Trustees, CEOs, Ophthalmologists, Optometrists, Administrators, Nurses and Quality Managers.

RESOURCE PERSON

Dr. Suneeta Dubey
Chairperson-Quality Resource Centre, HOD-Glaucoma services, Associate Medical Director, Dr. Shroff's Charity Eye Hospital



VISION 2020: The Right to Sight INDIA
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Introduction:

Medical/health records form an essential part of a patient's present and future health care. As a written collection of information about a patient's health and treatment, documents are used essentially for the present and continuing care. A careful detailed recording of patient's medical information ensures quality care for during patient repeat visits. A negligence of this protocol can result in a wrong treatment. Also, negative legal repercussions can be avoided in proper documentation and appropriate communication of patient information is adhered to.

In addition, medical records are used in the management and planning of health care facilities and services, for medical research and the production of health care statistics. NABH standards also cover pertinent points on medical documentation which are mandatorily followed by NABH accredited hospitals or hospitals planning to achieve NABH accreditation.

Keeping the importance in view, as a part of Knowledge Hub initiative, VISION 2020 INDIA in association with Cybersight/ Orbis conducted an hour long webinar on Medical Documentation on 06 December 2018. The technical resource for the webinar was Dr Suneeta Dubey, Dr Shroff's Charity Eye Hospital, Delhi.

Objective of the webinar:

- ***Build member hospitals' capacity by offering correct and comprehensive knowledge regarding importance of medical documentation***
- ***Orienting member hospitals on - Documentation and its Types -manuals, policies, procedures, forms, formats, records, sops, work instructions, standard operating procedures preparation and implementation, relevance of medical documentation, medical records completion (components), consent policy, medico-legal cases policy documentation, medical records retention policy, content and policy of handling discharge***

Participation:

Encouraging participation observed in the webinar. Against the total of 115 registrations 43 participated. This webinar was attended by Trustees, CEOs, Ophthalmologists, Managers and Administrators.

Programme:

The session started with a welcome address by **Mr Phanindra Babu Nukella**, CEO, VISION 2020 INDIA. He outlined the objectives of the webinar and introduced the resource person, Dr Suneeta Dubey.

Further, **Dr Suneeta Dubey** commenced the session with introduction to medical documentation and its importance that documentation is used to evaluate professional practice as part of quality assurance mechanisms such as audits and accreditation processes, legislated inspections and critical incident reviews. She further added that it should be assumed that any and all clinical documentation will be scrutinised at some point.

Dr Suneeta discussed about the challenges in clinical documentation and shared few important points:

- Medical school and residency programs don't teach clinical documentation practices
- Physician's clinical documentation importance is not priority for the healthcare organizations
- Multiple providers are needed, with increased inconsistency between provider documentation
- Unstructured and inconsistent processes for recording and collection of information are prevalent

Dr Dubey explained on what all includes professional documentation, various types and elaborated on different types of documentation. She also explained about the differences between various documents such as forms and formats, explained about policies, check lists and Standard Operating Procedure (SOP).

Dr Dubey emphasized on documentation of every aspect of care and said that proper documentation can help track serious events and can help in tracking Endophthalmitis. She explained about various forms which can be filled in for each case and also spoke about organizational policy for documentation and explained how this can be useful in case of any serious events.

The mandatory legal requirements were explained by Dr Dubey and shared some points:

- Each page of the medical record must include patient's name and medical record number / UHID
- All entries into the record must be signed, with name, date and time
- Include original signature, full name and professional title (or electronic signature if electronic health record used)

- Incorrect entries must be identified clearly
- Use only approved abbreviations and standardized terminology

Further, Dr Dubey spoke about Error Correction and Confidentiality of Documents and also explained on how documentation can be improved through proper monitoring.

Session ended with question and answer session.

Dr Phanindra Babu Nukella thanked Dr Suneeta Dubey for her support and to delegates for their participation.

Webinar recording:

The entire webinar was recorded. Please refer to the link given in the email to download the entire recording of the webinar can be heard or downloaded:

<https://vimeo.com/304945135>

Gratitude:

- *VISION 2020 INDIA is sincerely thankful to Dr Suneeta Dubey for his valuable time and kind support for the cause.*
- *Sincere thanks to Cybersight/ Orbis India team, and Mr Gangadhar from Cybersight, Australia for their support in conducting the webinar through Cybersight platform*
- *Our sincere thanks to all the delegates, participated in the webinar and thanks for their encouraging response*
- *We are extremely thankful to each and every one who supported us to make this webinar a grand success*

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