Reviewing the Completeness of Files in MRD in a Super Specialty Hospital (Aakash Healthcare, Dwarka, New Delhi)

(01 Feb - 30 April 2018)

Internship and Dissertation Report Submitted in Partial Fulfilment of the Requirements for the Award of

Post-Graduate Diploma in Health and Hospital Management

Batch 2016-18

By

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PG/16/041

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in recognition of having successfully completed his/her

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He comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish him all the best for future endeavours

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TO WHOMSOEVER IT MAY CONCERN

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The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

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The following dissertation titled **"Reviewing of Files in MRD in a Super Specialty Hospital" at "Aakash Healthcare, Dwarka, New Delhi"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

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This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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FEEDBACK FORM

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ABSTRACT

Reviewing Completeness of Files in MRD in a Super Speciality Hospital

Incompleteness of medical records is a significant problem affecting the quality of health care services. Improving the completeness of patient's records is an important step towards improving the quality of healthcare. To identify gaps in medical record maintenance, it is important to carry out audit of the records, note the shortcomings and take corrective measures to rectify the identified problem. A Cross Sectional Descriptive Study was conducted at MRD in a Super Specialty Tertiary Care Hospital. A checklist was prepared, as per study variables, to audit the medical records of all patients admitted in the month of January 2018 at the hospital. In total 342 files were audited. The MLC files for the given duration were not made available for audit. Non-Probability Convenience Sampling Technique was used for the study. The findings of the study showed that in general compliance level of medical records was quite high. Informed consent form, nursing records, Patients rights and responsibilities form almost met the standards set by the NABH. The major deficiencies noted were in face sheet, admission request form, general consent form, estimate of expense sheet, Signature of doctor's and consultant in initial assessment sheet and doctors progress notes. These need to be carefully monitored and doctors made aware of their responsibility to completely fill each entry in these forms, which not only form the basis of documentation of care given and aids in the continuity of care, but also is an important document in case of any litigation. Regular medical record audits and an ongoing training to all the members of the healthcare team could go a long way in ensuring complete and proper documentation of patient medical records. Due to great strides made in the medical field over the last few decades, there has been a radical improvement in the modes of investigations and treatment aspects needing an up-to-

date, secure and efficient medical record system in the Medical Records Department. Maintaining a well planned Medical Records System is the responsibility of the medical records department with full co-operation from all health care personal. Medical records are an index of a Health Institution and Medical Records department is the back bone of Health information system.

Key words Completeness of patient's records, quality of healthcare, identify gaps and shortcomings, corrective measures, full co-operation from all health care personal.

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It is indeed my pleasure to present the dissertation on "Reviewing the Completeness of Files in Medical Record Department in a Super Speciality Hospital". I sincerely extend my appreciation, gratitude and sincere thanks to Dr A K Khokhar, Dean (Training), at International Institute of Health Management and Research, New Delhi, for his valuable guidance and co-operation in completion of this project.

I am grateful to the management of Aakash Healthcare, Dwarka, New Delhi, for providing me the opportunity to carry-out Internship-cum-Dissertation in their organisation. I would also like to express my gratitude to the staff of all medical and non-medical departments of the hospital who took time out from their busy schedule to educate me in detail the nuances of the tasks and duties performed by them. This helped me to understand the tasks performed by various departments and their linkages, thereby, providing me with an insight into the functioning of a modern super speciality Hospital.

I express my deep gratitude and heartfelt thanks to Dr Kamal K Parwal, Chief of Medical Services, Aakash Healthcare, for his magnanimity and constant support, without which I wouldn't have been able to complete the Dissertation. During the internship I was assigned for audit of Patient Medical Documentation which helped me in observing the functioning of Medical Record Department closely. Thus the Internship-cum-Dissertation training has helped me in understanding the functioning of a super speciality hospital in general and MRD in particular.

I convey my deep and sincere thanks to Mr A K Harnal, Manager and Mrs Seema Rathi, Medical Record Technician, Medical Record Department, for helping me out by answering even the silliest queries, pertaining to the hospital and its functioning and also for providing their constant support and advices.

Col Rajesh Kumar
PG/16-18/041
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ACRONYMS / ABBREVIATIONS

1. IPD- In Patient Department
2. NABH- National Accreditation Board for Hospitals & Healthcare Providers
3. MAS-Marker Assisted Selection
4. ENT- Ear Nose Throat
5. ICU-Intensive Care Unit
6. CCU- Critical Care Unit
7. CTVS- Cardio Thoracic Vascular Surgery
8. IT-Information Technology
9. HDU – High Dependency Unit
10. OPD-Out Patient Department
11. NHS- National Health Scheme
12. IOM- Institute of Medicine
13. HAI- Hospital Acquired Infection
14. FHL- Functional Health Literacy
15. Doc's IA- Doctor's Initial Assessment
16. Nursing IA- Nursing Initial Assessment
17. NA-Not Applicable
18. Doc's CP- Doctor's Care Plan
19. Nursing CP- Nursing Care Plan
20. MRD- Medical Record Department
21. BOO- Board of Officers

LIST OF ANNEXURE

SECTION 1: OVERVIEW

Aakash Healthcare, Dwarka, New Delhi

WE CARE, HE CURES


Aakash Healthcare
Super Speciality Hospital
We care, He cures
VISION
MISSION
VALUES
I C A R E


Aakash Healthcare
Super Speciality Hospital
ICARE

SECTION 1: INTERNSHIP REPORT

(01 Feb - 30 Apr 2018)

Introduction

1. Mr. J.C. Chaudhry, the Chairman of Aakash Institute started teaching with one institute in 1988 with 12 students. Today after 30 years of perseverance and excellence, Aakash is a household brand, with more than 150 centres across the country, training more than 1,25,000 students every year, turning them into accomplished medical and engineering professionals.

2. Aakash Healthcare is a subsidiary of the Aakash Group, and is a state of the art healthcare facility and the first smart hospital in this part of the city. Their patient-centric policy, erudite doctors and compassionate staff offer the best in class healthcare for everyone. Healthcare was a palpable choice for the parent organization, since this sector shall benefit the institute's enormous alumni network spread across continents.

3. In the month of November 2011, Dr. Aashish Chaudhry envisioned a smart orthopedic clinic for the people of Dwarka, New Delhi, which is Asia's biggest residential colony. The clinic thrived as a result of his ethical and transparent healthcare practices, and in present-day Dr. Chaudhry is a celebrated orthopaedic surgeon, having performed innumerable successful orthopaedic surgeries, giving agility and the ease of movement to the incapacitated.

4. Aakash Healthcare is a super specialty hospital, with state of the art infrastructure, path breaking technology, offering unrivalled healthcare services. Dr. Aashish Chaudhry, the founder and Director of Aakash Healthcare, aims to make Aakash Healthcare the most preferred healthcare

brand by providing compassionate, inexpensive, and world class healthcare services, with a talented team of doctors, and ultra-modern technology, ensuring speedy recovery.(1)

5. **Infrastructure Highlights**

(a) 230 Beds in Phase 1.

(b) 70 Bedded Medical and Surgical Critical Care Unit.

(c) 24x7 Cardiac Emergency & Trauma Services.

(d) 15 Bedded Dialysis Unit.

(e) Advanced Neonatal ICU.

(f) Ward Bed Options - Suite, Deluxe, Twin Sharing and Economy.

(g) 8 Modular OTs.

(h) Flat Panel Cath Lab

(i) State-of-the-art diagnostic equipments that include - 3.0 Tesla MRI, 128 slice CT scan, Flat panel C-Arm, and 4-D Ultrasound to name a few.

(j) Automated Waste & Laundry Management System for efficient waste management.

(k) Pneumatic Chute System.

6. Aakash Healthcare is under the process of obtaining the accreditation by the National Accreditation Board for Hospitals & Healthcare Providers (NABH), accreditation programme for healthcare organizations. It also aims to obtain accreditation from National Accreditation Board for Testing and Calibration Laboratories (NABL) as well as international bodies.

Vision

7. To become the most desired heath care brand by providing compassionate, caring and world class service with the help of talented team of doctors, professionals and latest technology.

Mission

8. To achieve highest patient satisfaction index by delivering patient centric best healthcare service amongst the local and extended community.

Values

9. Aakash Healthcare values define their organization and their ethos and what they stand for: ***ICARE***. These values are:

I**:** Integrity

C**:** Compassion

A**:** Accountability

R**:** Respect

E**:** Excellence

Organization Profile

10. Aakash Healthcare, Dwarka provides Centre of Excellence in following Departments:

(a) Cardiology and Cardiac Surgery.

(b) Orthopaedics and Joint Replacement.

(c) Neurology.

(d) Pulmonology.

(e) Oncology.

(f) Urology Sciences.

(g) Clinical Nutrition.

(h) Plastic and Cosmetic/Reconstructive Surgery.

(j) Dentistry.

(k) Endocrinology.

(l) ENT, Hearing and Speech.

(m) Internal Medicine.

(n) Ophthalmology and Refractive Surgery.

(o) Trauma and Emergency (24 x 7).

(p) Obstetrics & Gynaecology.

(q) Physiotherapy.

(r) Health Check.

(s) Blood Bank and Transfusion Medicine.

(t) Dermatology.

(u) Mental Health and Behavioural Sciences.

(v) Radiology.

(w) Critical Care.

Patient Information

11. **Patient Rights**

(a) Be treated with respect, consideration, compassion and dignity, in a safe and clean environment regardless of your age, gender, race, origin, religion, sexual orientation or disabilities.

(b) Full protection of your privacy, dignity and confidentiality pertaining to your care discussions, examinations, and treatments.

(c) A clear and understandable explanation by your doctor about your diagnosis, as well as the benefits and risks of each treatment, expected outcome and change in medical condition

(d) Protection from physical abuse and neglect.

(e) Receive information from the hospital regarding the expected cost of treatment and payment policies

(f) Request for a copy of your medical records as per protocol.

12. **Patient Responsibilities**

(a) Providing complete and accurate information, including your full name, address, telephone number, date of birth, particulars of next-of-kin and insurance company/ TPA/ employer, past illness, and medication details wherever required.

(b) Keeping appointments, being on time for appointments, and calling your doctor / hospital if you cannot adhere to the appointment timing.

(c) Actively participating in your treatment plan and keeping your doctors and nurses informed about the effectiveness or recovery of your treatment.

(d) Ensuring safety of your valuables. (It is advisable to leave valuables at home and only bring necessary items.)

(e) Treating all hospital staff, other patients and visitors with courtesy and respect.

(f) Abiding by the hospital rules and safety regulations.

(g) Understanding all instructions before signing the consent forms.

13. **Hospital Facilities**

(a) **Rooms**: At Aakash Healthcare there are these following room categories:

(i) **Suite:** A Suite at Aakash Healthcare has an attached living room for attendants and visitors with a separate washroom, Wi-Fi Connectivity, a mini refrigerator, a television set, a microwave, a music player, safe locker and a bed side locker, dedicated nursing staff, a housekeeper, and in room dining facility for the attendant.

(ii) **Deluxe:** A deluxe room at Aakash Healthcare has an attendant bed, Wi-Fi Connectivity, a mini refrigerator, a television set, safe locker and a bed side locker, in room dining facility for the attendant and dedicated nursing staff for the room.

(iii) **Single Room:** A single room at Aakash Healthcare has an attendant bed, Wi-Fi connectivity, a mini refrigerator, a television set, a bed side locker, and an in room dining facility for the attendant.

(iv) **Twin Sharing:** Twin sharing rooms at Aakash Healthcare has an attendant bed, a television set and a bed side locker to keep your essentials.

(v) **Multi Bed Room:** A Multi bed room at Aakash healthcare has attendant chairs and a bed side locker to keep your essentials.

(b) **Cafeteria**: The cafeteria at Aakash Healthcare is open all day and night, with an assorted range of food and beverage options to choose from. It is located at the ground floor, and is open to employees and visitors. Another healthy food corner setup by Pappa Curry is open from 8:00am to 9:00 pm.

(c) **Laundry Services**: Laundry services are provided for attendants at their behest.

(d) ATM.

(e) **Lounge for visitors**: It is located on the 2nd floor with recliners.

(f) **Internet Access**: The entire facility is Wi-Fi enabled.

(g) **Travel Desk**: Aakash Healthcare provides an all-round patient care. If a patient needs travel arrangements, he gets in touch with the travel desk and they shall get his or her travel tickets done in no time.

(h) **Pharmacy**: Aakash Healthcare has a 24x7 pharmacy located on the ground floor, and one can get medicines anytime one wants.

(i) Prayer and meditation room.

Medical Record Department

14. During the Internship period, I was attached with the Medical Record Department of the Aakash Healthcare, Dwarka. The organization of Medical Record Department comprises of one Senior Manager assisted by an Assistant Manager.

15. While being with the Medical Record Department of the Aakash Healthcare, Dwarka, I was provided with the opportunity to be part of audit of the Patient Medical Documents. I was tasked to carry out audit of medical records of all patients admitted in the month of January 2018. Audit as such is the evaluation of data, documents and resources to check performance of systems so that they meet the specified standards. Audit in the wider sense is simply a tool to find out what is being done now; this often is to be compared with what has been done in the past, or what is the intention to achieve in the future.

Other Key Learning

16. In addition to carrying out the project assigned, the following training was also carried out by me:

(a) Understanding the process flow of CSSD, radiology department, food and beverages department, MRD, bioengineering department.

(b) Understanding the process of implementation and training in the hospital in accordance of NABH accreditation.

(c) Understanding the Admission and Discharge process.

(d) Learned the purchase process for procuring drug in the pharmacy.

(e) Familiarized with the HR department and policies of the Hospital.

(f) Understood the Bio Medical Waste Management of the Hospital.

(g) Specific learning about the project study undertaken.

(h) The job of a hospital administrator is dynamic, flexible and is full of challenges.

(i) Quality control and patient satisfaction is a dynamic process.

(j) Shortage of trained technical manpower/multi-tasking of the available manpower leads to lesser patient satisfaction.

SECTION 2: DISSERTATION

SECTION 2- DISSERTATION

Introduction

1. It is believed that in ancient India i.e. King Ashoka's time, physicians kept their patients' records. In the recent past, in 17th Century, St. Bartholomew Hospital in London was the first hospital to keep written records; this practice was followed by some hospitals in USA. However, it was the American College of Surgeons and American College of Physicians that pushed for keeping written records in the beginning of last century.(2)

2. In India, it was the Mudaliar committee (1963) that stated its importance (3) and later on, Review committee for Health and Hospital (Jain committee, 1968) brought out the poor state of medical records and suggested creation of proper medical records section in all hospitals. (4)

3. McGibony stated that medical records are clinical, administrative, scientific, and legal documents pertaining to patient care, where in sufficient data are recorded as per the sequence of events to justify diagnosis, warrant treatment and the final outcome. (5) In Medical record, all data and information relating to patients personal and social data, details of his ailment, investigations, clinical findings, diagnosis and treatment given along with follow-up and end results are recorded. (6) The standard of a patient record depends mostly on the person entering the data and information in the medical record. It is important for all the clinicians, nursing staff and para medics who make entries in the patient records to understand the significance of complete and accurate records. They should be also aware of the legal and medical implications

of poor maintenance of the medical records. A medical record helps a healthcare provider to chart out and assess patient's treatment and it also helps in provision of care by several healthcare providers. The accurateness and legibility of the information and data Contained in a medical record helps in providing good quality of care. (7) Maintenance of record is not only required for licensing and accreditation purposes but also assists healthcare providers to ensure that the patient receives adequate and proper care. Statues, accreditation standards and professional associations lay down standards to be achieved in relation to legibility, accurateness and completeness of medical records. (8)

4. Medical records provide details on and about, beginning and evolution of hospital, statistical analysis, pattern and types of cases admitted in the hospital etc. Medical Records must be thoroughly and methodically compiled, stored and preserved for the benefit of all i.e. hospitals, care providers and patients. At times to a busy physician the medical record may appear to be a complex document which requires a lot of time to complete. However, at the same time he fully understands and appreciates that a complete and accurate medical record will help in providing adequate and accurate treatment to the patient. It will also help in training, research and improved education and also assist in growth of his status and stature.

5. Fully complied medical records are essential for treatment of patients, for litigation purposes, financial purposes and for research and is based on the principle "People forget, but records remember". Medical record department is an important department of every hospital. Information obtained from the medical record department can be utilized for monitoring and supervision of quality of patient care, in measuring the performance of the medical staff,

utilization of the hospital resources and in compiling data and information for training and research purposes. Information culled from the medical records are also used by various Government departments for planning purposes and allotment of funds for health care system of the country .The basic aim of the Medical Record Department is to build and sustain systems which assist health care providers, research, financial organizations, and last but not the least the needs of the patient.

6. Medical record is extremely personal document and many ethical and legal issues are associated with it. Important issues are the unauthorised access and safe storage, retention and final disposal. The medical record consists of various types of noting entered over a period of time by health care professionals, noting down their observations, drugs and therapies prescribed, diagnostic results, radiological reports, etc. Proper maintenance of medical records is the duty of health care providers. The medical record provides information for planning patient care and documents communication among patient and health care provider and other professionals contributing to the patient's care. Medical record also documents compliance with institutional, professional or governmental regulation. Further, individual medical records also serves as a document for training of medical students/resident physicians and provide required information and data for internal hospital auditing and quality assurance. Data can also be obtained from medical records for medical research and development.

7. A well maintained medical record indicates good quality of care, and can also provide data and information to improve the quality. Medical records not only provide information but also act as a means of communication for patient care. Now a day, medical record has also

become an important legal document. The enclosures of a medical record and requirements of their storage, should meet the laid down legal requirements. Improper records and inadequacy of information will go against the doctor and hospital in case of litigation. The medical record provides adequate information for evaluation of patient care.

Purpose and Scope of Medical Records

8. The hospital medical records serve various purposes. It is useful to:

(a) **To the Patient.** The basic aim of maintaining medical record is to improve the patient care. It is a written document in support of the care rendered to a patient on scientific basis.

(i) It documents the history of illness and also clinical story of the patient.

(ii) It helps in avoiding omissions and repetitions of investigations and treatment procedures, particularly drugs.

(iii) It helps in continuity of medical care.

(iv) It serves as evidence in court of law.

(v) Provides compensation in case of disability.

(vi) It help patient to obtain certain medical and sickness certificates or disability benefits under various schemes.

(b) **To the clinician.** It helps clinicians in:

(i) Planning treatment modalities for patient.

(ii) Quality assurance.

(iii) Assurance of continuity of care.

(iv) Evaluation of medical practice.

(v) To help in continuing medical education and research.

(vi) Protection of clinicians in event of legal disputes.

(c) **Hospital and hospital administration.**

(i) Type and quality of work undertaken.

(ii) Evidence of quantum and quality of care rendered.

(iii) Evaluate work and performance of clinicians.

(iv) Evaluate services of hospital.

(v) Planning of hospital, extension of facilities or introduction of new facilities.

(d) **To Public Authorities**. It provides important data in situation analysis or community diagnosis for planning of various health programs and health care delivery system for the community. It provides data which are hospital based.

(i) Prevalence rate of disease.

(ii) Incidence rate of disease.

(iii) Disability rates.

(iv) Death rates.

(e) **To Medical Education and Research**. Various epidemiological studies cannot be conducted without the help and support of medical records. Various interventional studies like randomized clinical trial (RCT) are based upon medical records which are most important tools of evidence based medicine. The results of clinical trials are heavily dependent upon meticulously maintained medical records.

(g) **Medico Legal Importance of Medical Records**. The medical record should be meticulously written and all the details should be written in a lucid manner, legible and easily understandable. To meet the legal requirements and avoid complications, the records must fulfill the following criteria:

(i) It should be complete in all respect.

(ii) It should provide adequate information in respect of medical care rendered to the patient.

(iii) Information must be accurate. It should not be based upon presumptions. It must be factual.

(iv) It should be legible and the document must be signed by the consultant.

9. **Functions of Medical Records Department**.

(a) Assembling of the medical records.

(b) Quantitative analysis of the records.

(c) Deficiency check.

(d) Completion of incomplete records.

(e) Indexing.

(f) Analysis and statistics.

(g) Numbering and filing.

(h) Storage and retention of records.

(i) Retrieval of records.

Rationale of the Study

10. Medical records are a reflection of medical care provided to the patient in the course of stay in the hospital. A well maintained medical record assist in communication, co-ordination and promote efficiency and effectiveness of treatment. It aids in "seamless" continuity of care by presenting the client's past and present health status and medical treatment and future healthcare plans. Medical record auditing is one of the tools of auditing to assure quality, validity and accuracy of medical services through reviewing medical records on the basis of designed parameters as per the best practices and standards laid down.

11. The health care facility has recently been established and a requirement was felt to carry out a study to assess the existing deficiencies and take corrective measures for proper medical record maintenance and to hasten up the process for immediate and simultaneous corrective actions for sustainable improvement.

Review of Literature

12. Ian Pullen and John Loudon (2006) in the journal of "Improving standards in clinical record keeping" said that medical records are the most basic of clinical tools. They provide a permanent account of individual considerations and the reasons for clinical decisions. Medical records are crucial for efficient communication and good clinical care, though they are accorded low priority often, they are generally badly maintained and are not easily retrievable. Many times the courts and independent enquiries have commented adversely on the quality of records resulting in poor patient care. (9)

13. Physicians, researchers and hospital administrators consider medical record maintenance as an important aspect for continuity of care, safety, quality of care, and compliance. (10) Karkkainen and Eriksson state that standardized forms will improve precise and directed information; however, a poorly designed form will lead to more document content but will do little for better patient care. The requirement is to design systems that are patient centric and also have the benefits of standardization leading to adequate, more accurate, concise, precise, and updated information transfer among various members of the multi and interdisciplinary team. (11)

14. The completeness of medical record is an important issue. Croke (12) cites that non compliance of documentation procedure as one of the top six reasons for nurses facing malpractice suits. Stokke and Kalfoss(13) found many gaps in terms of completeness of nursing

documentation. Patient care plans, investigations, diagnosis and probable outcomes where absent to the tune of 18% to 45% of the time.

15. Medical record acts as a communication tool between care providers, gives justification for reimbursement of services, and if required serves as a medico legal document. (14) Many studies in past have concluded that physicians' handwriting is often illegible. (15-16) Illegible handwriting may lead to erroneous documentation, inaccurate billing, litigation and loss of time and resources. It will lead to frustration of health care providers. (17-19) Susan J Burnett et al (2011) feel that only by methodical, periodic audit of the occurrence of missing clinical information can one know the effect on clinical decision making and patient care of new technology, service reorganization, given fiscal environment, temporary and reduced staffing level. (20)

16. Evaluation of medical records system of a teaching hospital in a developing nation was done in respect of its ease of access, compliance, satisfaction, any shortcomings, and suggestion for improvisation and to reiterate importance of Medical records system in education, training and research. In this study (Kumar et.al, 2011), approx 60% participants opined that >50% of the hospital records were fully complaint. In the interest of the patient, the consultant has to give some time to fill and bring up to date the medical record of the patient. All the doctors must consider that only by proper maintenance of medical records, the health of the patient can be protected and only such a document can be utilized for research, training and education purpose. More than half of the participants (57.5%) felt that it is difficult and time consuming to obtain specific information of patients from the records and also to obtaining patients data for medical

requirements (57.5%). About 42.5% of respondents felt that information and data from the existing system can be used for education purpose only to some extent. The main reason for this is to obtain required information from the records; it has to be done manually which is time consuming. This can be easily surmounted by making use of computers in various wards, which will assist in feeding patient information quickly and efficiently. Networked electronic medical record system is an ideal alternative for the current system. Such system provides for uploading laboratory data from sections of the hospital, assisting timely and efficient patient care. The main advantage of an electronic medical system is that the data can be accessed and shared at multiple sites, also multiple users can upload data simultaneously, and further such information can be backed up and stored at multiple sites. Such a system also helps in information being communicated between multiple locations such as from laboratory to physician. In the present teaching hospital there is a requirement of implementation of a hospital-wide patient registration and medical records system, which basically includes a simple, custom-made electronic data base to manage patient information, have uniform medical records forms, set procedures and better human resource management efforts. (21)

17. As per Mogli, (2009) the plan to establish of medical records is in three phases. In first phase survey of the present status of medical records needs to be done. In the second phase depending of the findings of the survey, appropriate systems and policies and procedures should be laid down. Training of the affected manpower should also be carried out. This will help in organizing the medical record departments. EHR can be thereafter established in third phase which will also include education, training, and monitoring of the progress being made. In this phase, the author studied the importance of medical records. Main problem noticed was that the concept of Medical Record System was not very clear earlier. It was noted that MRDs' in some hospitals were very poorly organized, records were found to be missing, laboratory and radiology reports were also not available in the records. These resulted in creating new records

and new investigation orders with each visit of the patient. All these lead to discontinuity in patient care. It also led to repetition of physicians' work like medical history documentation, physical examination of the patient, repeated similar investigations and prescription of drugs. All this culminated in chaotic patient care services, confusion and duplication of work. To develop software for medical records, it should be insured that meticulous preparation of domain of all functions is done. Other issues to be insured are EHR related interoperability and adherence to accreditation standards, classification of diseases list, alerts, reminders, and clinical decision support systems for quality improvement. A 360 degrees examination needs to be done to identify and incorporate all required features stated above in the EHR that would meet the need of 21st Century. (22)

18. Physicians are the principal author of medical records and enter the majority of patient specific clinical information. To be relevant to patient care, it is necessary that all medical records are complete and accurate. To encourage residents to understand, learn, and apply best practices in medical record documentation is to have such systems and processes that are common and shared across the hospitals between medical practitioners, hospital administrators and IT professionals. These processes may be uniform forms for ease of completion, effective communication with seniors, effective training and education campaigns. It is therefore very much essential to develop an advanced and sophisticated set of strategies that encompasses all these key stakeholders. (23)

19. As per Joseph Thomas (2009) adequate maintenance of medical records requires concentrated effort of number of patient care givers. The doctor is the key person, who not only oversees the process but also contributes to the process by making entries about the patient medical history, consent forms, physical examination, treatment plans, medications, operative records, referral notes, discharge summary and medical certificates. Further, there is also a

requirement of proper and detailed recording of nursing care, laboratory data, diagnostic reports, pharmacy records, and billing process. For proper maintenance of medical records paramedical and nursing staffs also need to be trained. (24)

Objective

20. To analyze the completeness of medical record files of patients at a super specialty hospital using suitably evolved guidelines.

21. **Specific Objectives.**

(a) To check the completeness of medical record files of patients discharged in the month of January 2018 from a super speciality hospital on following key parameters:

Face sheet, Admission request form, Discharge/Transfer/DAMA/DOR/Death summary, financial estimate/counselling, Initial medical assessment, Doctor's progress notes, Consent forms, Anaesthesia record, Surgery records, nursing parameters, and dietary forms.

(b) To identify the areas of improvement/ highlight major deficiencies and provide implementable suggestions for improvement.

Methodology

22. **Study Area.** The study was carried out in a Super Specialty Tertiary Care Hospital (Aakash Healthcare Super Specialty Hospital, Dwarka).

23. **Study Design**. Descriptive Cross Sectional Study. The study was carried out for completeness of medical records of all the in patients discharged during the month of January 2018 from the hospital.

24. **Study Period.** The study duration was from 01 Feb to 30 Apr 2018. First two weeks of the study period was utilized for gaining work experience and on the job training. Thereafter collection and analysis of data on the selected topic for dissertation was done in addition to the job being done as an intern.

25. **Study Population**. All patients discharged in month of January 2018 from the hospital.

26. **Sample Size**. A total of 342 records were examined for the study. The MLC records were not made available for the study as they were kept separately.

27. **Study Variables**. A pre defined criteria was set on which the in patient medical records were analyzed. The data were fed into Microsoft Excel 2010 and analyzed on the basis of criteria selected.

28. **Study Tool/ Data collection Tool.** Suitably evolved checklist keeping in view the quality guidelines and also the NABH guidelines as applicable was prepared.

29. **Sampling Technique**. Non-Probability Convenience Sampling Technique was used.

30. **Data Source**. Secondary data was obtained by collecting required information from the medical records of the in patients discharged in the month of January 2018 from the hospital.

31. **Data Analysis**. The data was analysed with the help of Microsoft Excel 2010.

Study Findings and Results

32. **Department wise Breakdown of Cases.** A total of 342 medical record files were examined. The breakup of the records audited speciality wise is as under:

Table 1: Total Medical record files audited

Department	No of Files
Neurology	17
Ophthalmology	16
Orthopaedics	30
Paediatrics	50
Obstetrics & Gynaecology	47
Nephrology	7
Oncology	6
Pulmonary Medicine	8
Urology	5
ENT	7
General Surgery	27
Cardiology	20
Internal Medicine	102

Fig1: Total Medical Record File Audited

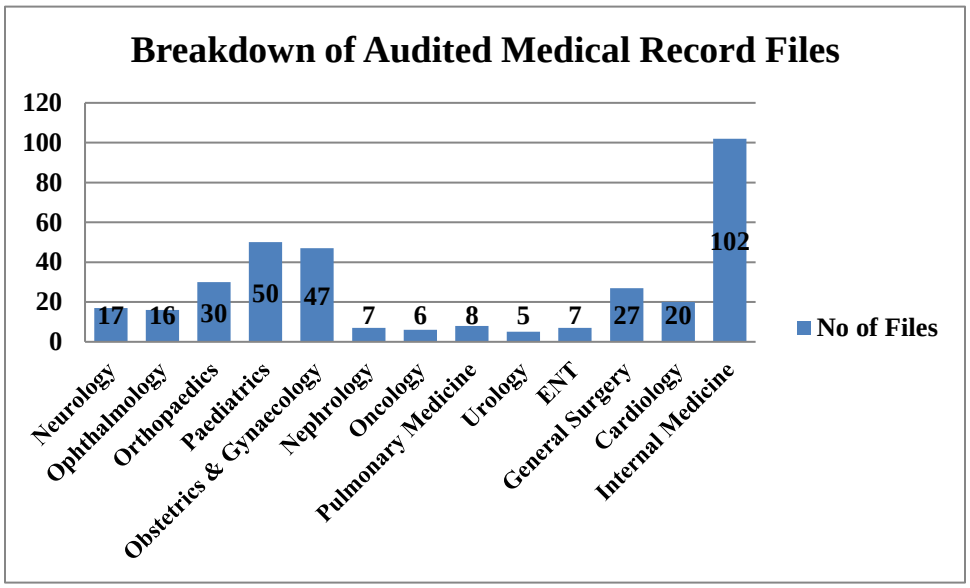


Figure 1 reflects department wise total number of medical records that were audited. Maximum numbers of files were from Internal Medicine followed by Orthopaedics. Urology had the minimum number of cases.

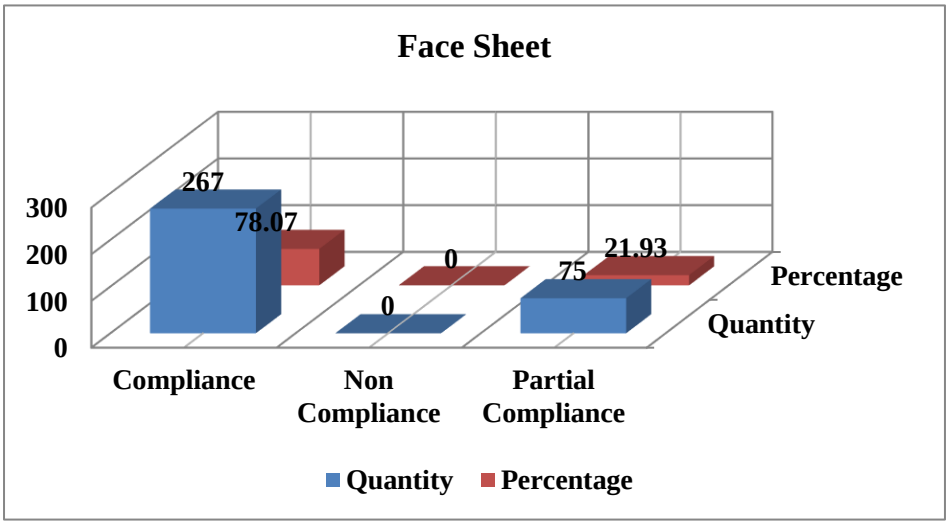
33 **Face Sheet.** All 342files audited had face sheet. Few face sheets were found to be partially filled. The details are as under:

Table 2: Face Sheet

Face Sheet	Quantity	Percentage
Compliance	267	78.07
Non Compliance	0	0
Partial Compliance	75	21.93

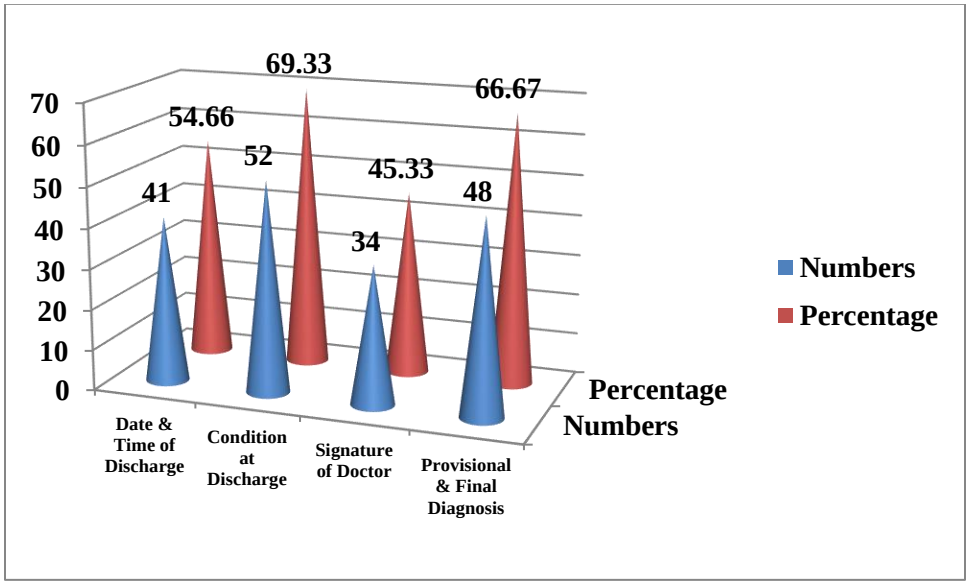
A total of 75 files were found with partially filled face sheets. It works out to be approx 22 percent of the total files audited.

Fig 2: Face Sheet



The main points missed out in partial complaint face sheets are reflected in the figure given below:

Fig3: Partially Complaint Face Sheet



It can be seen from the figure above that 'condition at discharge' was missed out in approx 70 percent of the partially complaint forms followed by 'provisional and final diagnoses'.

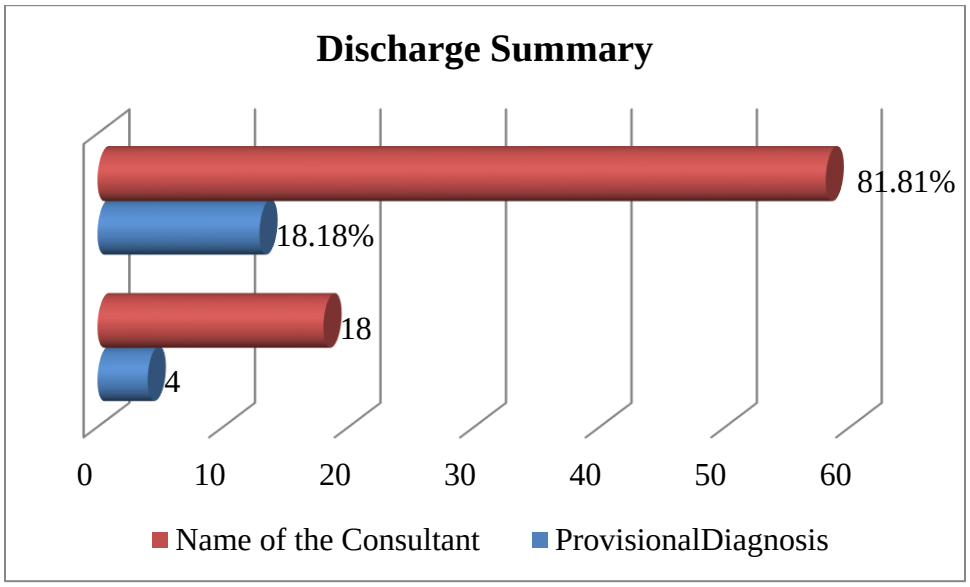
34. **Discharge/Transfer/DAMA/DOR/Death Summary**. Of the 342 files examined, all the files had this document. However, 26 documents had partial compliance. The details are as under:

Table3: Discharge Summery

Discharge Summary	Quantity	Percentage
Compliance	316	92.39
Non Compliance	0	0
Partial Compliance	22	7.60

The details of partial compliance are as follows:

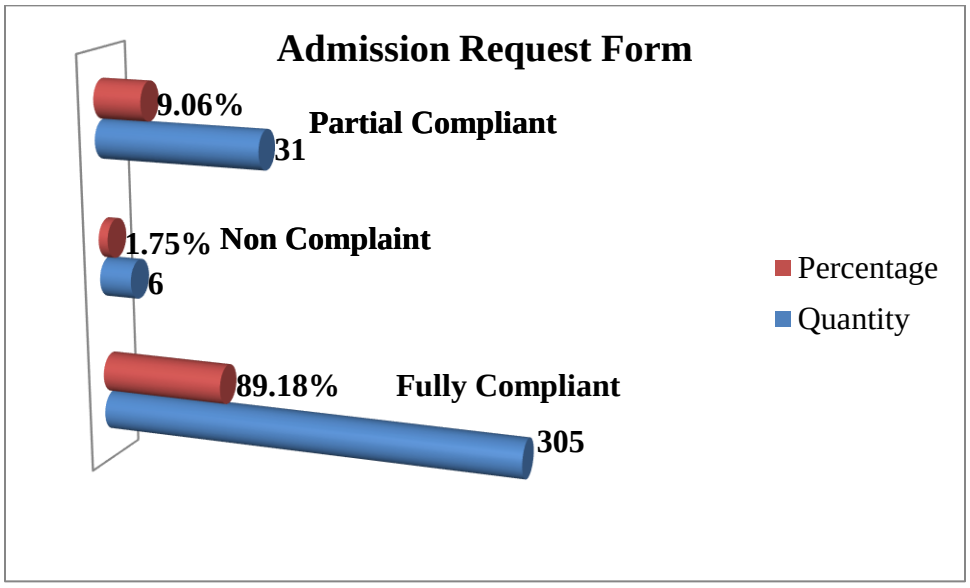
Fig4: Details of Partial complaint Discharge Summery



As is evident from the above figure, a total of 18 discharge summary did not reflected doctor's name or signature and four of them did not have provisional diagnosis. That works out to be 81.81% and 18.18% non compliant summaries respectively.

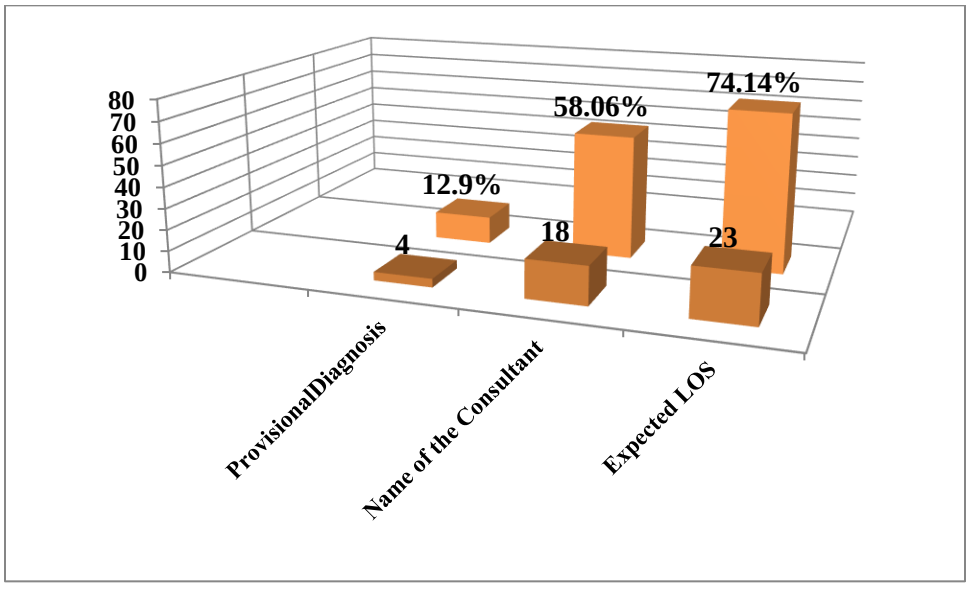
35. **Admission Request Form.** Compliance in this form was 305, where as six files were found without admission request forms. Further 31 forms had certain details missed out. The same is reflected in the figure that follows:

Fig5: Details of Admission Request Form



Further, the details missed out in the admission request forms are as under:

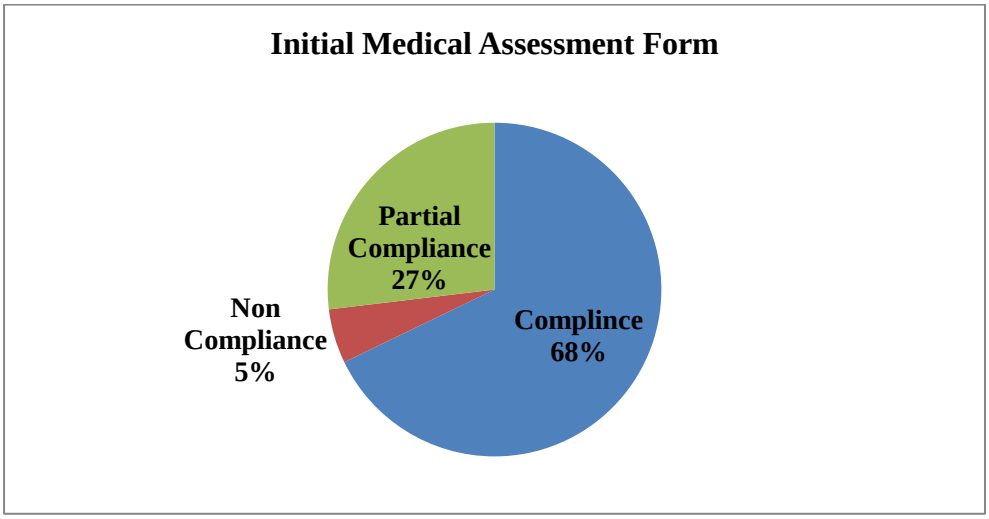
Fig6: Details of Partially Complaint Admission Request Form



12.9%, 58.06% and 74.14% forms were found to be without provisional diagnosis, name of the consultant and expected LOS respectively.

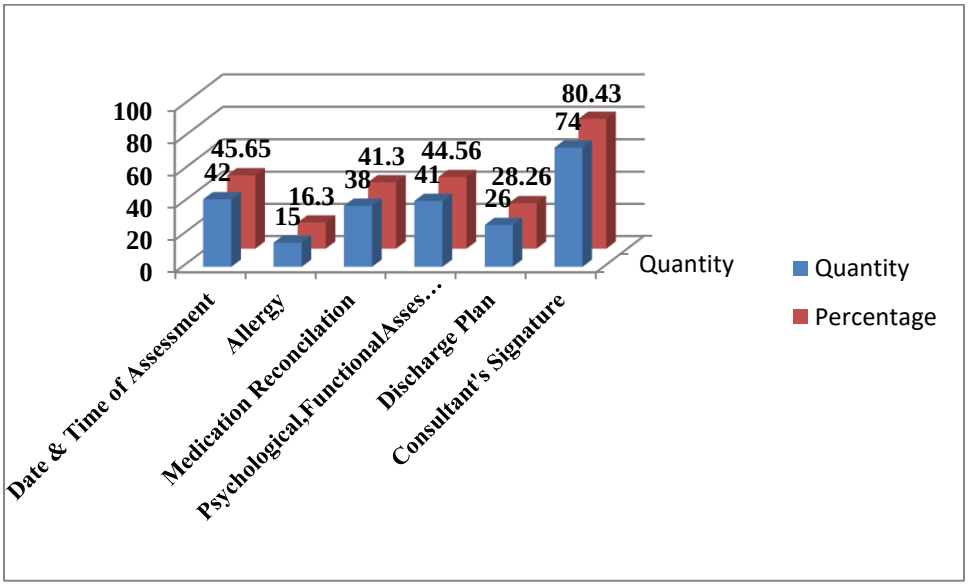
36. In Patient Initial Medical Assessment Form. Out of 342 files audited, 232 forms were found to be completely filled. However, in 18 files this form was found missing and 92 forms were found with incomplete details. The same has been depicted in the figure below:

Fig7: Initial Medical Assessment Form



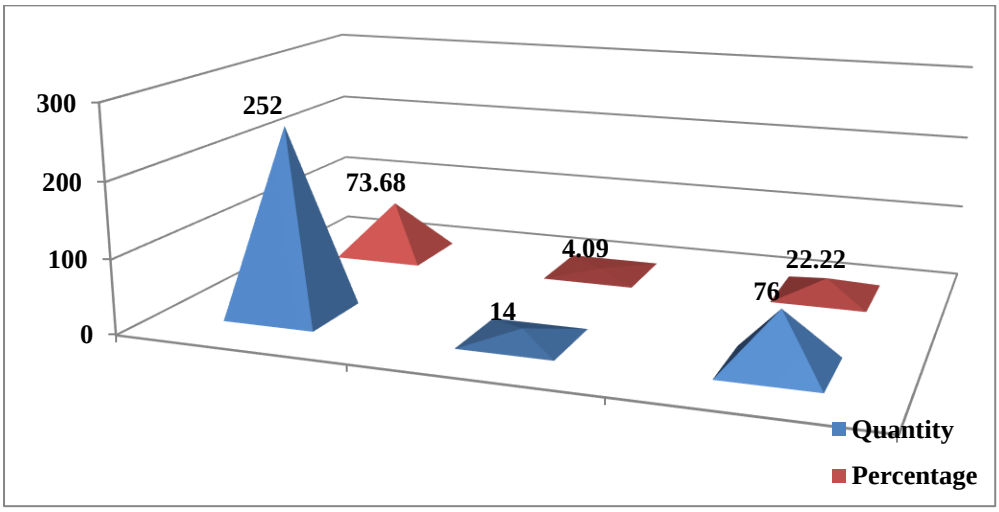
The details of fields left blank in partially complaint forms are reflected in the figure below:

Fig8: Details of Partial compliance in Initial Medical Assessment Form



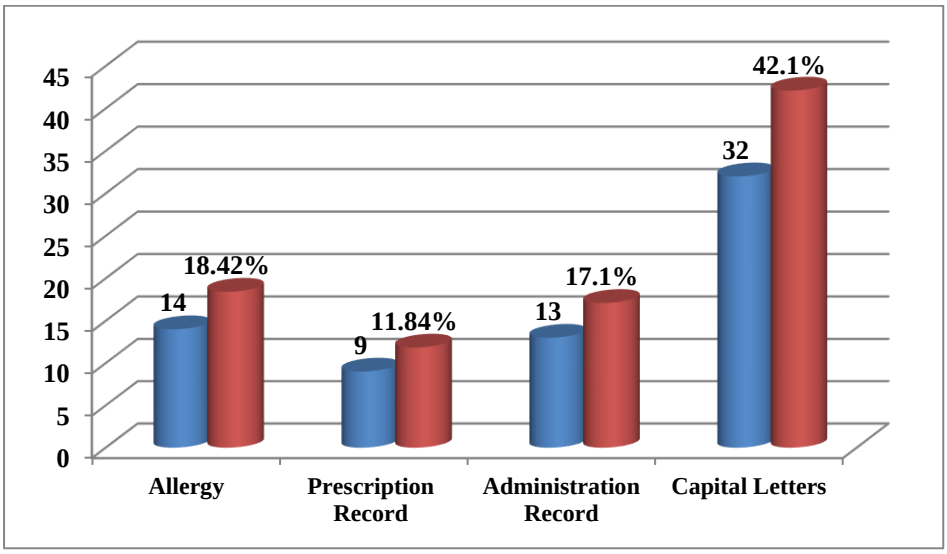
37 **Medication Administration Record**.Compliance, non compliance and partial compliance in this form was 252, 14 and 76 respectively. The same in depicted in the figure given below:

Fig9: Medication Administration Record Details



The details left out in partial compliant medication assessment records are given in the figure below:

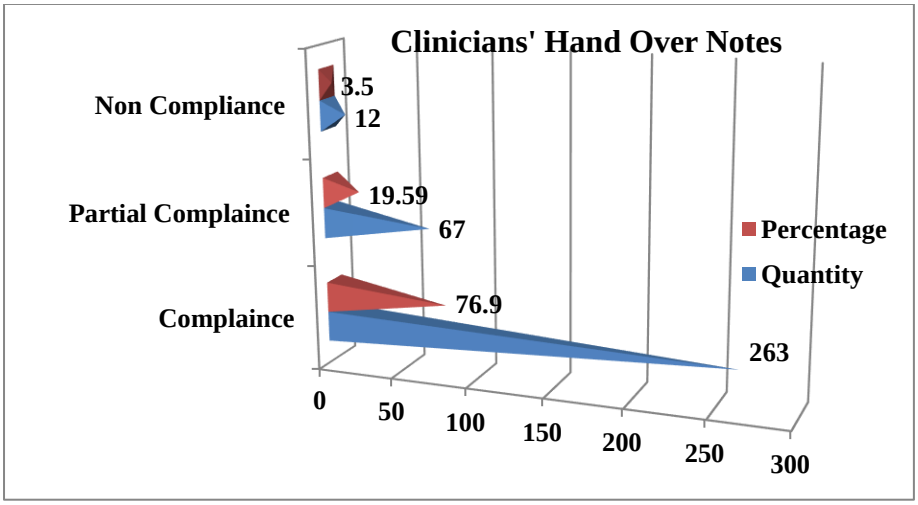
Fig10: Details of Incomplete Medication Administration Record



The main issue noticed in this document was not using capital letters for the drugs prescribed.

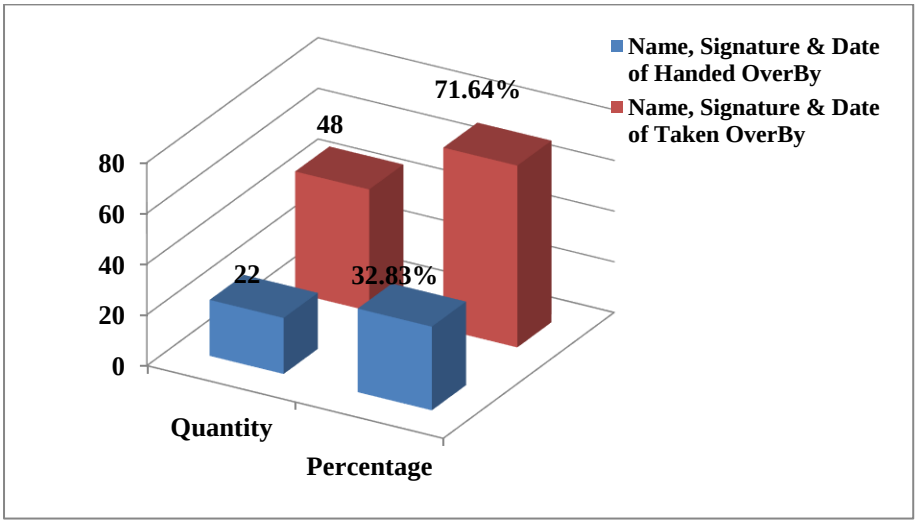
38. **Clinicians' Hand Over Notes.** A total of 263 clinicians' hand over notes was found to be fully completed. Whereas, 67 notes were found to be incomplete and12 of the medical records did not have the clinicians' hand over notes. The same details are reflected in the figure given below:

Fig11: Clinicians' Hand Over Notes Compliance



Of the partially completed clinicians' hand over notes, the requirements which were not attended to are given below:

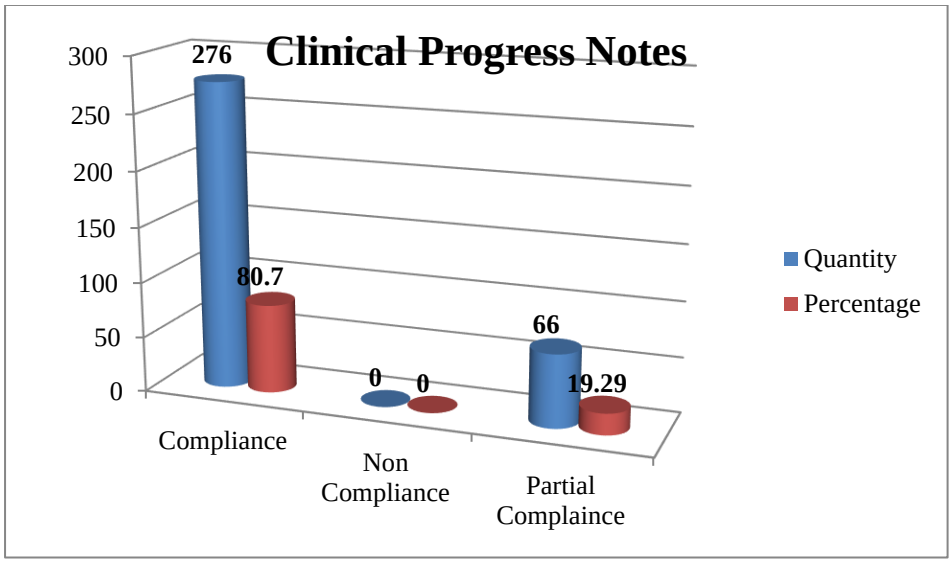
Fig12: Partial compliance details of Clinicians' Hand Over Notes



Maximum problem was found to be in the column Taken over by, which was left blank.

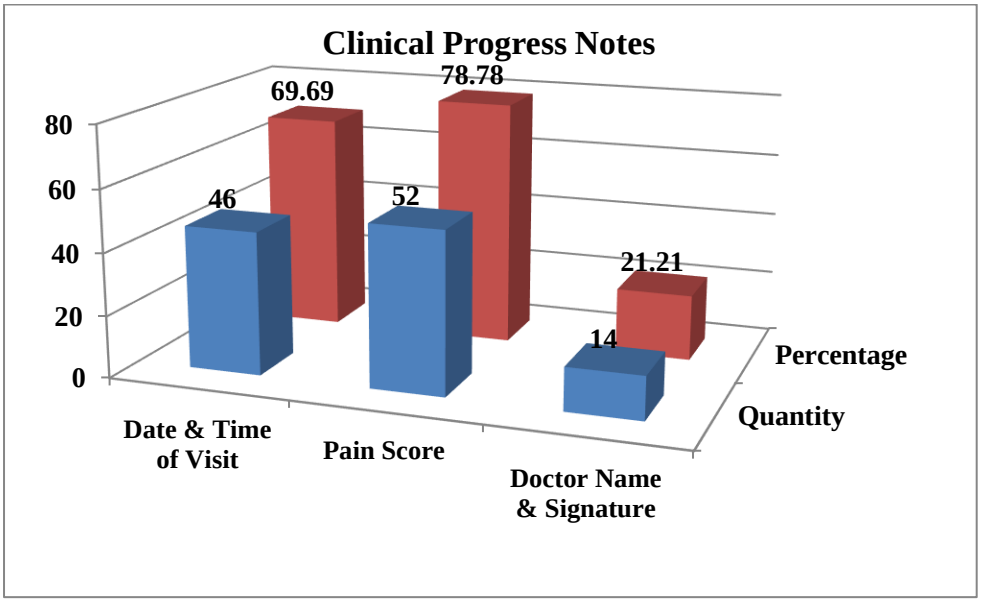
39. **Clinical Progress Note**. All 342 files had this document. However, 66 of them were incomplete in certain respects. That is more than 80 percent of medical records were fully compliant; where as 19 percent of the medical records had partially filled Clinical progress notes. The details are given below:

Fig 13: Clinical Progress Note Compliance



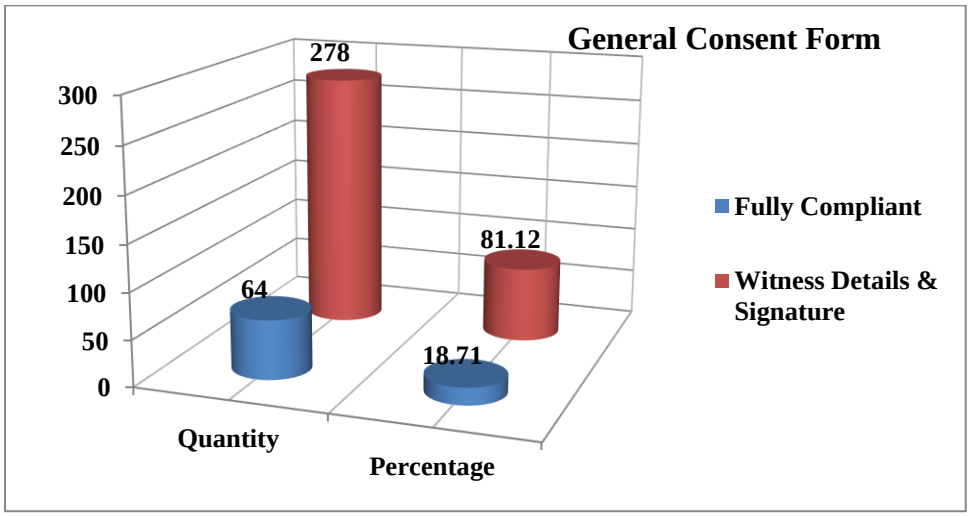
The details of partially completed clinical progress notes are as per the figure given below:

Fig14: Breakdown of Non complaint Clinical Progress Notes



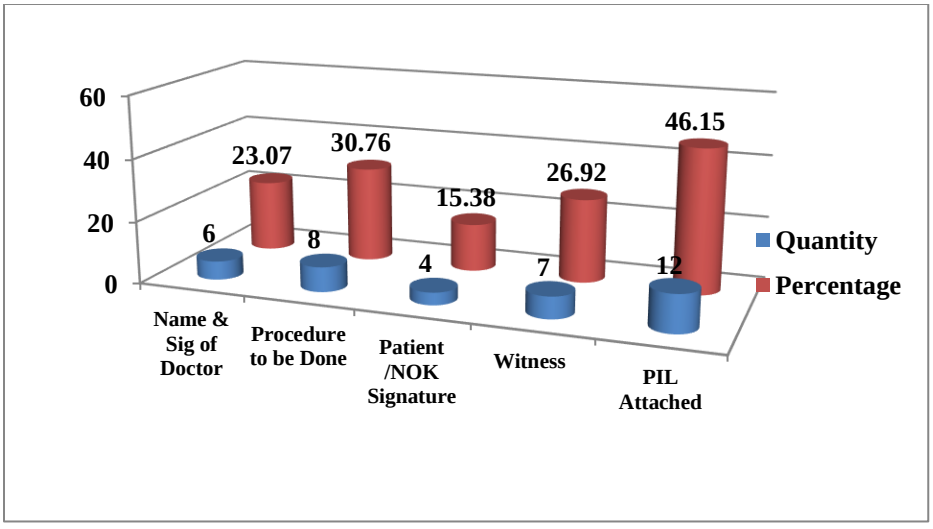
40. **General Consent Form.** All the medical records had general consent form. However it was noted that most of them did not had the details and signature of witness. The same has been reflected in the following figure:

Fig15: Partial Compliance in General Consent Form



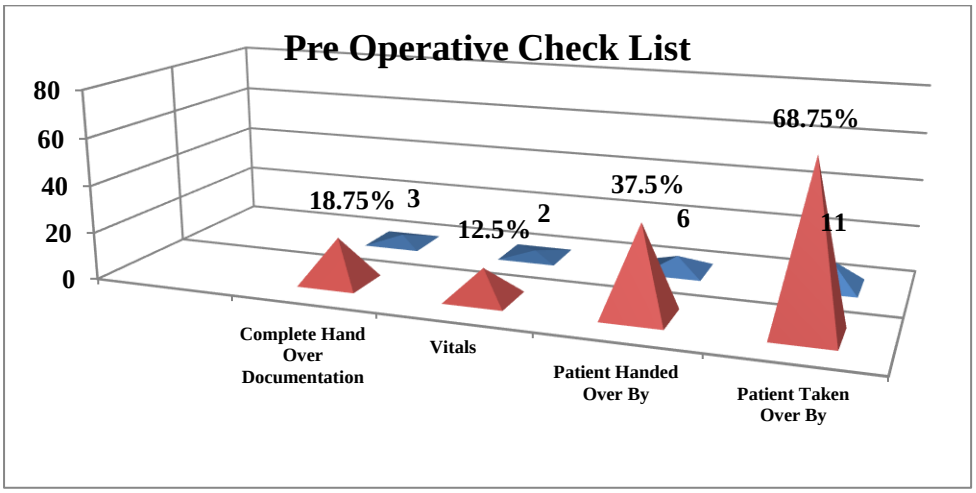
41. **Informed Consent Form**. There were a total of 224 medical records with informed consent. Of these, 198 were completed with all details. However, 26 forms i.e. approx 12%, were noted to be with deficiencies. The details of the same are reflected in the following figure:

Fig16: Informed Consent Form: Details of Partial Compliance



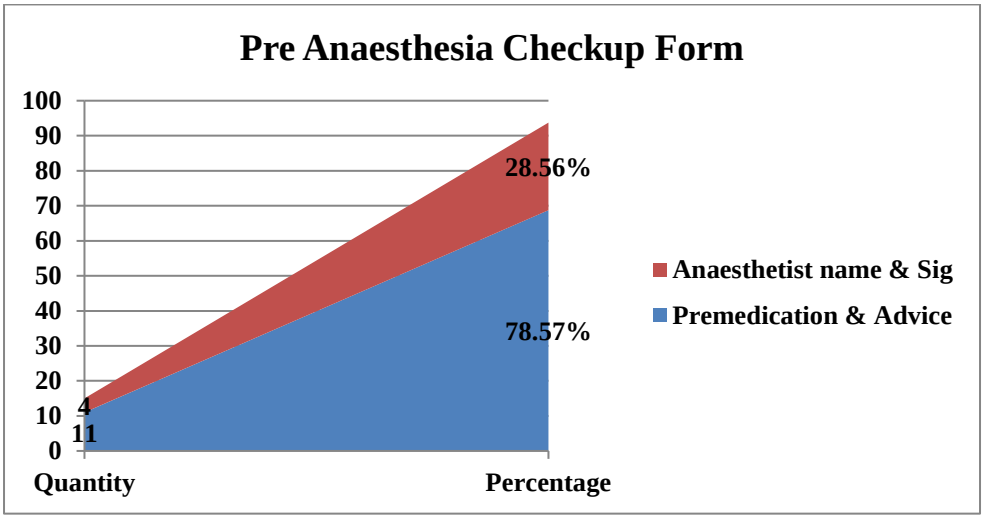
42. **Pre-Operative Check List.** There were in total 129 surgical cases. Of these, all the files had the pre operative check list, though 16 of the forms were found deficient in some aspect or other. The details are as given below:

Fig17: Deficiencies in Pre Operative Check List



43. **Pre Anesthesia Checkup Form.** There were 129 surgical cases in all. There was no case of non compliance. A total of 14 forms i.e.10.85% of the forms were found to be partially complaint. These details of fields missed out are shown in the following figure:

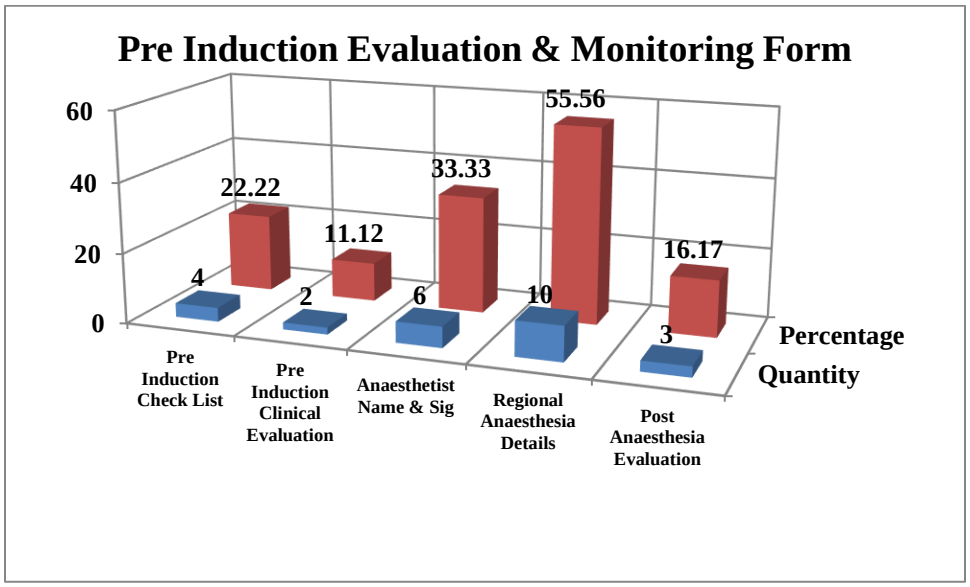
Fig18: Deficiencies Noted in Pre Anesthesia Checkup Forms



Eleven forms were found to be without premedication and advice and four forms were found without anesthetist name and signature.

44. **Pre Induction Evaluation & Monitoring Form.** Of all the medical records, 111 were fully compliant. Partial compliance was in 18 files while no files were found without this form. This works out to 86.04% compliance and balance approx 14% were found to be non compliant. The details of incomplete forms are as shown below:

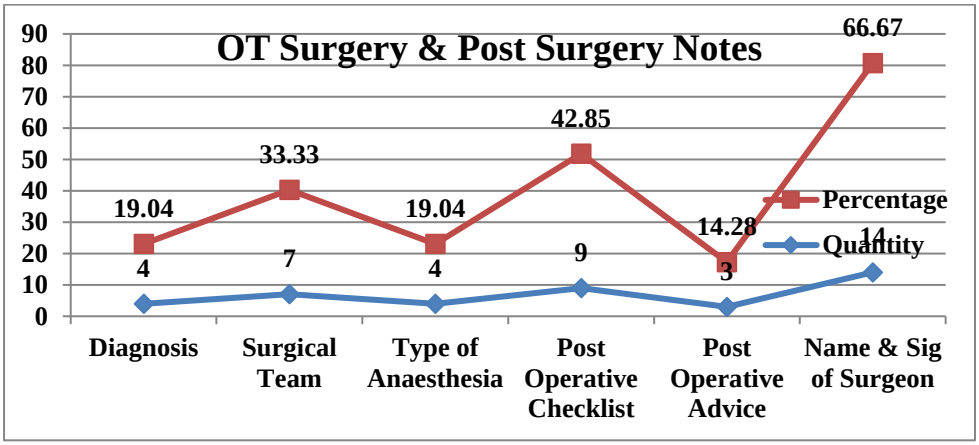
Fig19: Shortcomings Noted in Pre Induction Evaluation & Monitoring Form



As can be seen in the above figure, regional anesthesia details were missed out in the maximum cases i.e. 55.56% of all the partial compliant forms had this deficiency. In six of the forms, Anesthetists missed out to sign the form. Other issues noted were with pre induction check list and pre induction clinical evaluation, where certain fields were not filled in the forms.

45. **OT Surgery & Post Surgery Notes**. All 129 surgical cases had surgery and post surgery notes, of which 21 notes were incomplete. Observations are reflected in the figure below:

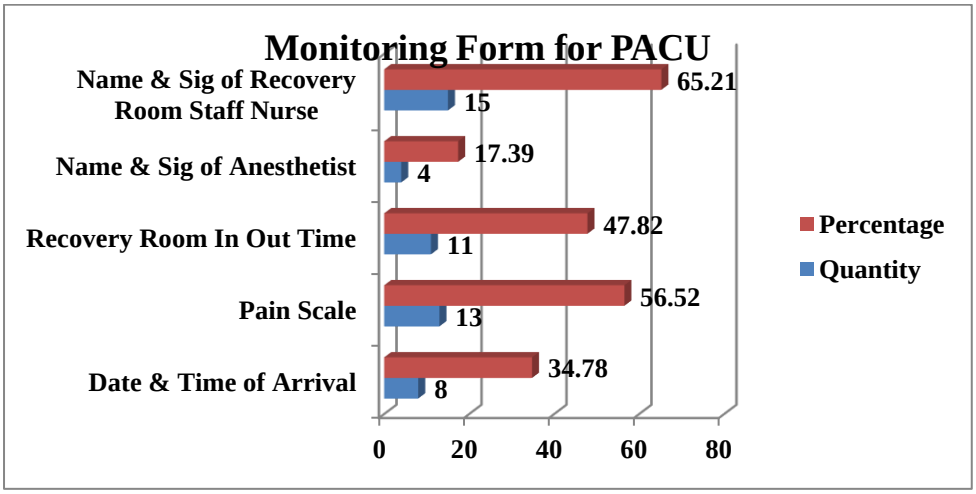
Fig 20: Observations on OT Surgery & Post Surgery Notes



It was noticed that 14 forms (66.67% of the partially complied forms) were without the name and signature of the Surgeon, followed by post operative checklist, wherein nine forms were found to be partially filled post operative checklist.

46. **<u>Monitoring Form for PACU</u>**. It was noted that all the 129 medical records had the monitoring form for PACU. Of the 129 forms, 106 forms were fully compliant as per the checklist. However, 23 of them were not filled in toto. The details of the partially complaint forms are as under:

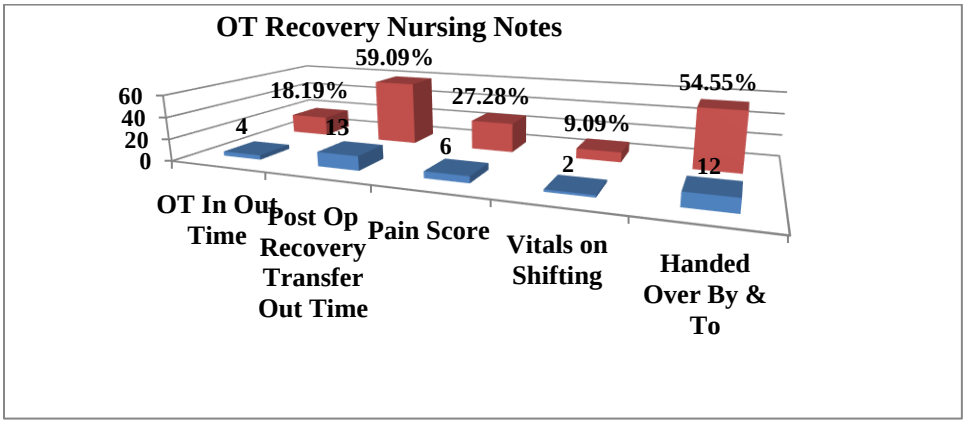
Fig 21: Deficiencies Noted in Monitoring Form for PACU



As it is evident from the above figure pain scale was not marked in approx 56% of the partially complaint forms. Recovery room in out time was also not reflected in about 48% of the forms.

47. **OT Recovery Nursing Record.** Of the 129 records, 107 were complete in all aspects and 22 of the records were having some fields not filled. The details of these 22 records are as follows:

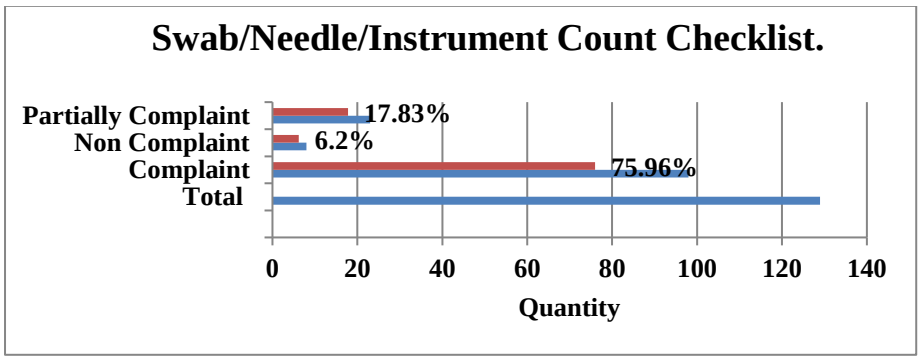
Fig 22: Incomplete OT Recovery Nursing Notes



Post op recovery transfer out time was missing 13 records, where as in 12 records signature and particulars of 'handed over to or by' was not found.

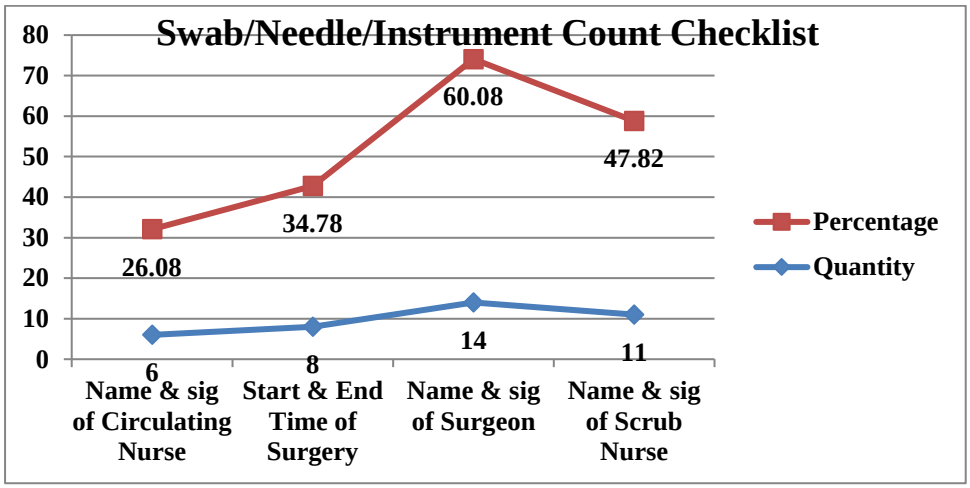
48. **Swab/Needle/Instrument Count Checklist**. In all there were 129 surgical cases, of which the checklist was found in 121 files. Further, 98 checklist were complete and 23 of them were partially completed. The same in depicted in the figure given below:

Fig 23: Compliance of Swab/Needle/Instrument Count Checklist



As shown above, there were a total of 23 checklists which were partially completed. The details of partially completed forms are under:

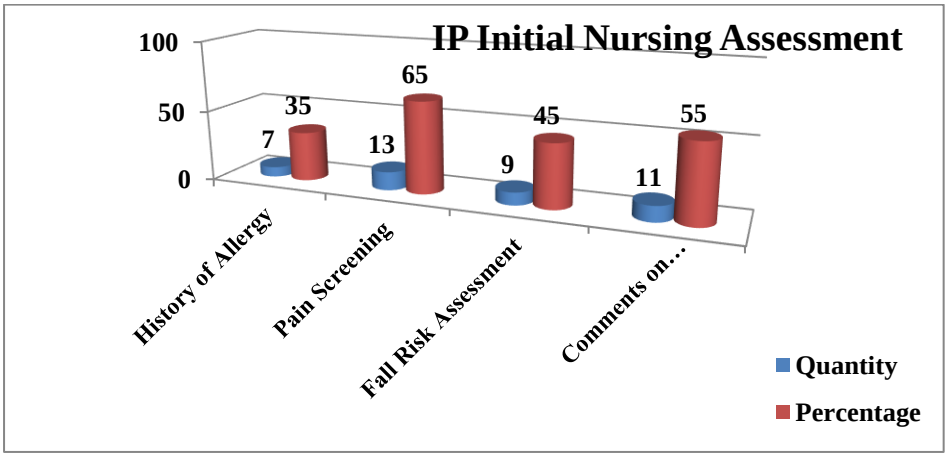
Fig 24: Details of Partially Compliant Swab/Needle/Instrument Count Checklist



The major deficiency noted was missing of name and signature of the Surgeon followed by scrub nurse.

49. **IP Initial Nursing Assessment.** Out of 342 medical records, all the records had this assessment form. However 20 forms were found incomplete in some fields, Details of these incomplete forms are as under:

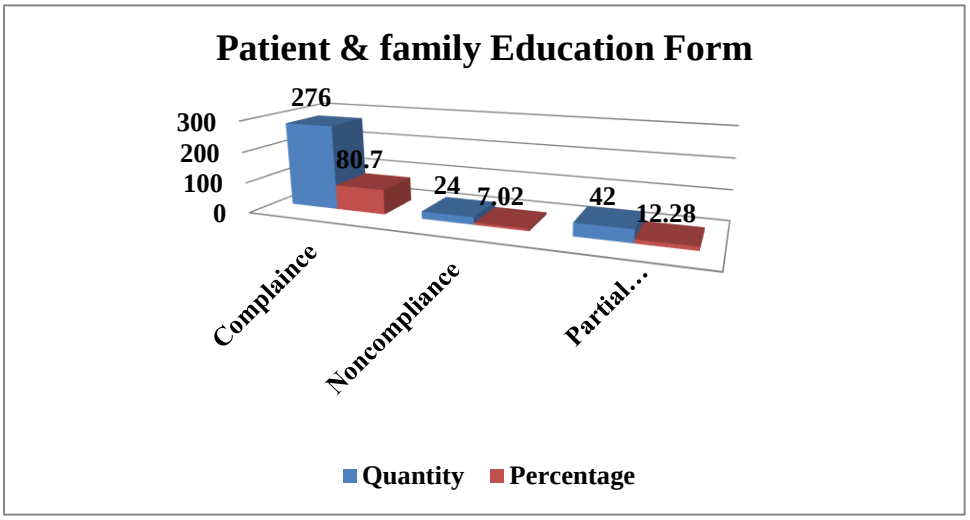
Fig 25: Shortcomings Noted in IP Initial Nursing Assessment Form



Main point missed out was on pain screening which was approx 65% of partially filled forms.

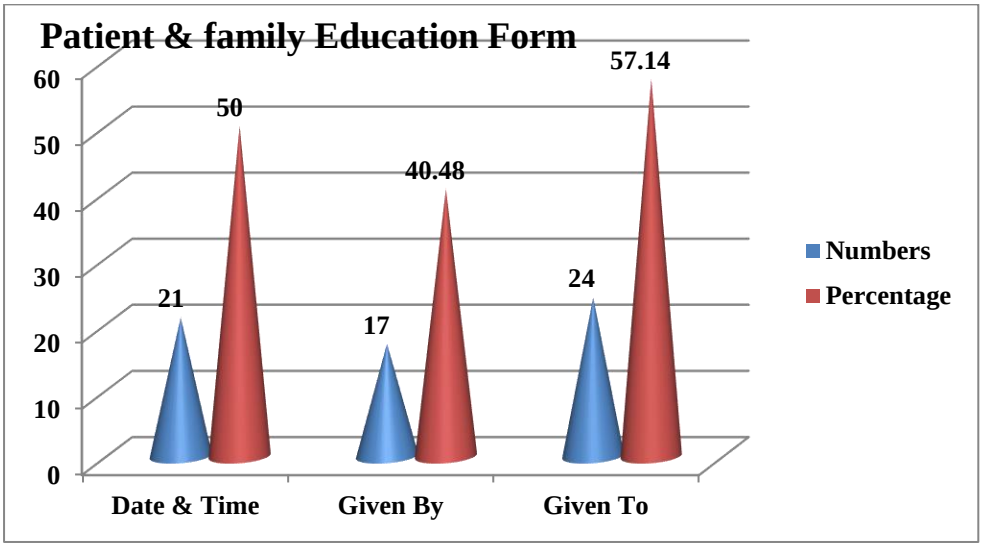
50. **Patient & family Education Form.** The compliance level of this form was 277, partial compliance was 42 and noncompliance was at 24 out of 342 forms. The same is depicted in the figure given below:

Fig 26: Compliance Level of Patient & family Education Form



The details of partially complaint forms are as under:

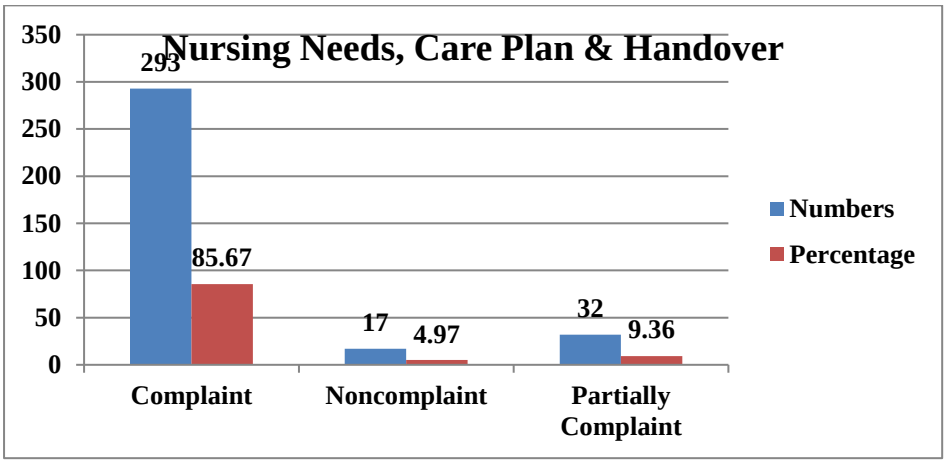
Fig 27: Details of Partially Complaint Patient & family Education Form



Of 42 forms found partially filled, 24 were found with the details of 'Given to' and 21 did not reflect 'date and time'.

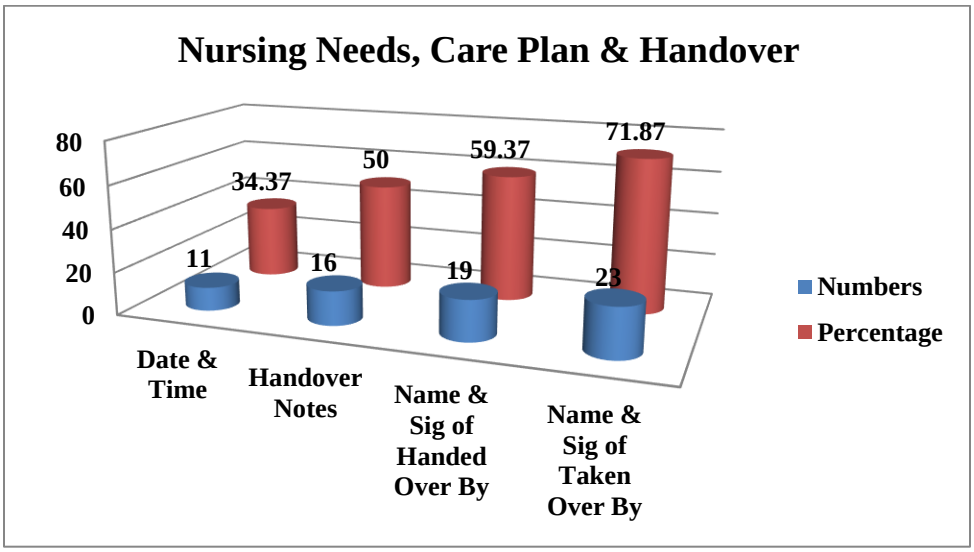
51. **Nursing Needs, Care Plan & Handover Form.** There were 293 fully complaint forms, 17 noncompliant and 32 partially complaint forms. The same is depicted in the figure as follows:

Fig 27: Nursing Needs, Care Plan & Handover Form



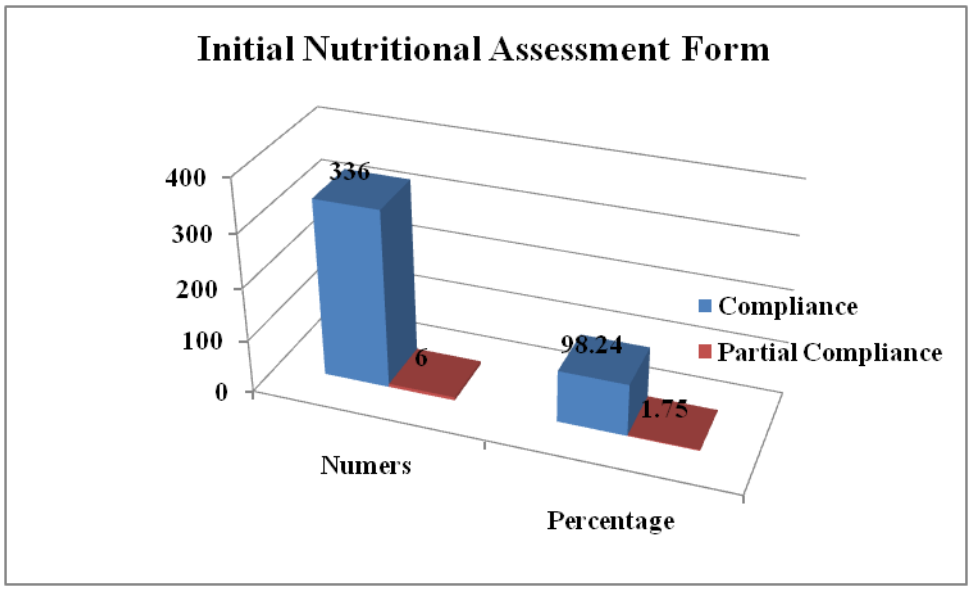
'Name and signature of taken over by' was found to be missed out in maximum forms, followed by 'Name and signature of handed over by, Further details are as given below:

Fig 28: Breakdown of Partially Complaint Nursing Needs, Care Plan & Handover Form



53. **Initial Nutritional Assessment Form.** This form was found in all the reviewed files and almost all of them (98.24%) were found in order. In all, only six forms i.e. 1.75% were found wanting in some field. In two of the forms patient label was missing and in four of the forms 'Date and time of assessment' was missing.

Fig 29: Compliance of Initial Nutritional Assessment Form



Discussion

54. Medical records are the document that provides a window to physicians and other medical staff to have a look at the patients' medical history and have an idea about patient prior care. It also assists in understanding the present diagnosis and position, and consequently prepare appropriate treatment plan. Medical records have long been an important tool of patient care. To ensure continuity of care for patients, it is imperative to keep good and complete medical records, which can be handwritten or electronic. Health care providers and others concerned persons are able to use satisfactorily maintained medical records to recreate the essential parts of each patient care without the need to refer to memory. If medical notes are adequately maintained and updated, it becomes easy for the healthcare providers to carry on where a colleague left off.

55. The main purpose of medical records is to ensure continuity of care of the patient. Medical records are also required to be retained in medico legal cases where the patient pursues a claim for injury sustained at work place or traffic accident. Health providers require good medical records to defend themselves against a complaint or medical negligence claim as they provide an insight into the clinical judgment that was implemented at that time. It is understood that if a medical record is good enough for continuity of care, it will also meet the legal requirements. Such records will also assist in improving patient satisfaction, for planning purposes and also for scientific studies.

56. The study was undertaken to get to know the present standard of medical records being maintained in the hospital and level of adherence to the laid down guidelines. It is important to know the present status of documentation to identify the gaps and steps that are required to be taken to improve the quality of records to an acceptable label.

57. It is generally seen that maintenance of medical records are given low priority and they are poorly maintained most of the time. They are also not readily available. However, in this study, it was noted that though being a new hospital, which has started functioning approx six months back, the standard of documentation was quite satisfactory.

58. Standardization of medical record documentation can increase concise and direct information. However, badly designed forms may increase the contents; they provide insufficient support for patient care. Effort should be made to create a system that is patient centric at the same time garner the benefit of standardization, such as accurate, precise and up to date information. It should also facilitate transfer of information among all the members of the interdisciplinary team. This aspect needs to be debated and acted upon at the earliest to avoid duplicity and cut down on information that may not be of much importance. Issue of completeness of medical records is also important as failure of complete documentation was one of the main reasons for law suits.

59. Regular and systematic auditing of medical records should be done to identify gaps in maintenance of the documents and take timely corrective measures to eliminate them and also to ensure that new deficiencies do not creep in the records. A suitably constituted committee should

carryout periodic audit to ensure this aspect. Physicians being the main contributor to the medical records have to ensure that accurate and detailed information is entered in the documents for better patient care subsequently. Further, only such completed documents can be utilized for research and education purposes.

60. For easy and timely retrieval and also to avoid mistakes in the documents, there is a need for digitization of the medical records. In the hospital part of the medical record has already been digitized, where in nutritional, Physiotherapy and Diagnostic reports are available on line. Certain physician and nursing documents of the medical record has also been digitized. It should be the endeavor to switch over to EMR at the earliest for easy accessibility of data and also for sharing of the same data at multiple sites by multiple users simultaneously. It will also help in data entry simultaneously from more than one terminal. It will also help in storage of the records at more than one site, thus providing robustness to the medical record system.

61. In this study, 342 files where audited. It was noticed that Face Sheet needed more attention, as almost 22% of the files we are found to be with partial compliance. Admission request form also needs to be filled more deliberately as partial compliance level was more than 20%. In initial medical assessment form, partial compliance was almost 27% and non compliance was 5%. Not using capital letters for medicine in Medication Administration Form was noted as major deficiency. Similarly in clinicians' handover notes partial compliance was almost 20%, mainly name, signature and date of taken over by were missed out. In Clinicians' progress notes date and time of visit and DMC no were found to be missing. The surgical and

nursing forms were found to be generally well maintained. However there is always a scope for improvement.

Recommendation

62. After going through the medical records of the patients, who were admitted in the month of January 2018, the following are recommended:

(a) All the forms and records should be filed in the Medical Records as per pre determined sequence. This will make it easy to check that all required forms have been incorporated in the records and nothing is missed out.

(b) All the columns in the forms should either be filled or crossed out or written 'Not Applicable' as may be the case. This will reduce the chances of malpractices subsequently.

(c) There is a requirement to carry out detailed study of all the forms and standardize them so that information filled is not duplicated. It will also cut down on unnecessary documentation.

(d) Face Sheet should be filled at the time of admission and it should be completed and balance of information filled in at the time of preparation of Discharge form.

(e) Physicians may go in for getting their stamp made with their name, DMC number and other required details to be affixed below their signature. This will ensure that these details are not missed out inadvertently.

(f) Posters on importance of medical records may be displayed at suitable places in the hospital, to remind the concerned staff and environment in general, about the importance of the medical records.

(g) A speech to text software may be made available to the physicians and other staff for dictating the notes directly in the digitized form in places where computers are being used.

(h) Time limit should be laid down for completion and move of medical records through various steps and should be ensured at all times.

(i) At the end of retention period of the medical record and before it is being destroyed, intimation may be sent to the patient about the same. If the patient so desires he may be handed over the file and a receipt obtained for records.

(j) Ensure no cuttings and overwriting. Wherever there are such entries which have been cut or overwritten, it should be initialed by the person making the changes.

(k) Issue of signature of witness in the general consent form should be resolved and PC staff may be instructed to sign in as witness where ever no relative or next of kin is present with patient.

(l) Ensure periodic internal audit of the medical records by a suitably constituted committee to ensure quality of maintenance of records. The deficiencies noted should be disseminated to the concerned persons at regular intervals to make amends.

(m) Periodic education and training programmes based on the issues noted in correct documentation should be organized.

(n) Floor managers should also be incorporated in checking and updating medical records before it is sent from the ward to MRD.

Conclusion

63. The study at hospital showed that in general compliance level of medical records was quite high. Informed consent form, nursing records, Patients rights and responsibilities form nearly met the NABH standards. Certain deficiencies were noted in face sheet, admission request form, general consent form, estimate of expense sheet, Signature of doctors and consultants in initial assessment sheet and doctors progress notes. This aspect requires close monitoring and doctors sensitised of their responsibility to leave no entry vacant in the forms. This forms the basis of documentation of medical care provided and helps in continuation of care, and also is an important document in case of any litigation.

64. Regular audit of medical records and periodic training of all the members of the healthcare team will go a long way in full compliance and proper documentation of patient medical records. In an ever growing field of medical science, the importance of an accurate and authentic maintenance of medical records cannot be underestimated. In last two to three decades the medical science has grown by leaps and bounds and there has been a quantum jump in the modes of investigations and treatment methods. Due to this reason, there is a requirement to have

an up-to-date, secure and effective medical record system. The responsibility of maintaining a well planned and efficient Medical Records System is that of the medical records department with full co-operation and support from health care providers like physicians, nurses and other para medical staff. Medical records are an index of a health institution and Medical Records department is the back bone of health information system

65. Medical records System plays an important role in education, training and research purposes. A medical record provides detailed information about the disease of the patient and the treatment given to the patient. Such information must be used for training of the medics and paramedics staff at different stages of their study. This information can also be exploited to carryout research for the betterment of the present and the future generation.

66. The present system should be replaced by a Networked electronic medical record system. The networked electronic medical record system provides for diagnostic data to be uploaded from sections of the hospital, thus helping in timely and effective patient management. Major features of a networked electronic medical systems are that the data can be assessed and shared at multiple sites, several users can enter data concurrently, data gets backed up automatically at multiple sites, information and data can be shared between multiple locations such as from laboratory to physician etc. Wide area networks can connect remote locations. Web-based systems and some other client programs can also be repaired and improved over the internet without visiting remote locations.

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Annexure A

MEDICAL RECORD DATA COLLECTION SHEET

DEPT		UHID NO		IP NO	
			Available	Complete	Remarks
	Arng order	Name of Form	Yes/N0/NA	Yes/N0/NA	
Identification Section	1	Face Sheet			
	2	Discharge/Transfer/DAMA/DOR/ Death Summary			
	3	Code Blue Record Sheet			
	4	Admission Request Form			
Physician Section	5	Emergency/ OPD Ticket			
	6	Medication Administration Record			
	7	In Patient Initial Medical Assessment Form			
	8	Clinicians' Referral Form			
	9	Clinician Hand Over Notes			
	10	Clinician Order Sheet			
	11	IP Integrated Plan of Care			
	12	In House Transfer Summary			
	13	Clinical Progress Notes			
Surgery Case Section	14	Pre Anaesthesia Check Up Form			
	15	Procedural Safety Check List			
	16	Patient Information Literature Anaesthesia			
	17	Blood Transfusion and Verification Form			
	18	Form for Monitoring Procedure			
	19	Pre Operative Medical Assessment Form			
	20	Before Skin Incision (Time out)			
	21	OT Pre Induction Evaluation & Anaesthesia Monitoring Form			
	22	OT Surgery & Post Surgery Notes			
	23	Swab/ Needle/Instrument Count Check List			
	24	Monitoring Form for PACU			
Nursing Section	25	Pre Operation Check List			
	26	OT Recovering Nursing Record			
	27	ER Initial Nursing Assessment			
	28	IP Initial Nursing Assessment			

	29	IP Patient & family Education Need & Barrier			
	30	Patient & Family Education Form			
	31	Fall, Phlebitis &Pressure Sore Risk Assessment Tool			
	32	Nursing Needs, Care Plan & Hand Over			
	33	Vitals Monitoring Chart			
Dietician Section	34	Intake Output Chart			
	35	Blood Sugar Monitoring Chart			
	36	Restrain Monitoring Sheet			
	37	IP Nutritional Assessment Form			
	38	Critical Care Nutritional Chart(enteral)			
	39	IP Nutritional Progress Note			
	40	IP Nutritional Paediatric Assessment Form			
Consents	41	General Consent			
	42	Informed Consent			
Misc	43	Counselling Form			
	44	Patients Rights & Responsibilities			
	45	Patient Information Literature			
		DoA DoD			

Annexure B

MEDICAL RECORDS AUDIT CHECKLIST

S.NO	NAME OF DOCUMENT	REQUIREMENTS
1	**ADMISSION REQUEST FORM**	Name & Uhid No.
		Provisional Diagnosis
		Name Of Consultant & Sign.
		Expected Los
		Proposed Date & Time Of Admission
2	**FACE SHEET**	**On Admission**
		Name in Full
		Provisional Diagnosis
		Front office executive Name and Sign
		Discharge
		DOD & Time
		Final Diagnosis
		ICD Code
		Condition at discharge(circled)
		Signature by Consultant
		Patient/Next of Kin Signature
3	**GENERAL CONSENT FOR ADMISSION**	Patient demographics
		Name of the Doctor
		Signature of patient/ Surrogate, Date & time
		Witness Signature, Date & time
		Name and Sign of Front office executive
4	**INITIAL MEDICAL ASSESSMENT**	Date and Time of Assessment
		MLC
		Allergy
		Presenting Complaint(s)
		Past history
		Medication Reconciliation
		Psychological, Functional Assessment, Nutritional Assessment
		Pain Screening/ Assessment
		Provisional Diagnosis
		Plan of care

		Appropriate Discharge Plan
		Name and Sign of RMO
		Name and Signature of Consultant
		Whether Assessment was done within 2 hrs from Patient arrival time in ward
		Counter-signature by Primary Consultant within 24 hrs from time of admission
5	**INFORMED CONSENT**	Patient Label
		Name of the Doctor
		Procedure to be done
		Patient/ Next of kin Name, Signature
		witness name & Signature
		Dr's Name, Signature , Date & Time
		PIL attached or not
		PIL- Patient label
		PIL- Patient/ Next of kin Name, Signature WITH Date & Time
6	**CLINICIAN PROGRESS NOTES**	Patient label
		Date and time of Visit
		Pain Score
		Doctors name
		Doctors Signature
7	**CLINICIAN ORDER SHEET**	Patient Label
		Signature of Clinician
		Hospital Staff Signature
8	**CLINICIAN REFERRAL FORM**	Patient Label
		Provisional Diagnosis
		Reason for Referral
		Purpose of referral
		Type of referral
		Signature of refeering Clinician
		Note by Referred Clinician
		Name and signature of Referred Clinician
9	**CLINICIAN HANDOVER NOTES**	Patient label
		Notes
		Name and Signature of Handed over by

		Date and time
		Name and Signature of Taken over by
		Date and time
10	**IN-HOUSE TRANSFER SUMMARY**	Patient Label
		Shifting from and shifting to
		Date and Time of Transfer
		Documentation
		Name and signature of Transferring Clinician
		Date and Time
		Name and signature of Receiving Clinician
		Date and Time
11	**MEDICATION ADMINISTRATION RECORD**	Patient Label
		Allergy
		Complete Precription Record
		Diet orders
		Whether the Medication Orders are legible or not
		Signature of Doctor
12	**PATIENT & FAMILY EDUCATION FORM**	Patient Label
		Date and Time
		Given by: Name and Signature
		Given to: Name and Signature
13	**PRE-OPERATIVE CHECKLIST**	Patient Label
		Complete Handover documentation
		Vitals
		Patient handed over by (name, sign & time)
		Patient taken over by(name, sign & time)
14	**PRE ANAESTHESIA CHECKUP FORM**	Patient Label
		PAC Documentation
		PAC Evaluation
		Anesthesia Plan
		PAC fitness
		Premedication and Advise

		Anesthetist Name and Signature
15	**INFORMED CONSENT FORM FOR ANAESTHESIA**	Patient Label
		Name of the Doctor
		Procedure to be done
		Patient/ Next of kin Name, Signature
		witness name & Signature
		Dr's Name, Signature , Date & Time
		PIL attached or not
		PIL- Patient label
		PIL- Patient/ Next of kin Name, Signature WITH Date & Time
16	**PRE-OPERATIVE MEDICAL ASSESSMENT FORM**	Patient Label
		Diagnosis
		Surgery plan
		Need Assessment
		Name and sign of Surgeon
		Date and time
17	**PRE INDUCTION EVALUATION AND MONITORING FORM**	Patient Label
		Pre induction checklist
		Pre induction clinical evaluation
		Anesthetist name and signature
		Date and Time
		Regional Anesthesia details
		Anesthesia Monitoring
		Post anesthesia evaluation
		Name and sign of Anesthetist
		Date and time
19	**SURGICAL SAFETY CHECKLIST**	Patient Label
		Start Time and End Time
		Complete documentation
		Name and signature of Anesthetist
		Name and signature of Surgeon
		Name and signature of Staff Nurse

20	**OT- SURGERY & POST-SURGERY NOTES**	Patient Label
		Diagnosis
		Name of Surgery done
		Name(s) of Surgical team members –
		Type of Anesthesia given
		Procedure details - Incision given, findings, procedure steps
		Post operative checklist
		Post operative advise
		Name and signature of Surgeon/ Assistant Surgeon
		Date & Time
21	**FORM FOR MONITORING PROCEDURES**	Patient Label
		Date and Time of the procedure
		Name of the procedure
		Complete documentation
		Allergy
		Vitals
		Name and sign of Clinician performing sedation
		Date and time
		Name and sign of Staff Nurse
		Name and sign of Technician
22	**MONITORING FORM FOR PACU**	Patient Label
		Date & Time of arrival
		Name of the Surgery
		Pre-discharge assessment
		Pain scale
		Recover Room Transfer details
		Recovery Room in and Out time
		Name and signature of Anesthetist
		Name and signature of Recovery Room Staff Nurse
23	**DAMA/DOR/LAMA FORM**	Patient Label
		Complete Documentation
		Signature of patient or relative with address
		Signature of witness
		Name, Signature of Doctor, Date & Time in the form.

24	**DISCHARGE/ DEATH SUMMARY**	Patient Label/Demographics
		DOA and DOD
		Final Diagnosis
		Co-morbidities
		Discharge summary contains the reasons for admission, significant findings and provisional diagnosis, procedure(s) performed, medication administered, medication to be taken, follow up advice, other instructions in an understandable manner.
		How and when to obtain urgent care
		Whether LAMA/ not
		Doctor's Name and signature
		Death Summary- Statement of Cause of Death
		Date and Time of Death
		Signed by the Admitting Consultant only.
25	**DEATH CERTIFICATE**	Name of the Deceased
		Name of father/ husband
		UHID NO./Age/ Sex
		Residential Address
		Date & Time of Admission
		Date & Time of Death
		Cause of Death
		Name and signature of the Receiver with relationship
		Name, signature, date & time with DMC of the Doctor declaring the death.
1	**INITIAL NURSING ASSESSMENT**	Date & time of arrival
		History of Allergy
		Pain screening
		Fall Risk Assessment
		Comments on Vulnerability
		Vitals
		Nursing Care Plan
		Staff nurse name with sign
		Whether Assessment was done within 1 hr of patient arrival time in ward

2	**NURSING NEEDS, CARE PLAN & HANDOVER**	Patient Label
		Date and Time
		Handover Notes
		Name and Signature of Handed over by
		Date and time
		Name and Signature of Taken over by
		Date and time
3	**MEDICATION ADMINISTRATION RECORD**	Patient Label
		Allergy
		Complete Administration Record
		Signature of Nurse
4	**VITALS MONITORING CHART**	Patient Label
		Vitals
		Pain assessment
5	**INTAKE-OUTPUT CHART**	Patient Label
		Intake and Output with TIME
6	**OT RECOVERY NURSING RECORD**	Patient Label
		OT No
		ÓT In time and Out time
		Pre-op recovery receiving time
		Post-op recovery transfer out time
		Vitals
		PAIN score
		Vitals on shifting
		Handed over by- name and sign
		Handed over to- name and sign
7	**SWAB/ NEEDLE / INSTRUMENT COUNT CHECKLIST**	Patient Label
		Names of the Operating Team
		Date
		Start Time and End time of surgery
		Initial Count and Final Count
		Name and Sign of Circulating Nurse
		Name and sign of Scrub Nurse
		Name and sign of Surgeon

	INITIAL NUTRITIONAL ASSESSMENT	Patient Label
		Date & Time of Assessment
1	**IP - INITIAL PHYSIOTHERAPY SCREENING AND ASSESSMENT FORM**	Nutritional Screening
		Nutritional Assessment
		Dietician Plan of Care
		Dietician name & signature
		Date and Time
		Whether the Assessment was done within 24hrs from admission time
2	**IP- PHYSIOTHERAPY REASSESSMENT FORM**	Functional Screening
		Functional Assessment
		Chief Complaints
		Pain Assessment
		Provisional Diagnosis
		Patient and Family Education
		Physiotherapy Plan of Care
		Physiotherapist Name and Signature
		Date and Time
		Patient Label
		Physiotherapist Signature
		Patient Label
		Date and Time