Reviewing Patient Medical Documentation as Means to Enhance Patient Safety and Physician Defensibility in a Super Specialty Hospital

To Err is Human: Building a Safer Health System

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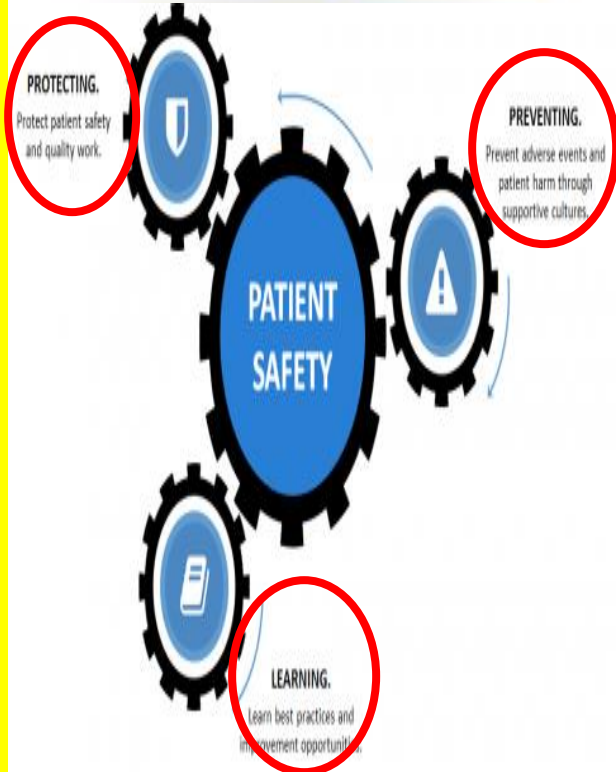
PG/16/040
Hospital Stream

- ***Patient safety is a discipline that emphasizes safety in healthcare through prevention, reduction, reporting, and analysis of medical and non medical errors that often leads to adverse effects***
- **Literature Review ****
- ***Medical Record is a physician's greatest asset in defending against allegations of negligence***
- ***Adequate, Clear, Legible, Credible, Accurate and Complete medical records are best defense against litigation and support Physician Defensibility***



Purview

- Problem Statement
- Aim
- Objectives
- Methodology & Procedure
- Observations & Analysis
- Key Findings & Recommendations

Problem Statement

- Patient safety should be supreme in a healthcare organisation
- Accreditation as means to establish standardised processes
- Documentation part of the processes and supports standardisation
- Internal Audit at MRD focuses on completing the ‘record’ as per procedure and legal angle
- Medical judgement is subjective hence not questioned

Problem Statement

- Varied type of non standardised medical education
- Gaps in understanding Patient Safety & Physician Defensibility
- Not part of evolution process of patient safety
- Deficiencies in preliminary education
- Measures required to plug- in holes
- Imperative for achievement of high standards of Patient safety

Aim

- To audit the patient medical documentation in In-patient wards, ICUs and MRD section contributing as means to enhance patient safety and physician defensibility in a super specialty hospital

Objectives

Analyze from perspective of an administrator in a *Hospital:*

- To establish role of documentation in the patient safety and physician defensibility
- To identify likely non-medical errors by doctors and nurses in Patient Medical Documentation having direct bearing on safety of patient
- To utilize internal audit as means to Patient Safety and physician defensibility
- To recommend a broad mechanism of internal audit so as to bring behavioral changes in the approach to documentation

Methodology

- **Study Area** Super Specialty Tertiary Care Hospital
- **Study Design** Cross sectional Descriptive study design
- **Study Period** 01 Feb to 30 Apr 2018
- **Study Population** Patient Medical Documents in IPD, ICUs and MRD
- **Sample Size**. 530 (Five Hundred and Thirty) Patient Medical Documents folders was audited
- **Study Tool** Existing Patient Medical Documentation Audit form
- **Sampling Technique** Non-Probability Convenience Sampling Technique

Procedure

- Initial understanding – audit checklist prepared
- Adapted with existing form for audit – management study
- MRD, IPDs, ICUs
- Focus on non medical errors
- Initial 230 patient file folders – No feedback to wards, ICUs
- Bal samples from wards, ICUs – periodic feedback to med staff
- Focus of audit – HOW and WHEN
- Data compiled for collective analysis and inference

Patient Medical Documents Scrutinized

- Face Sheet
- Admission Request Form
- IP Initial Assessment
- ER/ IP Nursing Initial Assessment
- Clinical Progress Notes
- Clinician Handover Notes
- Medication Administration Records
- Nursing Needs, Care and Hand over Plan
- IP Nutritional Assessment
- Vital Monitoring Chart
- General Consent Form
- Informed Consent Form
- Pre Op Check List
- Pre Induction Evaluation & Monitoring Form
- OT Surgery & Post surgery Notes
- Monitoring Form for PACU
- OT Recovery Nursing Record
- Swab/Needle/Instrument Count Check List

Medical Records Audit Checklist

S.No	Pt Medical Document/ Form	Requirements (Quality Indicators)
1	Admission Request Form	Name & UHID No
		Provisional Diagnosis
		Name Of Consultant & Signature
		Expected LOS
		Proposed Date & Time Of Admission
2	Face Sheet	On Admission
		Name In Full
		Provisional Diagnosis
		Front Office Executive Name And Signature
		Discharge
		DOD & Time
		Final Diagnosis
		ICD Code
		Condition At Discharge
		Signature By Consultant
		Patient/Next Of Kin Signature
3	General Consent For Admission	Patient Demographics
		Name Of The Doctor
		Signature Of Patient, Date & Time
		Witness Signature, Date & Time
		Name And Signature of Front Office Executive

MEDICAL RECORDS AUDIT CHECKLIST

S.NO	NAME OF DOCUMENT	ATTACHED	NOT ATTACHED	NOT APPLICABLE	REQUIREMENTS	FILLED	NOT FILLED	NOT APPLICABLE	REMARKS
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 exceutive Name and Sign				
					Discharge				
					DOD & Time				
					Final Diagnosis				
					ICD Code				
					Condition at discharge(circled)/Sign. of Doctor				
					Patient/Next of Kin Signature				
3	General Consent for Admission				Patient demographics				
					Name of the Doctor / Front office ex				
					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				
					Dischrge Plan				
					Name and Sign of RMO				
					Name and Signature of Consultant				
	INITIAL NURSING ASSESSME				DATE & TIME OF ARRIVAL				
					History of Allergy				

- Total 28 Forms
- 138 Quality Indicators

Patient Medical Documentation Audit Form

SAMPLE : PATIENT MEDICAL DOCUMENTATION AUDIT

S No	IP & UHID	DOA	DOD	Deptt	Face Sheet	IP Initial Med Assessment (Doc's IA)	ER/IP Initial Nursing Assess-ment	IP Initial Nutrition Assess-ment	Clinical Prog-ress Notes	Clinician Handover Notes	Medic-ation adm Record	Nursing Needs, Care Plan & HO	Vital Monit-oring Chart	IP Nutriti-onal Prog Notes	Gen & Infor-med consent Form	Surgical Form as applicable

Audit Done By :-

Signature

* Deficiencies to be noted

Action Taken:

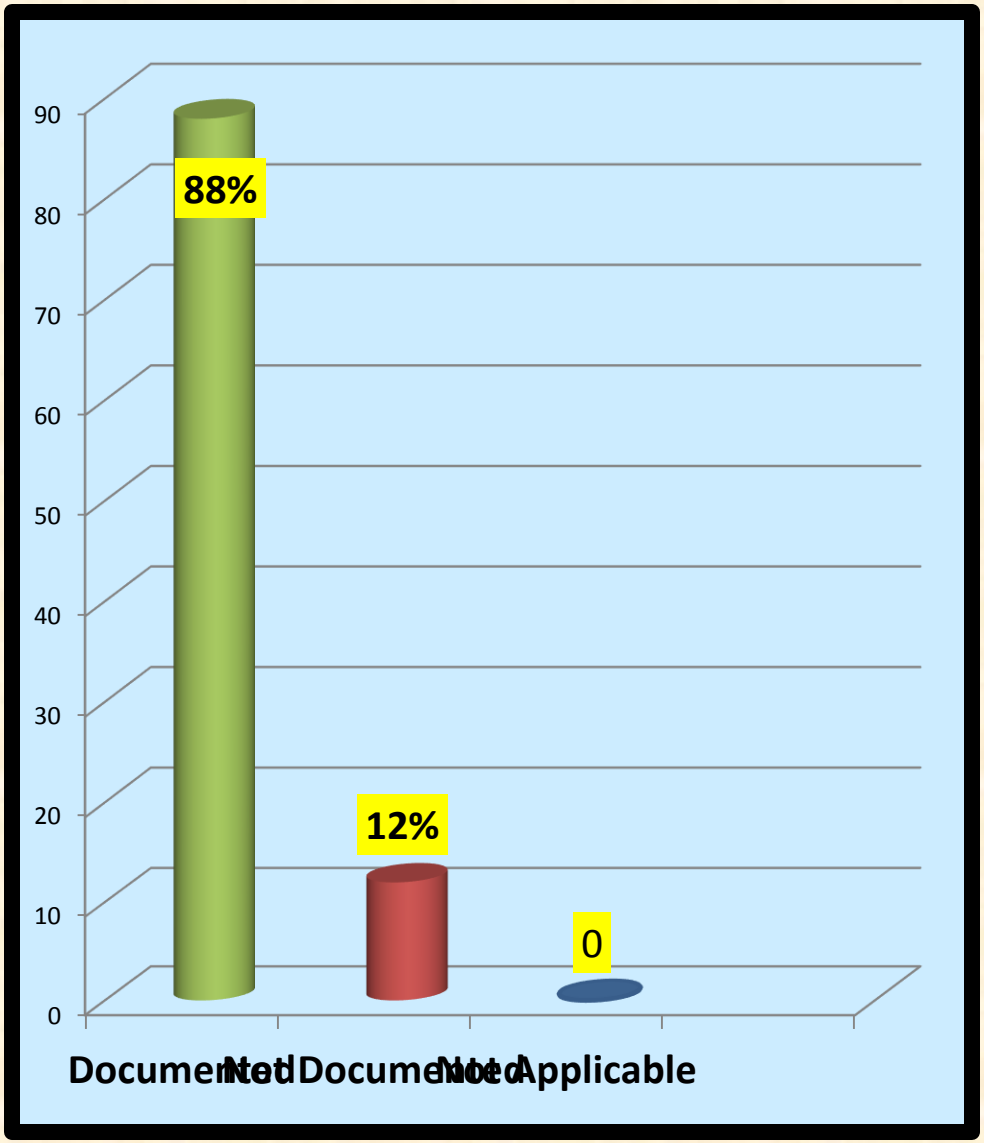
Observations & Analysis

"Fix me, don't harm me, and be nice to me"

Total Medical Record Files Audited

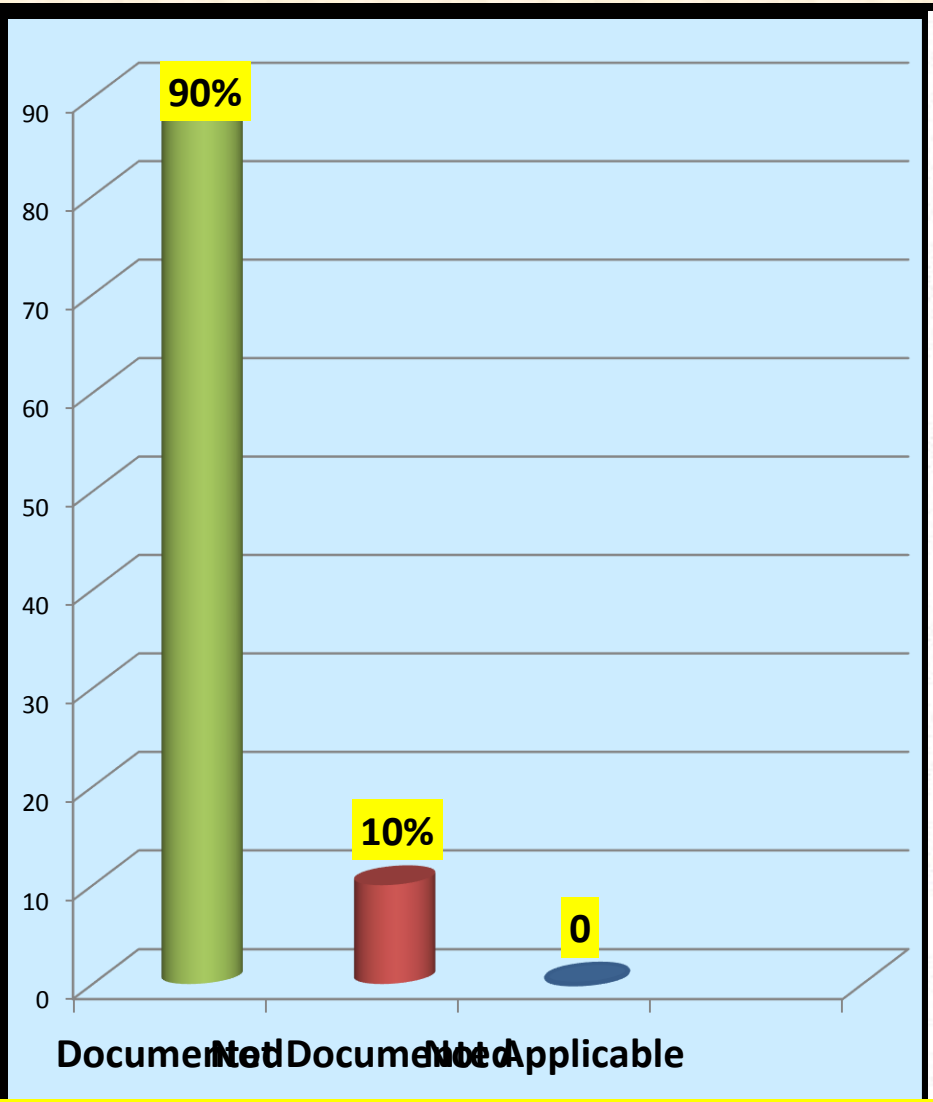
Department	No of Files
Neurology & Spine	19
Ophthalmology	15
Orthopaedics	44
Paediatrics	80
Obstetrics & Gynaecology	71
Nephrology	12
Oncology	03
Pulmonary Medicine	04
Urology	06
ENT	08
General Surgery	96
Cardiology & CTVS	31
Internal Medicine	141
Total	**530**

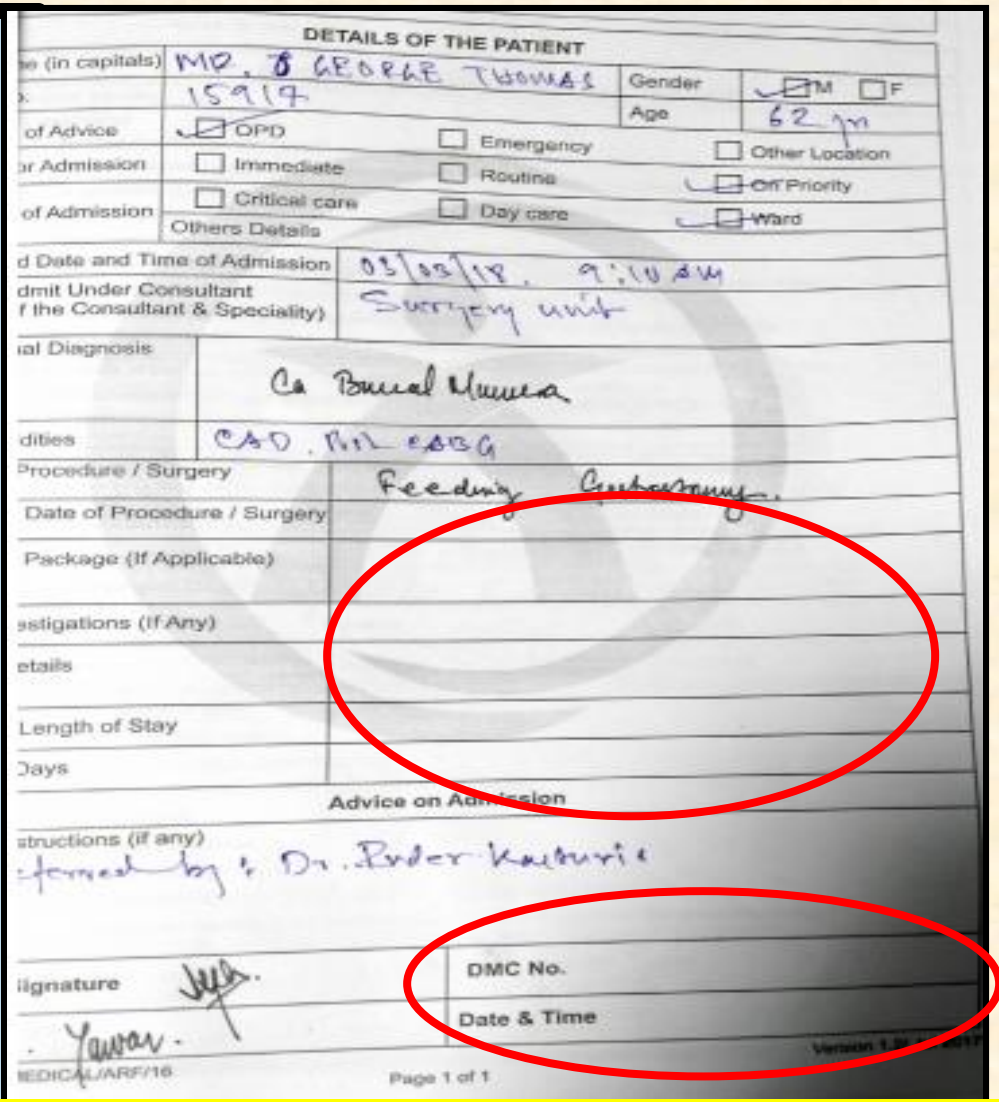
Date and Time of Inspection in Admission Request Form



- Endorsement of DTG by doctor indicates actual time taken for doctors to attend to patient after admission
- Time should not be more than 30 minutes
- 12% of Forms found deficient
- Absence of authentication in Admission Request Form
- Denies subsequent assessment an insight into vital initial thought process

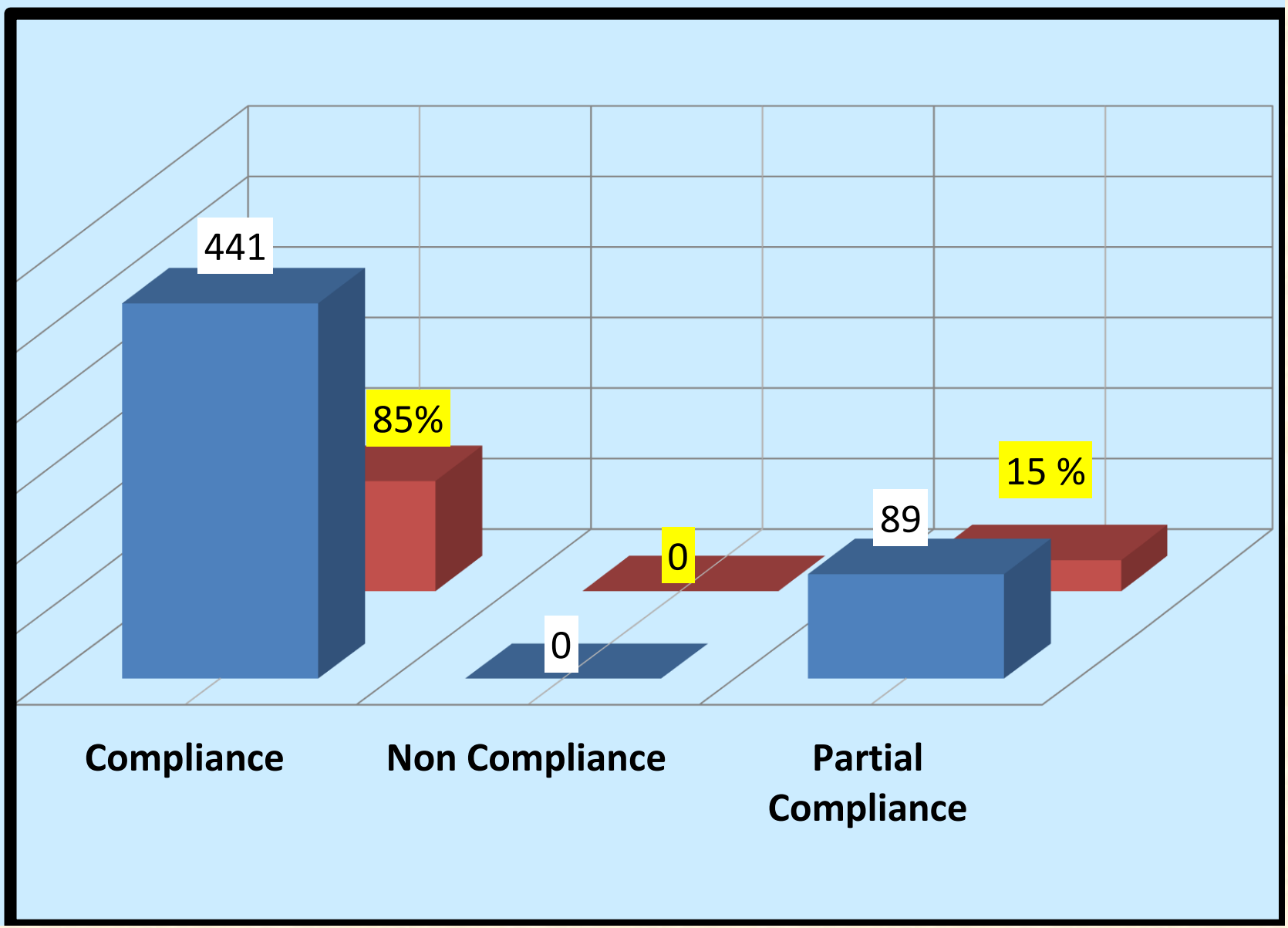
Name & Signature of Physician in Admission Request Form



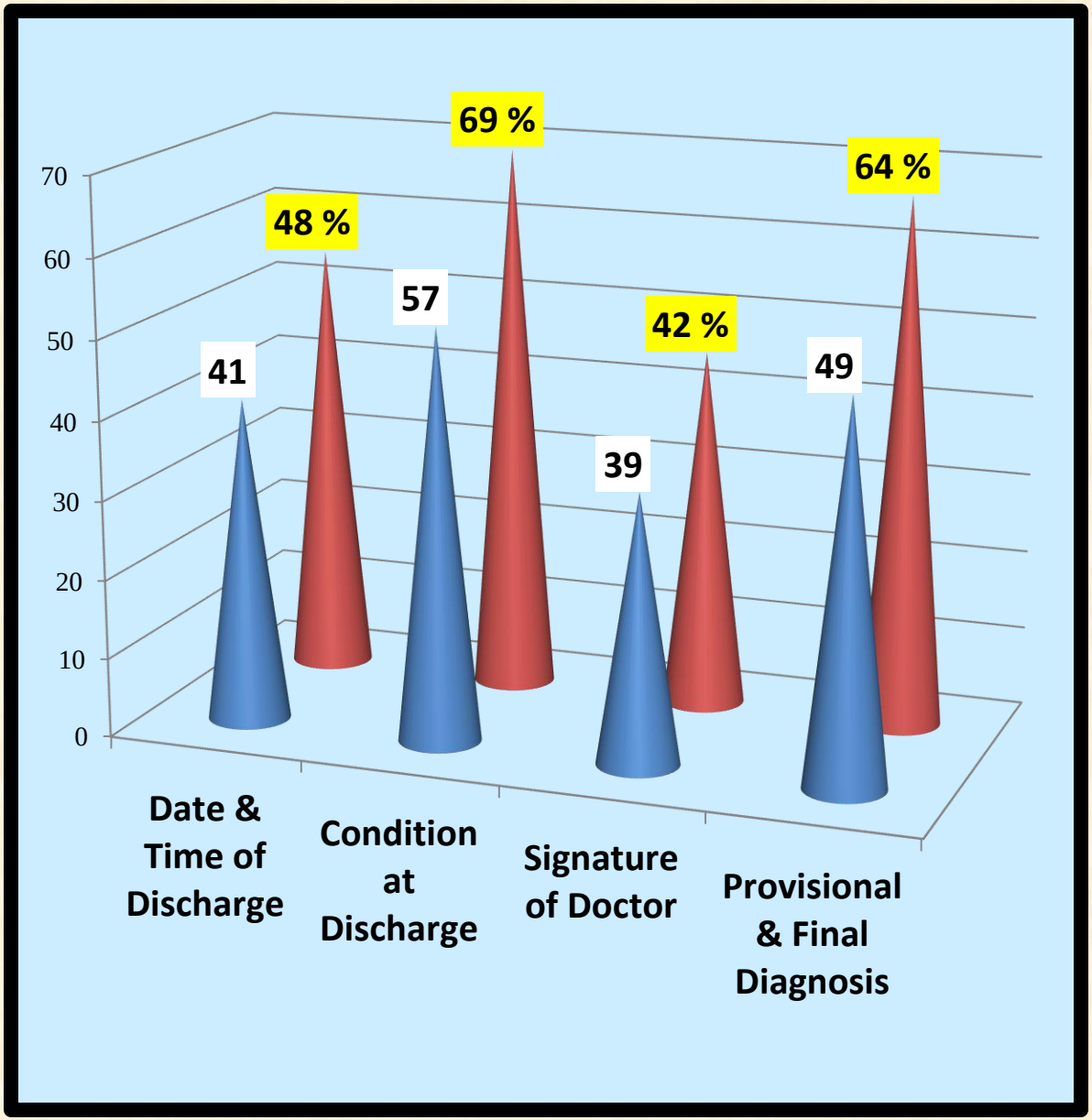


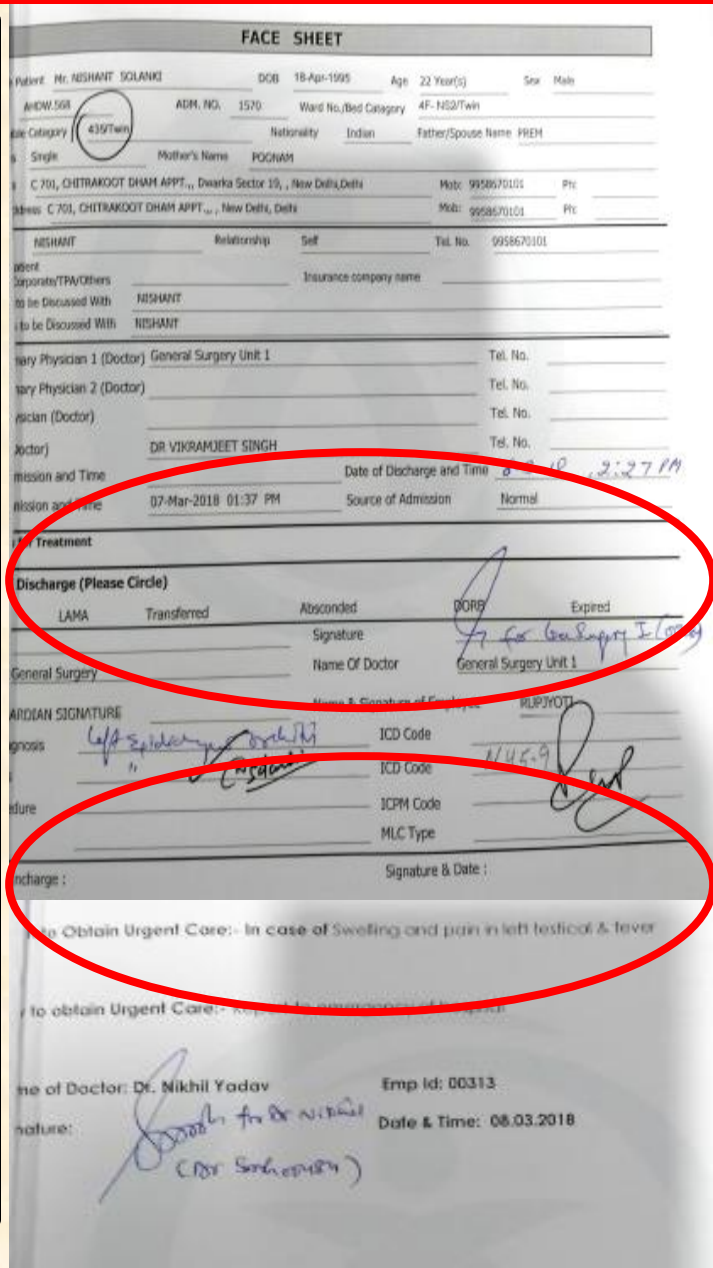
Name & Signature of physician not endorsed in 10% of forms

Face Sheets


441
85%
0
0
89
15 %
Compliance
Non Compliance
Partial Compliance

Partially Compliance Face Sheet




FACE SHEET

Patient Mr. NISHANT SOLANKI DOB 18-Apr-1995 Age 22 Year(s) Sex Male

ADM. NO. 1570 Ward No./Bed Category 4F- NS2/Twin

Nationality Indian Father/Spouse Name PREM

Mother's Name POONAM

C 701, CHITRAKOOT DHAM APPT.,, Dwarka Sector 10, , New Delhi,Delhi Mob: 9958670101

C 701, CHITRAKOOT DHAM APPT.,, , New Delhi, Delhi Mob: 9958670101

NISHANT Relationship Self Tel. No. 9958670101

Insurance company name

NISHANT

NISHANT

Tel. No.

Tel. No.

Tel. No.

Tel. No.

DR VIKRAMJEET SINGH

Date of Discharge and Time

07-Mar-2018 01:37 PM Source of Admission Normal

Discharge (Please Circle)

LAMA Transferred Absconded DORB Expired

Signature

Name Of Doctor General Surgery Unit 1

General Surgery

ICD Code

ICD Code

ICPM Code

MLC Type

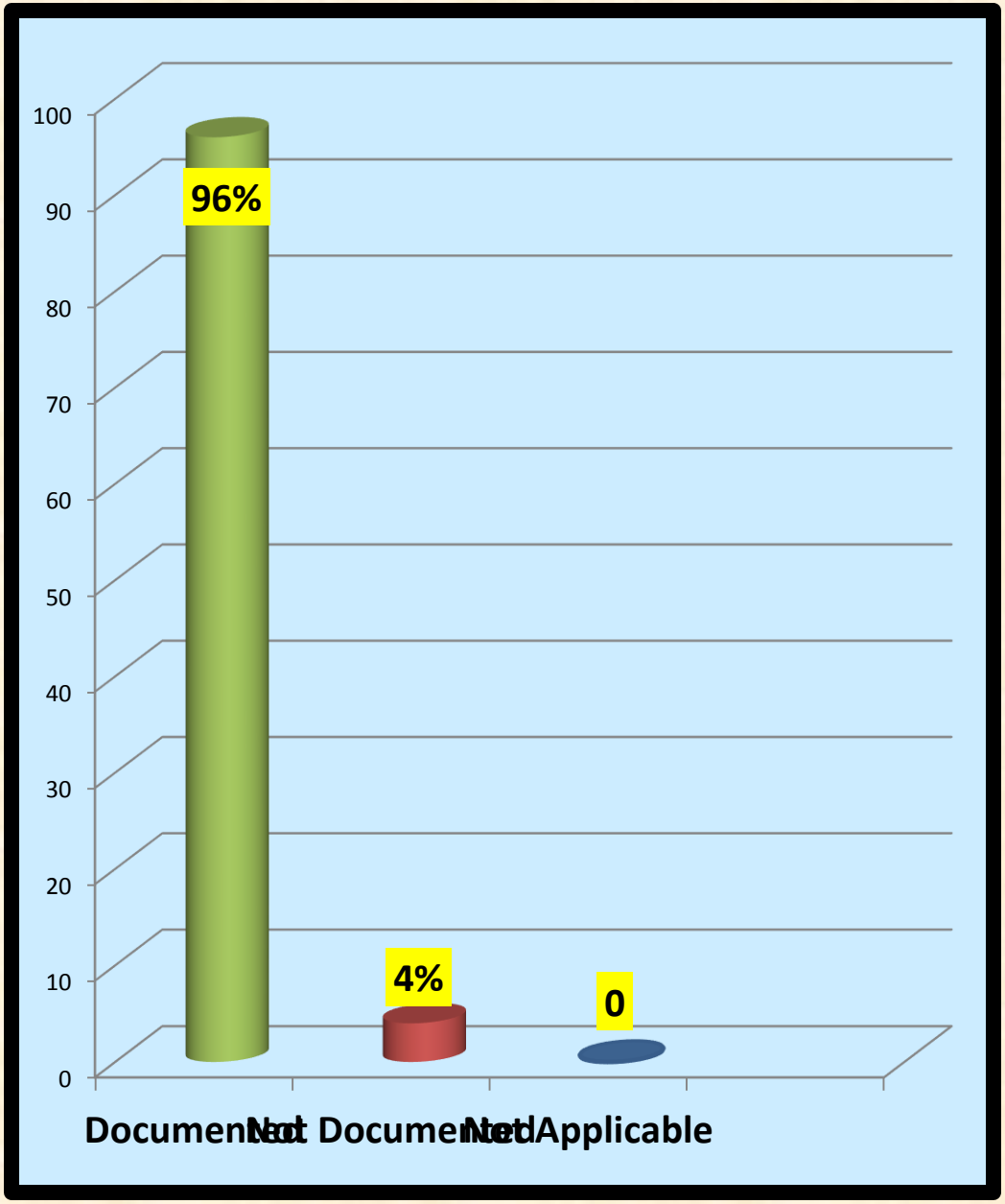
Signature & Date :

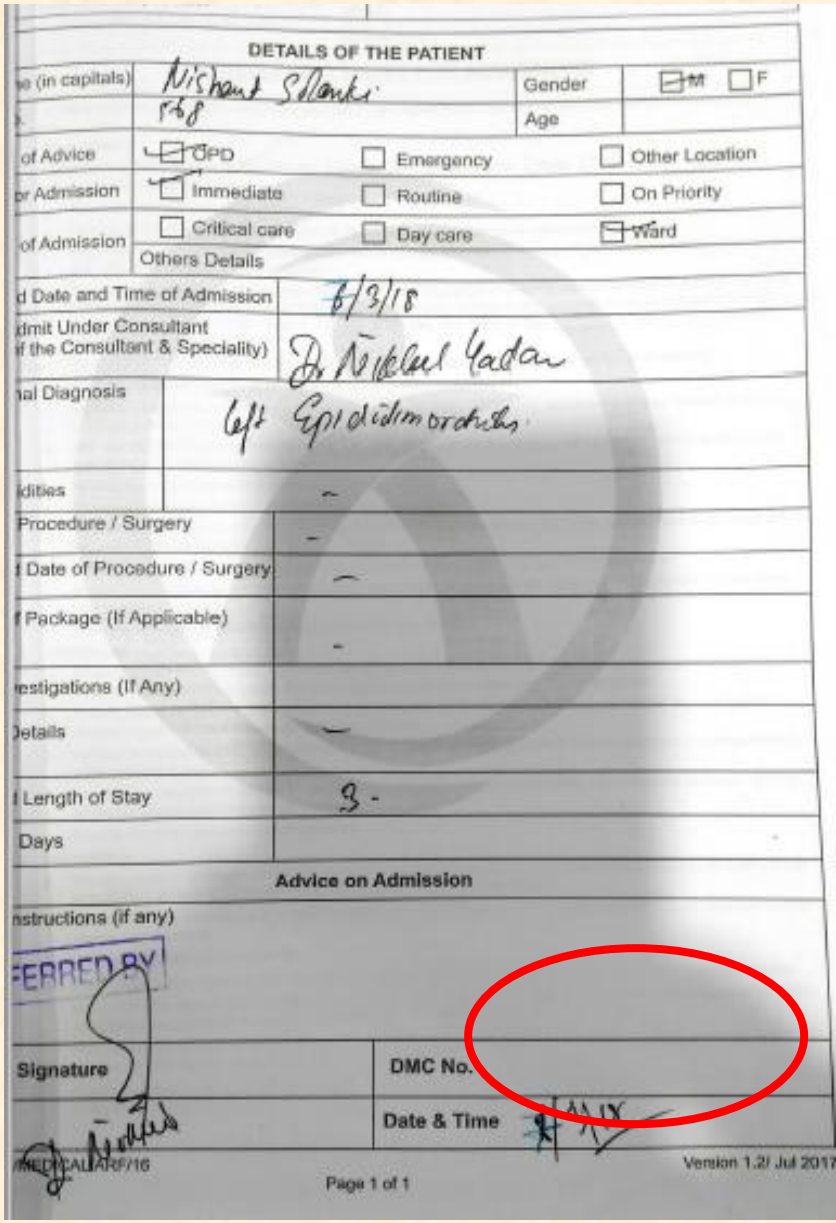
In case of Swelling and pain in left testicel & fever

Dr. Nikhil Yadav Emp Id: 00313

Date & Time: 08.03.2018

IP Initial Assessment (Doc's IA)





DETAILS OF THE PATIENT

e (in capitals)	Nishant Sharma	Gender	☑ M ☐ F
	568	Age	
of Advice	☑ OPD ☐ Emergency	☐ Other Location	
or Admission	☐ Immediate ☐ Routine	☐ On Priority	
of Admission	☐ Critical care ☐ Day care	☑ Ward	
	Others Details		
d Date and Time of Admission	6/3/18		
dmit Under Consultant f the Consultant & Speciality)	Dr. Nikhil Yadav		
al Diagnosis	Left Epididymoorchitis		
idities	-		
Procedure / Surgery	-		
Date of Procedure / Surgery	-		
Package (If Applicable)	-		
estigations (If Any)			
Details	-		
Length of Stay	3 -		
Days			

Advice on Admission

nstructions (if any)

FERRED BY

Signature

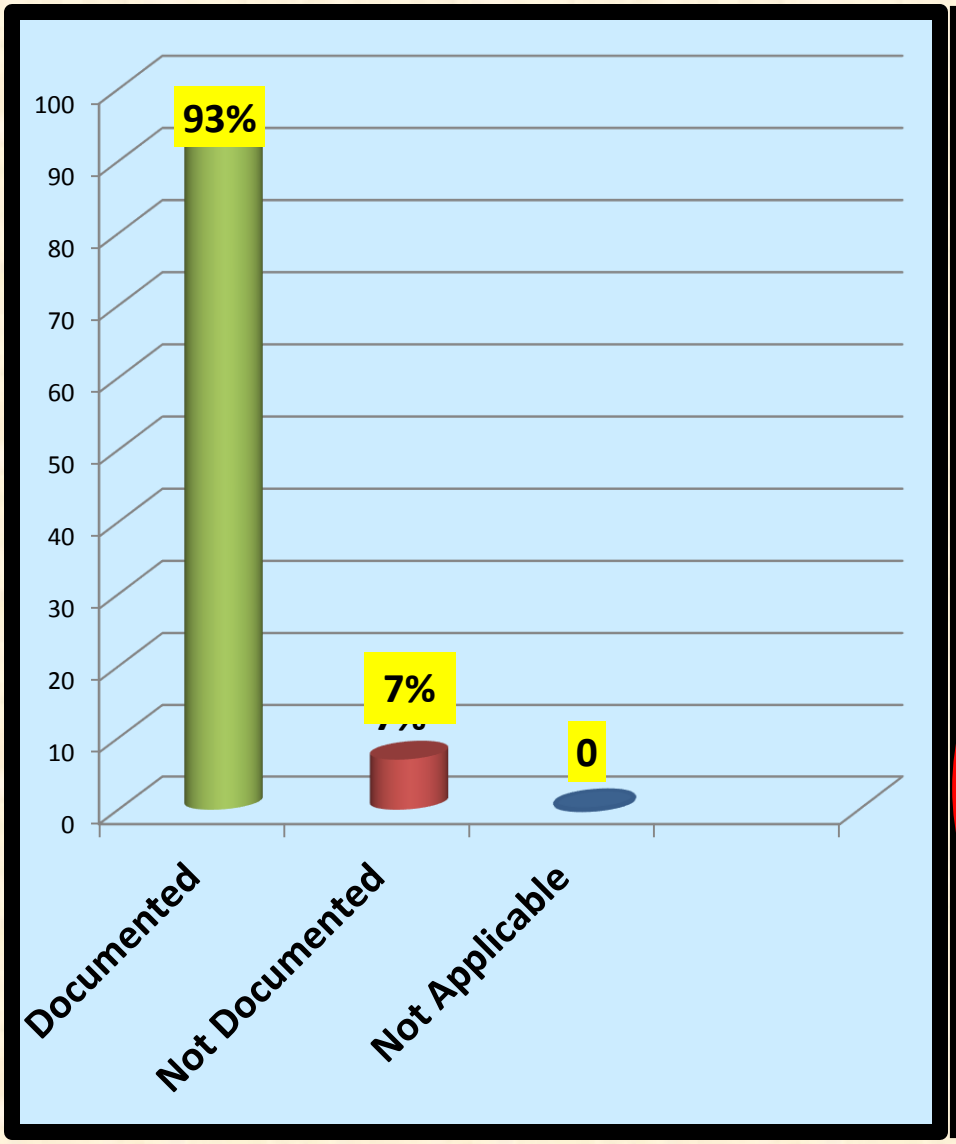
DMC No.

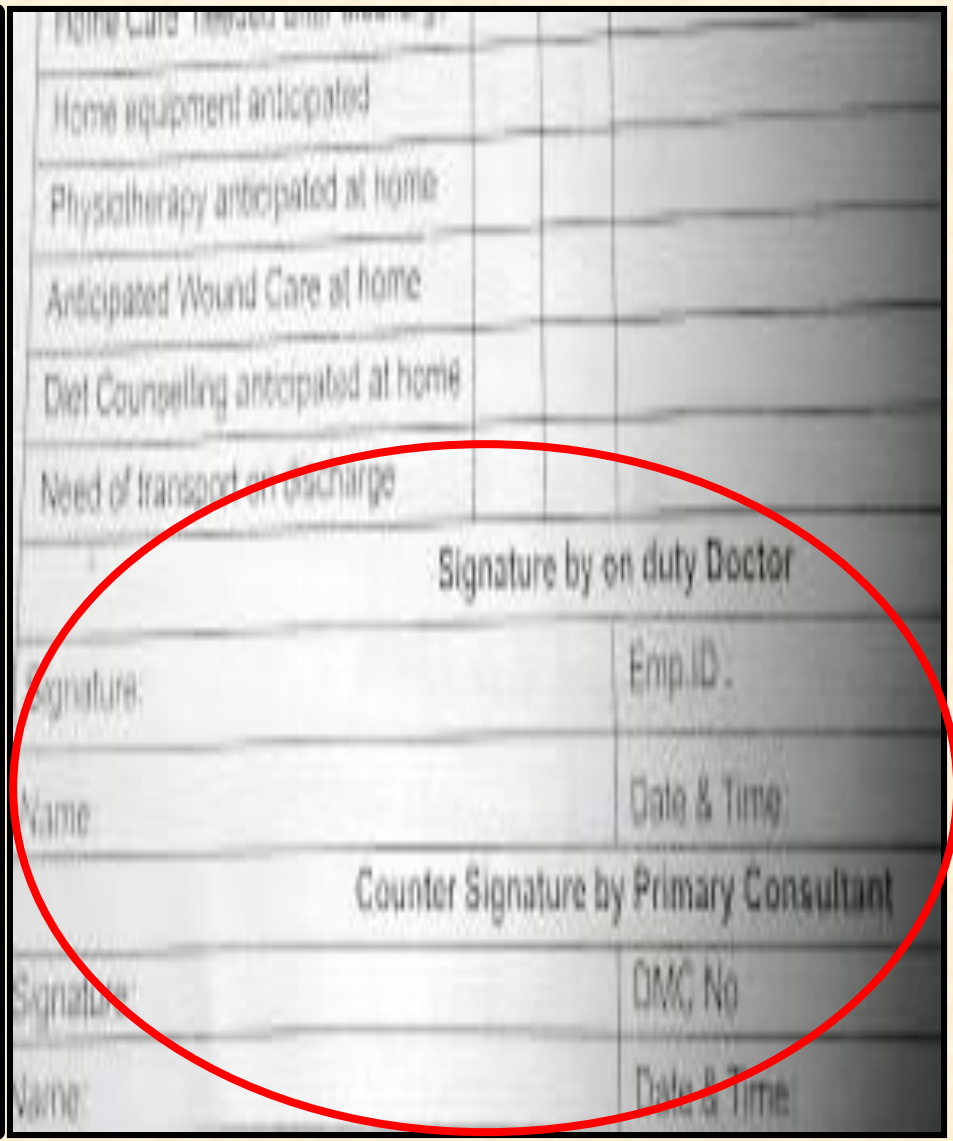
Date & Time

Page 1 of 1

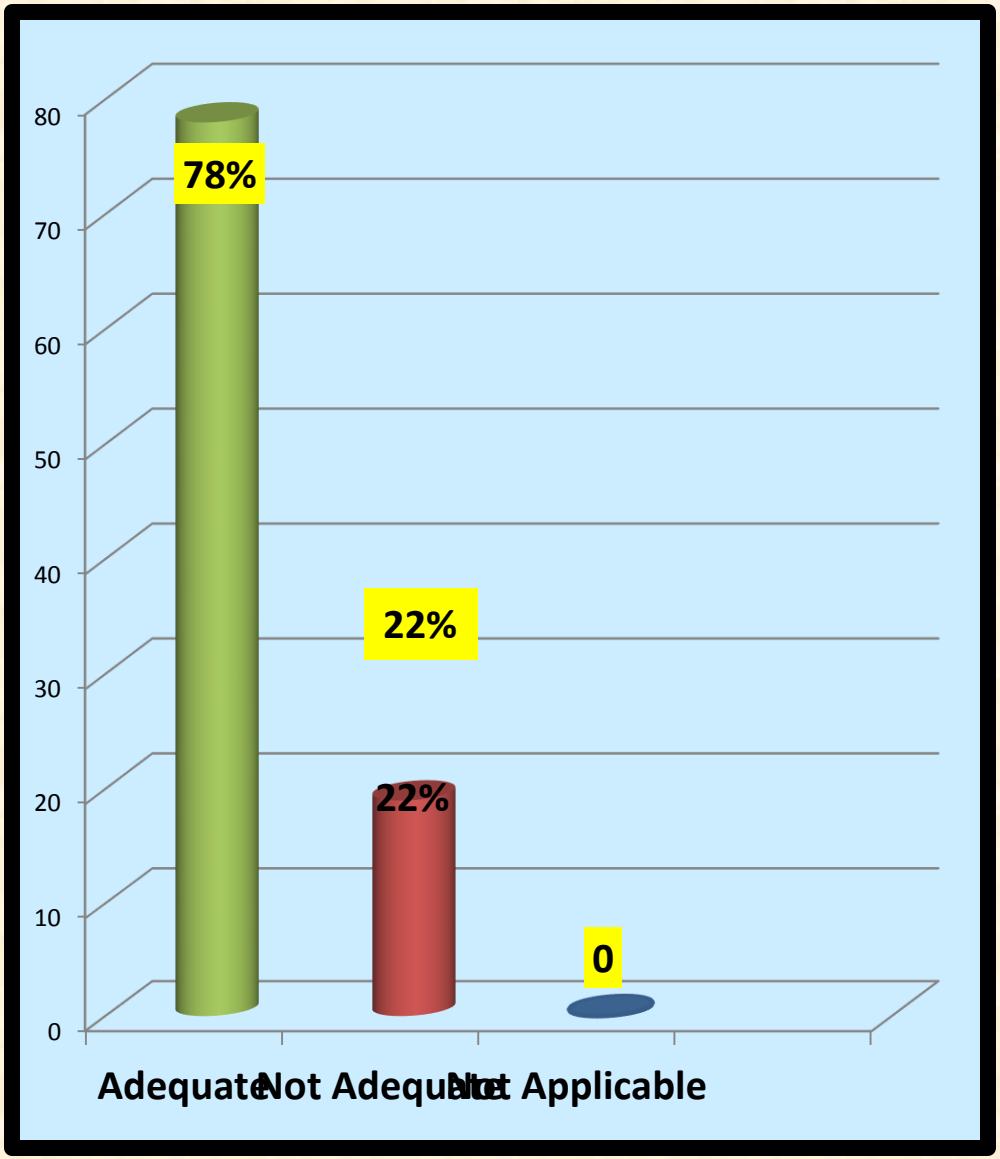
Version 1.2/ Jul 2017

Signature, Date and Time on IP Initial Assessment Form



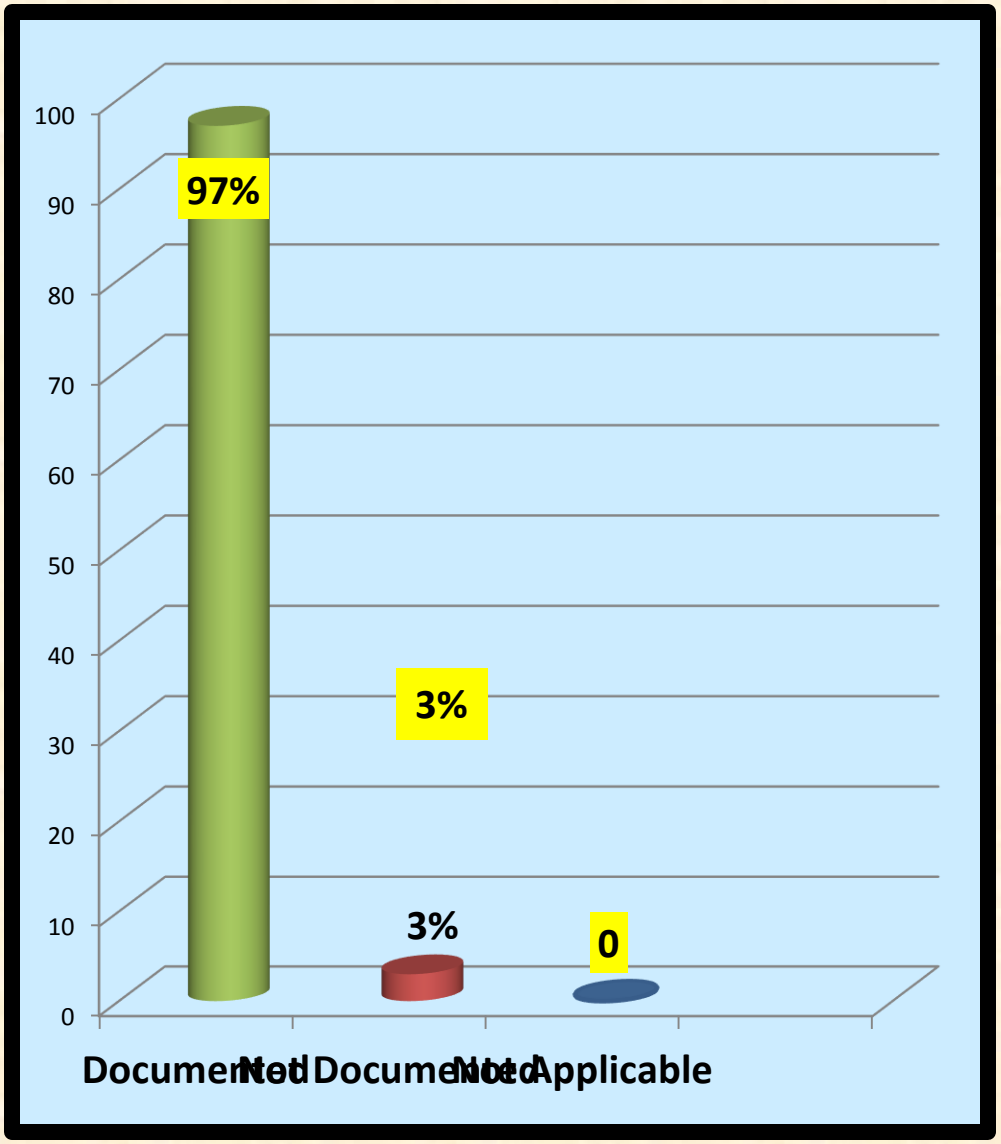


Adequacy of IP Initial Assessment Sheet (Doc's IA)



- Non-use of stamps
- Illegible signatures
- Not mentioning the time and plan of treatment
- Other deficiencies reduced the adequacy of the Doc's IA to 78%
- Fixing accountability for any delay /faulty treatment due to error in initial assessment difficult
- Auditing at documentation stage help in identifying erring doctors

Clinical Progress Notes (Doctors' Care Plan)

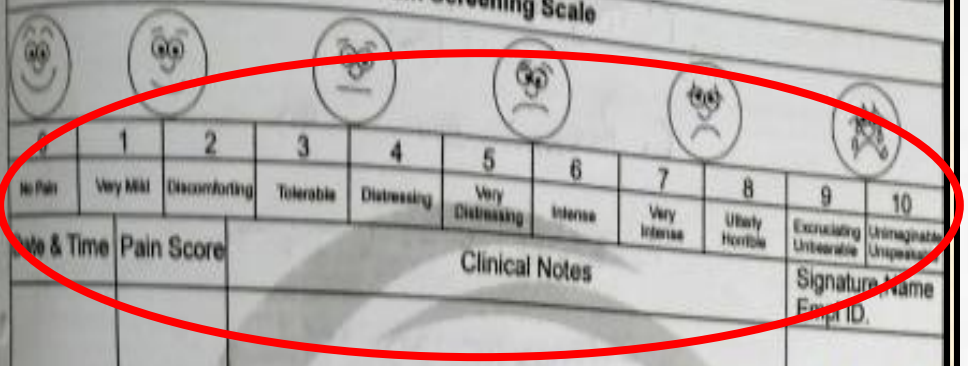


- 17 % of signatures of doctor illegible in Doctors' Note
- Absence of use of stamps by 94 % of the doctor's
- Authentication by Consultant in the Doc's CP inadequate, only 72 %
- Feeling of supremacy amongst senior doctors
- Doc's CP should be identifiable and putting stamp & signature should be the norm
- Maintain legal sanctity of record

Consult

CLINICIAN PROGRESS NOTES

Pain Screening Scale



0 No Pain	1 Very Mild	2 Discomforting	3 Tolerable	4 Distressing	5 Very Distressing	6 Intense	7 Very Intense	8 Utterly Horrible	9 Excruciating Unbearable	10 Unimaginable Unspeakable

Date & Time	Pain Score	Clinical Notes	Signature / Name / Emp ID.
		· Cap. Alprid Gld BD	
		* Cap. Pareda 5m BD	
		Advice Psychiatric opinion	

CLINICIANS' HAND OVER NOTES

Handover Points	Hand Over Notes
Diagnosis	# Proximal phalanx of (L) little finger
Surgery/Procedure done	CRIF & K-wire on 4/3/18 ↓ Local anesth.
Surgery/Procedure planned	–
Investigations due	–
Investigations Report Due	–
Referral Due	–
Consent Due	–
Drug Order	As per Rx chart
Family Counseling	Done.
Probable Date of Discharge	Not yet planned.
Discharge Planning	
Any Critical Concerns	Vitals monitoring.
Any Other Concern	–

Handed over by	Taken over by
Signature	Signature
Name of the Doctor Dr. Arunima	Name of the Doctor
Emp ID / OMC No. 00714/ 72323	Emp ID / OMC No.
Designation RMO	Designation
Date & Time 5/3/18 @ 9 pm	Date & Time

Medications Prescribed

Medications	Dose	Route	Frequency	Period
INJ METRONIDAZOLE 500ml	IV	START		
INJ MONOCEF 1gm	IV	Before Shift 1st		
INJ RANTAC	IV	Before Shift 2nd		
INJ PERINORM	IV			

Referral Advice

Referred to	Anaesthesia	2	3
Reason	PAC		
Purpose (Admission / Continuous care / Opinion /)	Opinion		
Type (Urgent / Routine / Regular)	Routine		

Diet Advice

NPO since last night

Plan of Care

Any Procedure / Surgery Planned	feeding Gastrostomy
Other Plan of Care	As per [illegible]
Goal of Treatment	

Discharge Planning

	No	Yes	Plan
Home Care needed after discharge			
Home equipment anticipated			
Physiotherapy anticipated at home			
Anticipated Wound Care at home			
Diet Counselling anticipated at home			
Need of transport on discharge			

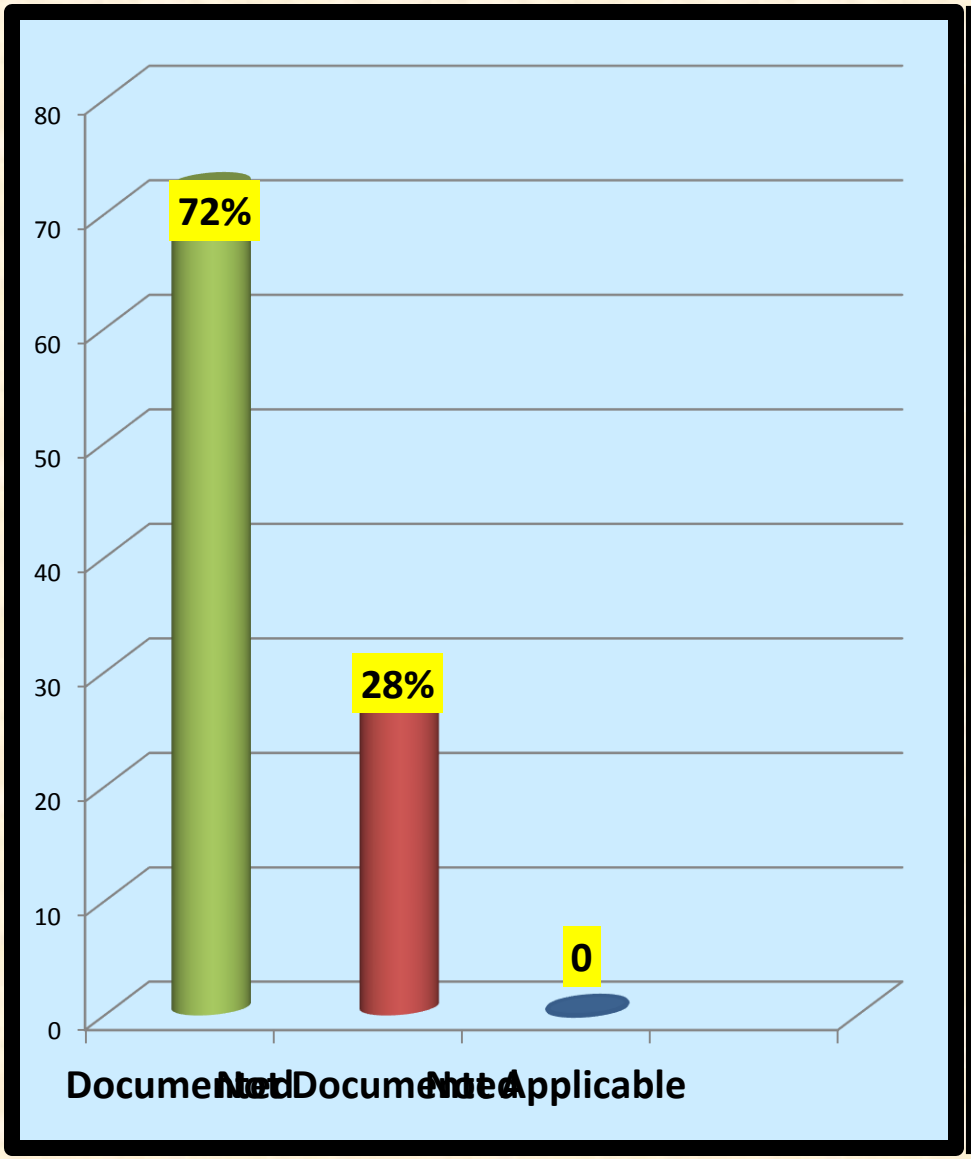
Signature by on duty Doctor

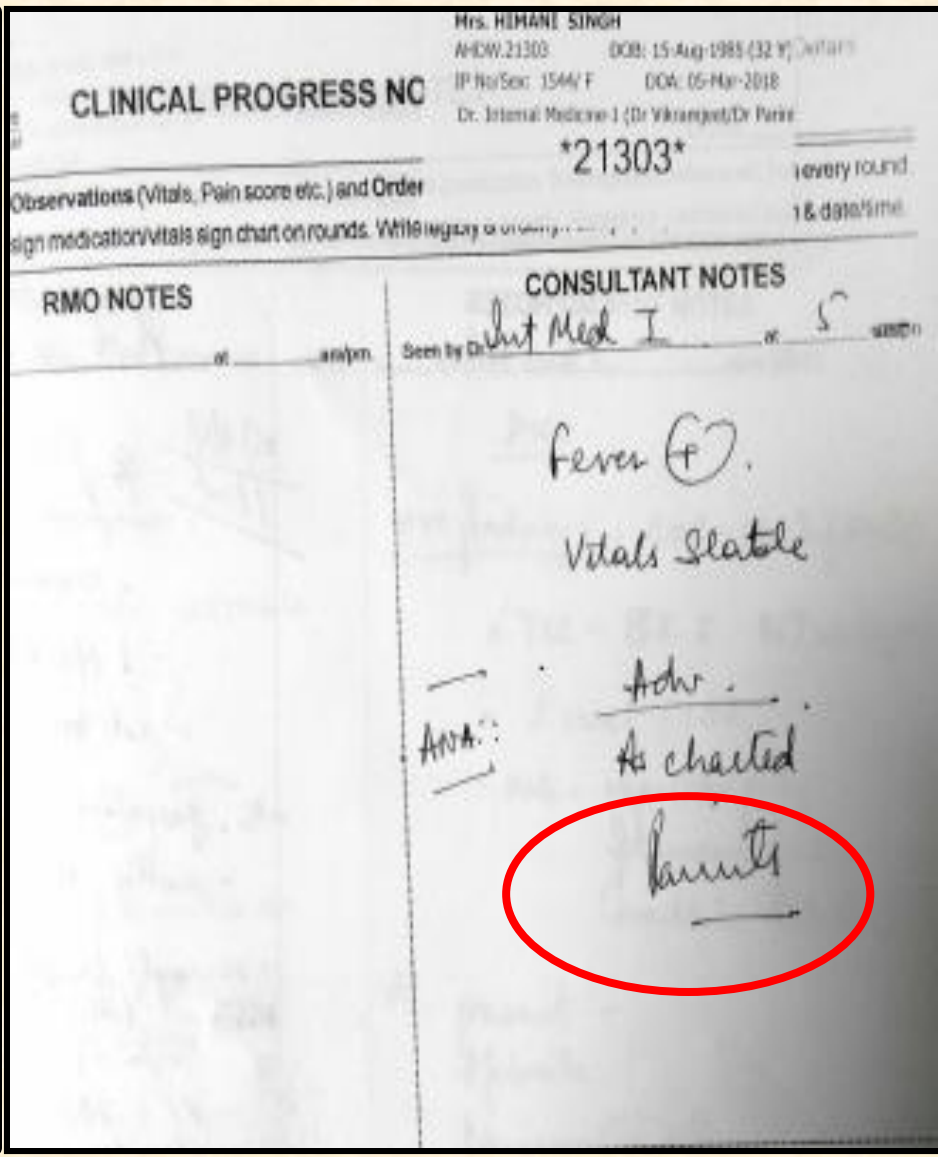
Signature:	Emp.ID :
Name:	Date & Time:

Counter Signature by Primary Consultant

Signature:	DMC No
Name:	Date & Time:

Authentication by Consultant in Doctor's Care Plan





CLINICIANS' HAND OVER NOTES

Handover Points	Hand Over Notes
Diagnosis	USA - CAD - DVD PQJL PTCA to LA (2011) PCART to RCA
Surgery/Procedure done	—
Surgery/Procedure planned	—
Investigations due	—
Investigations Report Due	CBC, RFT
Referral Due	—
Consent Due	~~AS Per Rx chart~~ —
Drug Order	AS Per Rx chart
Family Counseling	Done
Probable Date of Discharge	6/03/18 ± 2-3 days
Discharge Planning	AS Per decided by Consultant
Any Critical Concerns	Vitals monitoring
Any Other Concern	—

Handed over by		Taken over by	
Signature	[signature]	Signature	
Name of the Doctor	DR. Seemans John	Name of the Doctor	
Emp ID / DMC No.	00455/18616	Emp ID / DMC No.	
Designation	RMO	Designation	

Consu

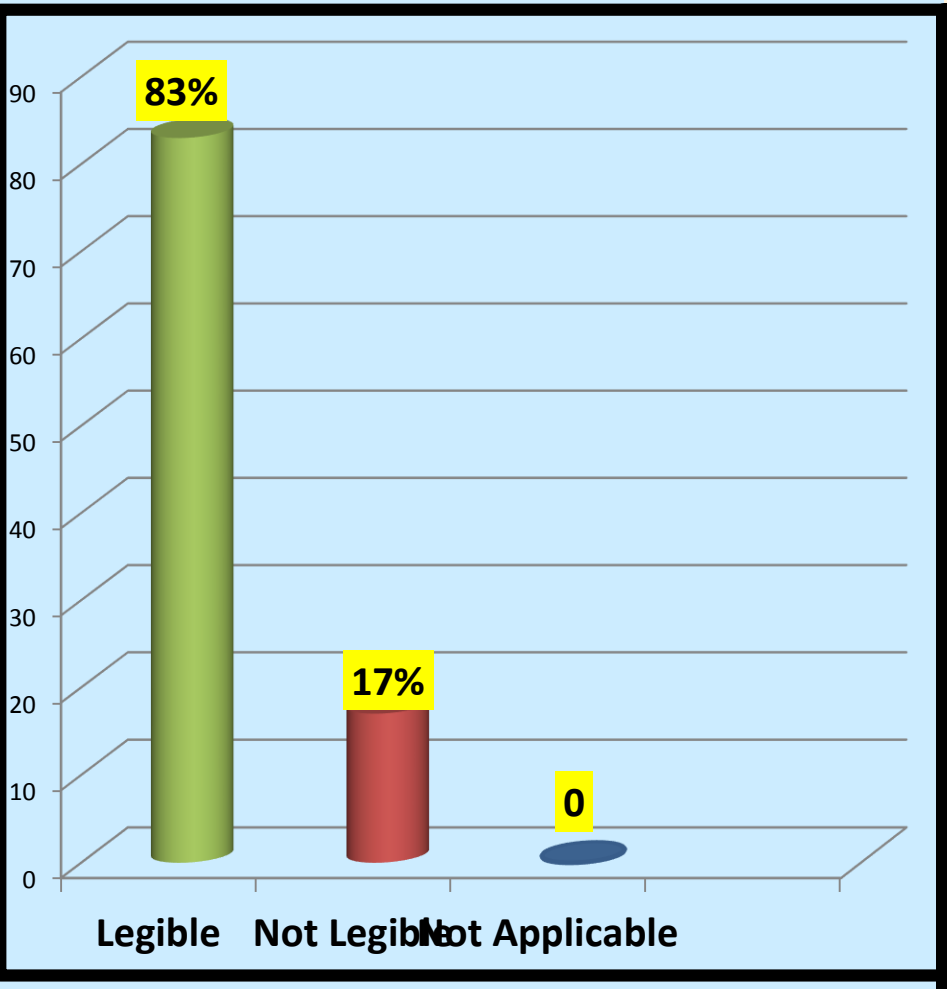
CLINICIAN PROGRESS NOTES

Pain Screening Scale

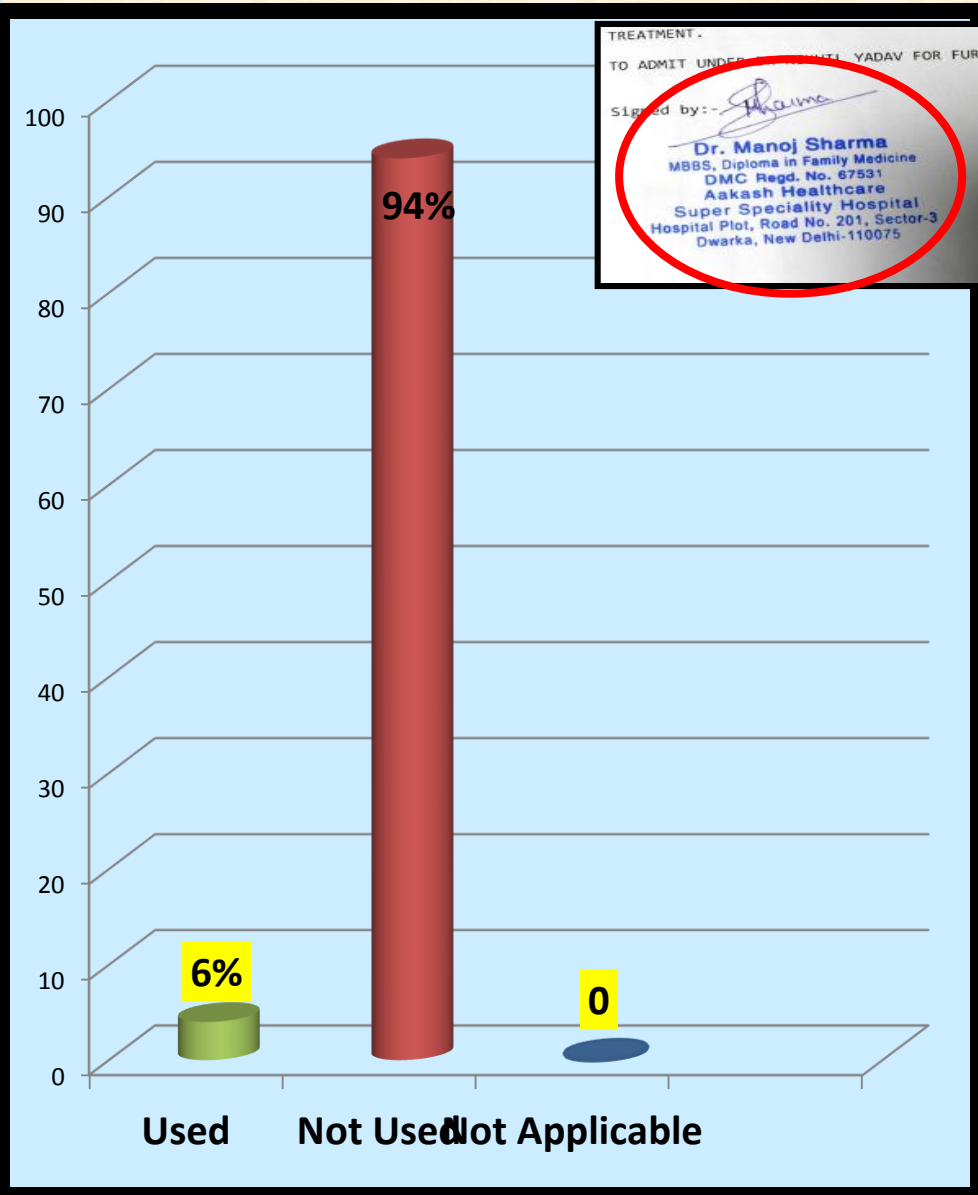
1	2	3	4	5	6	7	8	9	10
Very Mild	Discomforting	Tolerable	Distressing	Very Distressing	Intense	Very Intense	Utterly Horrible	Excruciating Unbearable	Unimaginable

Date & Time	Pain Score	Clinical Notes	Signature, Name Empl ID
7/3/18		C/S by AMA ... Phimosis c̄ balano prosthitis. Adv: Admission and Surgery (Circumcision c̄ debridement ↓ SA) Physician reference. NPO, inj Monocef 1gm iv OD after AS, inj Rantac, inj Gesinoom	

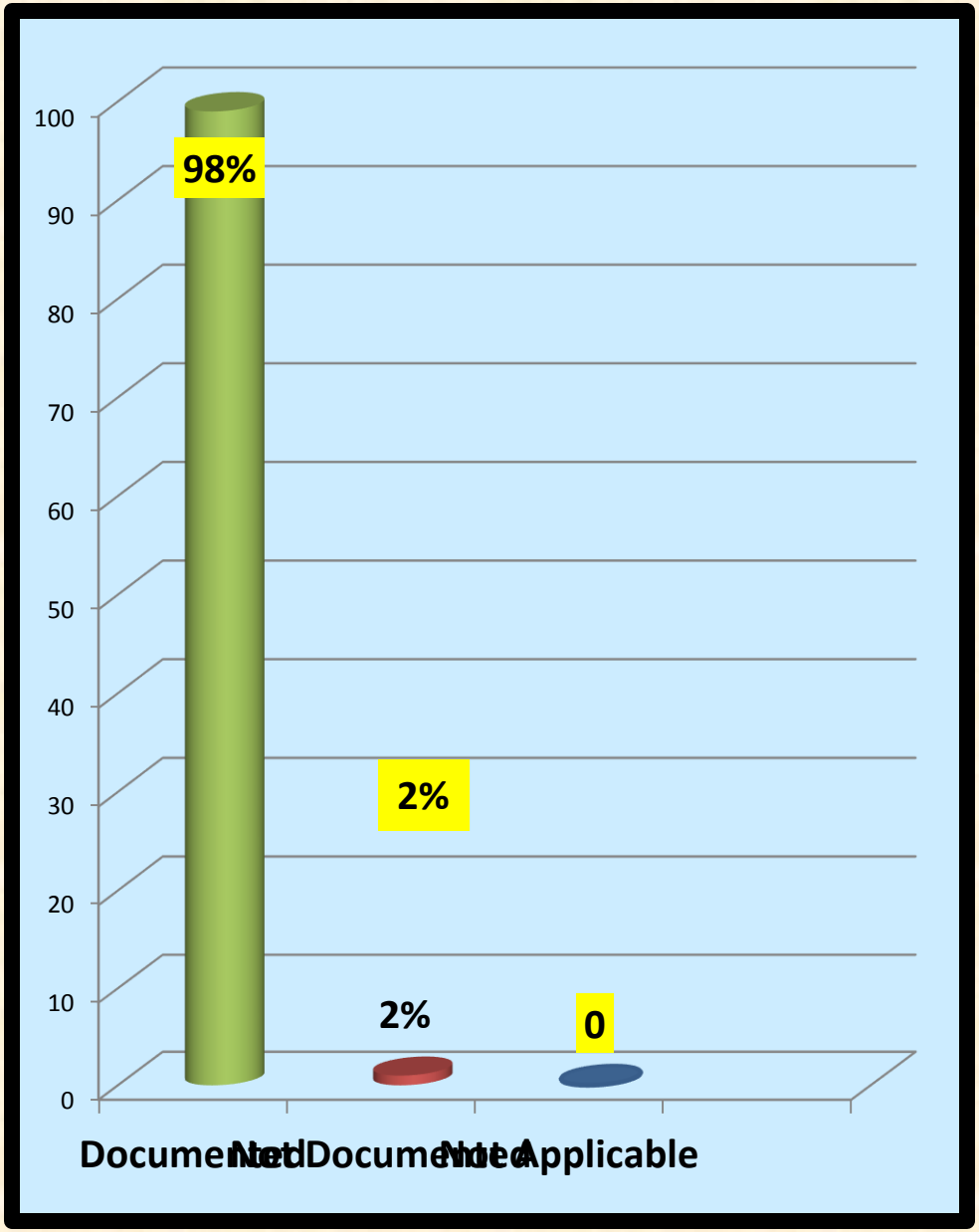
Legibility of Signature of Doctor in Doctors' Note



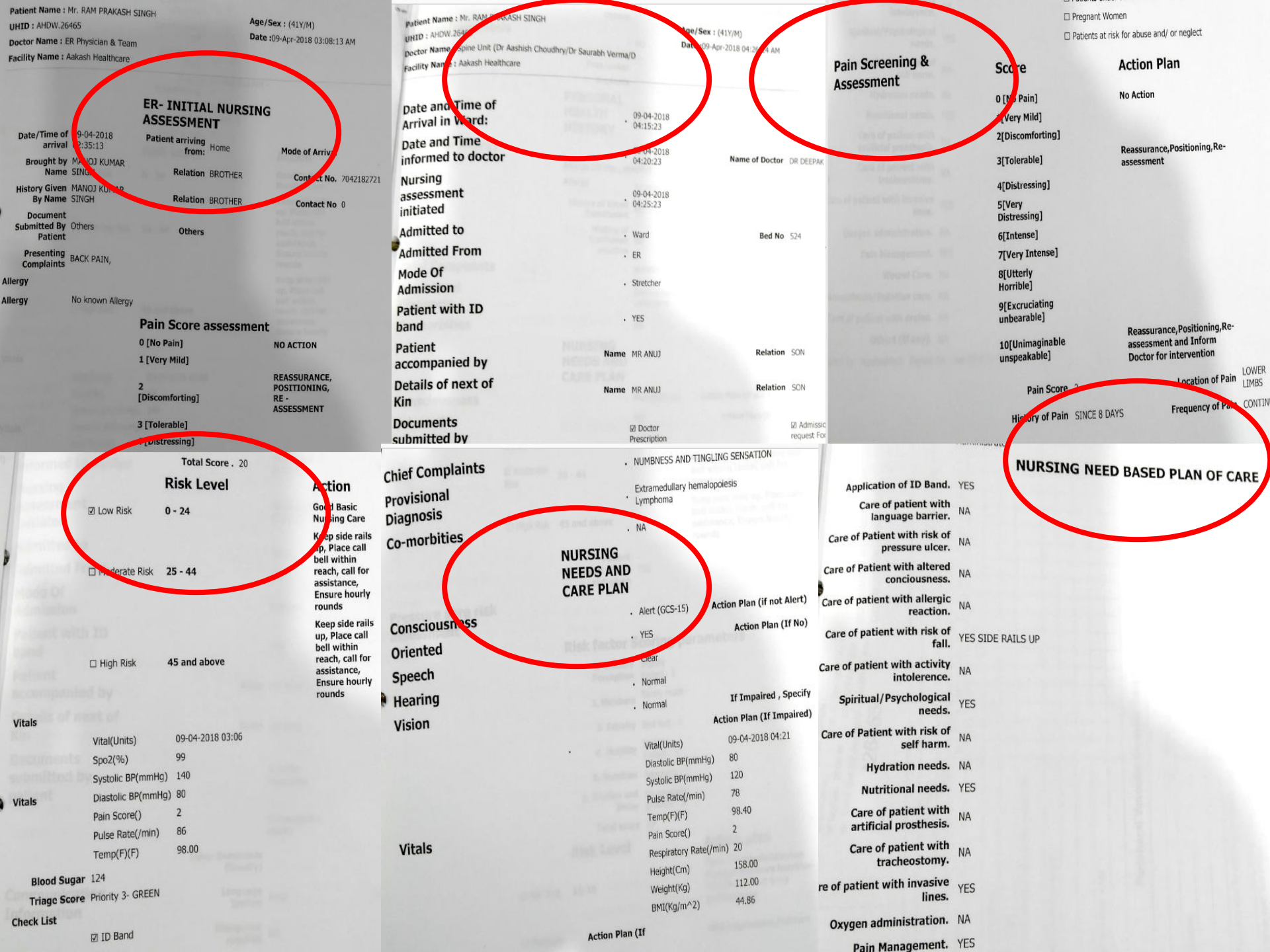
Stamp Used by Doctor's



Nursing Initial Assessment



- Nursing Plan maintained diligently (98%)
- Dichotomy in terms of variation in Pain Rating of 10%
- Pain scores reliable indicators to assess the effect of the treatment
- More time required for documentation due to repetitive entries at cost of patient care
- Simplification of documents required
- Enable Clinicians & nursing staff to devote more time for patient care



Patient Name : Mr. RAM PRAKASH SINGH
UHID : AHDW.26465
Doctor Name : ER Physician & Team
Facility Name : Aakash Healthcare
Age/Sex : (41Y/M)
Date :09-Apr-2018 03:08:13 AM

ER- INITIAL NURSING ASSESSMENT

Date/Time of arrival 9-04-2018 2:35:13
Patient arriving from: Home
Mode of Arriv
Brought by Name MANOJ KUMAR SINGH
Relation BROTHER
Contact No. 7042182721
History Given By Name MANOJ KUMAR SINGH
Relation BROTHER
Contact No 0
Document Submitted By Patient Others
Others
Presenting Complaints BACK PAIN,
Allergy
Allergy No known Allergy

Pain Score assessment

0 [No Pain]	NO ACTION
1 [Very Mild]	
2 [Discomforting]	REASSURANCE, POSITIONING, RE - ASSESSMENT
3 [Tolerable]	
[Distressing]	

Total Score . 20

Risk Level

		Action
☑ Low Risk	0 - 24	Good Basic Nursing Care
☐ Moderate Risk	25 - 44	Keep side rails up, Place call bell within reach, call for assistance, Ensure hourly rounds
☐ High Risk	45 and above	Keep side rails up, Place call bell within reach, call for assistance, Ensure hourly rounds

Vitals

Vital(Units)	09-04-2018 03:06
SpO2(%)	99
Systolic BP(mmHg)	140
Diastolic BP(mmHg)	80
Pain Score()	2
Pulse Rate(/min)	86
Temp(F)(F)	98.00

Vitals
Blood Sugar 124
Triage Score Priority 3- GREEN
Check List
☑ ID Band

Patient Name : Mr. RAM PRAKASH SINGH
UHID : AHDW.26465
Doctor Name : Spine Unit (Dr Aashish Choudhry/Dr Saurabh Verma/D
Facility Name : Aakash Healthcare
Age/Sex : (41Y/M)
Date :09-Apr-2018 04:26:14 AM

Date and Time of Arrival in Ward:	09-04-2018 04:15:23	
Date and Time informed to doctor	09-04-2018 04:20:23	Name of Doctor DR DEEPAK
Nursing assessment initiated	09-04-2018 04:25:23	
Admitted to	Ward	Bed No 524
Admitted From	ER	
Mode Of Admission	Stretcher	
Patient with ID band	YES	
Patient accompanied by	Name MR ANUJ	Relation SON
Details of next of Kin	Name MR ANUJ	Relation SON
Documents submitted by	☑ Doctor Prescription	☑ Admissic request For

Chief Complaints	NUMBNESS AND TINGLING SENSATION
Provisional Diagnosis	Extramedullary hemalopoiesis Lymphoma
Co-morbities	NA

NURSING NEEDS AND CARE PLAN

Consciousness	Alert (GCS-15)	Action Plan (if not Alert)
Oriented	YES	Action Plan (If No)
Speech	Clear	
Hearing	Normal	
Vision	Normal	If Impaired , Specify
		Action Plan (If Impaired)

Vitals

Vital(Units)	09-04-2018 04:21
Diastolic BP(mmHg)	80
Systolic BP(mmHg)	120
Pulse Rate(/min)	78
Temp(F)(F)	98.40
Pain Score()	2
Respiratory Rate(/min)	20
Height(Cm)	158.00
Weight(Kg)	112.00
BMI(Kg/m^2)	44.86

Action Plan (If

Pain Screening & Assessment

Score	Action Plan
0 [No Pain]	No Action
1[Very Mild]	
2[Discomforting]	Reassurance,Positioning,Re-assessment
3[Tolerable]	
4[Distressing]	
5[Very Distressing]	
6[Intense]	
7[Very Intense]	
8[Utterly Horrible]	
9[Excruciating unbearable]	
10[Unimaginable unspeakable]	Reassurance,Positioning,Re-assessment and Inform Doctor for intervention

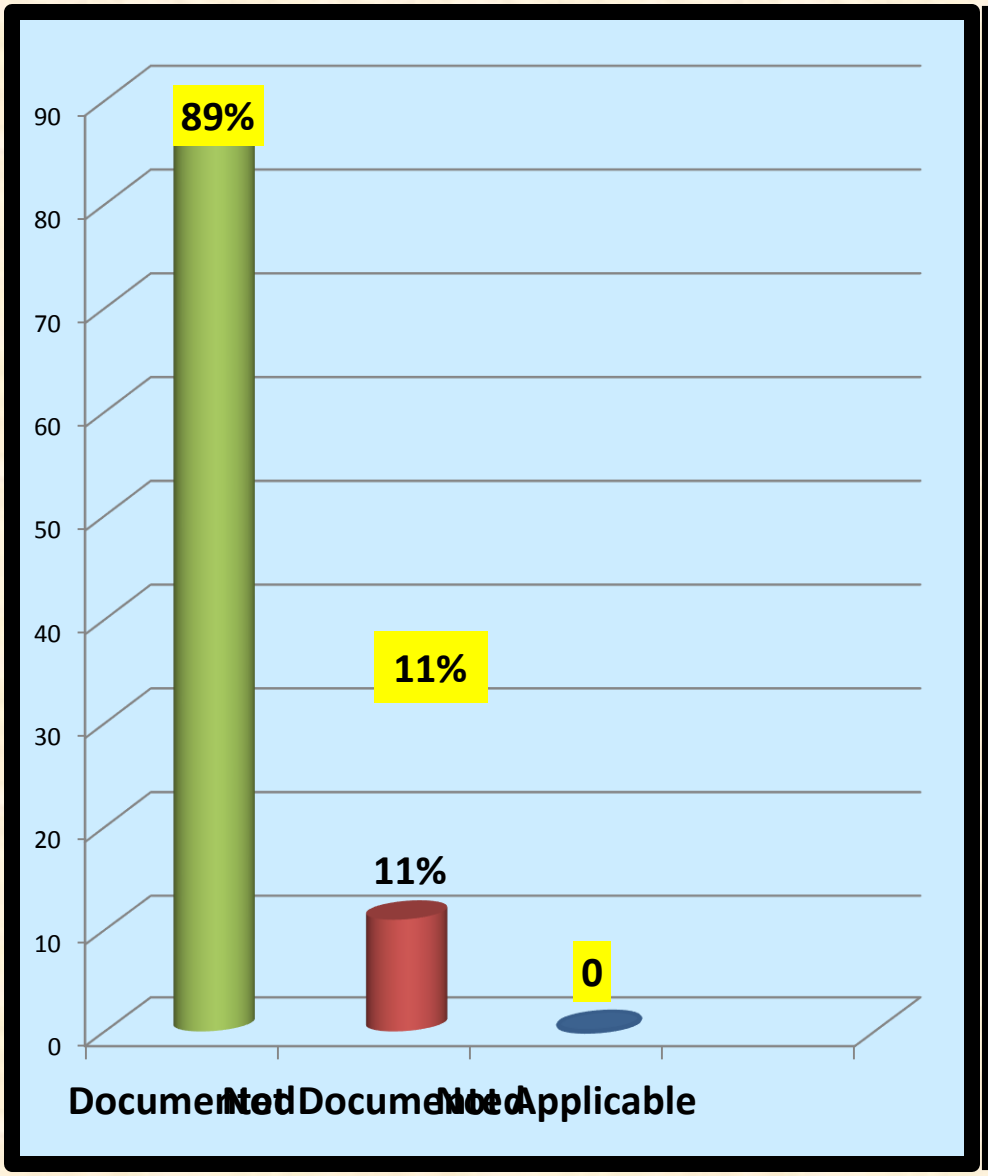
Pain Score 2
Location of Pain LOWER LIMBS
History of Pain SINCE 8 DAYS
Frequency of Pain CONTIN

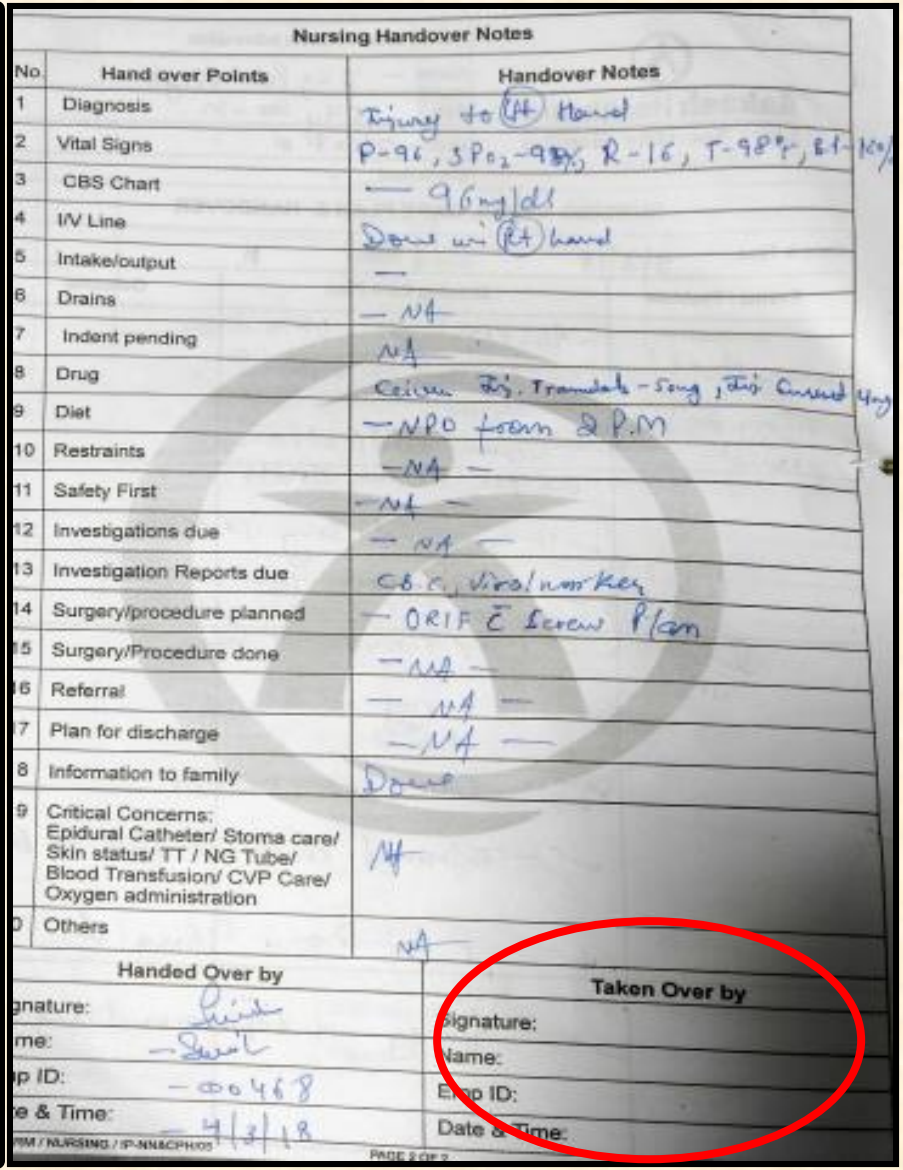
☐ Pregnant Women
☐ Patients at risk for abuse and/ or neglect

NURSING NEED BASED PLAN OF CARE

Application of ID Band.	YES
Care of patient with language barrier.	NA
Care of Patient with risk of pressure ulcer.	NA
Care of Patient with altered conciousness.	NA
Care of patient with allergic reaction.	NA
Care of patient with risk of fall.	YES SIDE RAILS UP
Care of patient with activity intolerence.	NA
Spiritual/Psychological needs.	YES
Care of Patient with risk of self harm.	NA
Hydration needs.	NA
Nutritional needs.	YES
Care of patient with artificial prosthesis.	NA
Care of patient with tracheostomy.	NA
re of patient with invasive lines.	YES
Oxygen administration.	NA
Pain Management.	YES

Daily Nursing Needs, Care & Hand over Plan





Nursing Handover Notes

No.	Hand over Points	Handover Notes
1	Diagnosis	Injury to (Rt) Hand
2	Vital Signs	P-96, SPO2-98%, R-16, T-98°F, BP-100/
3	CBS Chart	— 96mg/dl
4	I/V Line	Done in (Rt) hand
5	Intake/output	—
6	Drains	— NA
7	Indent pending	NA
8	Drug	Celcus Inj. Tramadol - 50mg, Inj Ceftriaxone 1gm
9	Diet	— NPO from 2 P.M
10	Restraints	— NA —
11	Safety First	— NA —
12	Investigations due	— NA —
13	Investigation Reports due	CBC, Viral marker
14	Surgery/procedure planned	— ORIF C Screw Plan
15	Surgery/Procedure done	— NA —
16	Referral	— NA —
17	Plan for discharge	— NA —
18	Information to family	Done
19	Critical Concerns: Epidural Catheter/ Stoma care/ Skin status/ TT / NG Tube/ Blood Transfusion/ CVP Care/ Oxygen administration	NA
20	Others	NA

Handed Over by	Taken Over by
Signature:	Signature:
Name:	Name:
Emp ID: 0468	Emp ID:
Date & Time: 4/3/18	Date & Time:

Nursing Handover Notes

S.No	Hand over Points	Handover Notes
1	Diagnosis	NCS
2	Vital Signs	B.P 160/120 Pulse: Temp: SPO2: 96%
3	CBS Chart	-
4	I/V Line	Yes, Shifted to RR
5	Intake/output	—
6	Drains	—
7	Indent pending	—
8	Drug	Shot medicines given in RR
9	Diet	-
10	Restraints	—
11	Safety First	Yes
12	Investigations due	
13	Investigation Reports due	CBC, LFT, KFT, PT/INR, Viral markers.
14	Surgery/procedure planned	-
15	Surgery/Procedure done	-
16	Referral	-
17	Plan for discharge	—
18	Information to family	Yes
19	Critical Concerns: Epidural Catheter/ Stoma care/ Skin status/ TT / NG Tube/ Blood Transfusion/ CVP Care/ Oxygen administration	
20	Others	

Handed Over by	Taken Over by
Signature: Nurse	Signature:
Name: Nurse	Name:
Emp ID: 529	Emp ID:
Date & Time: 1/3/21 9:40p	Date & Time:

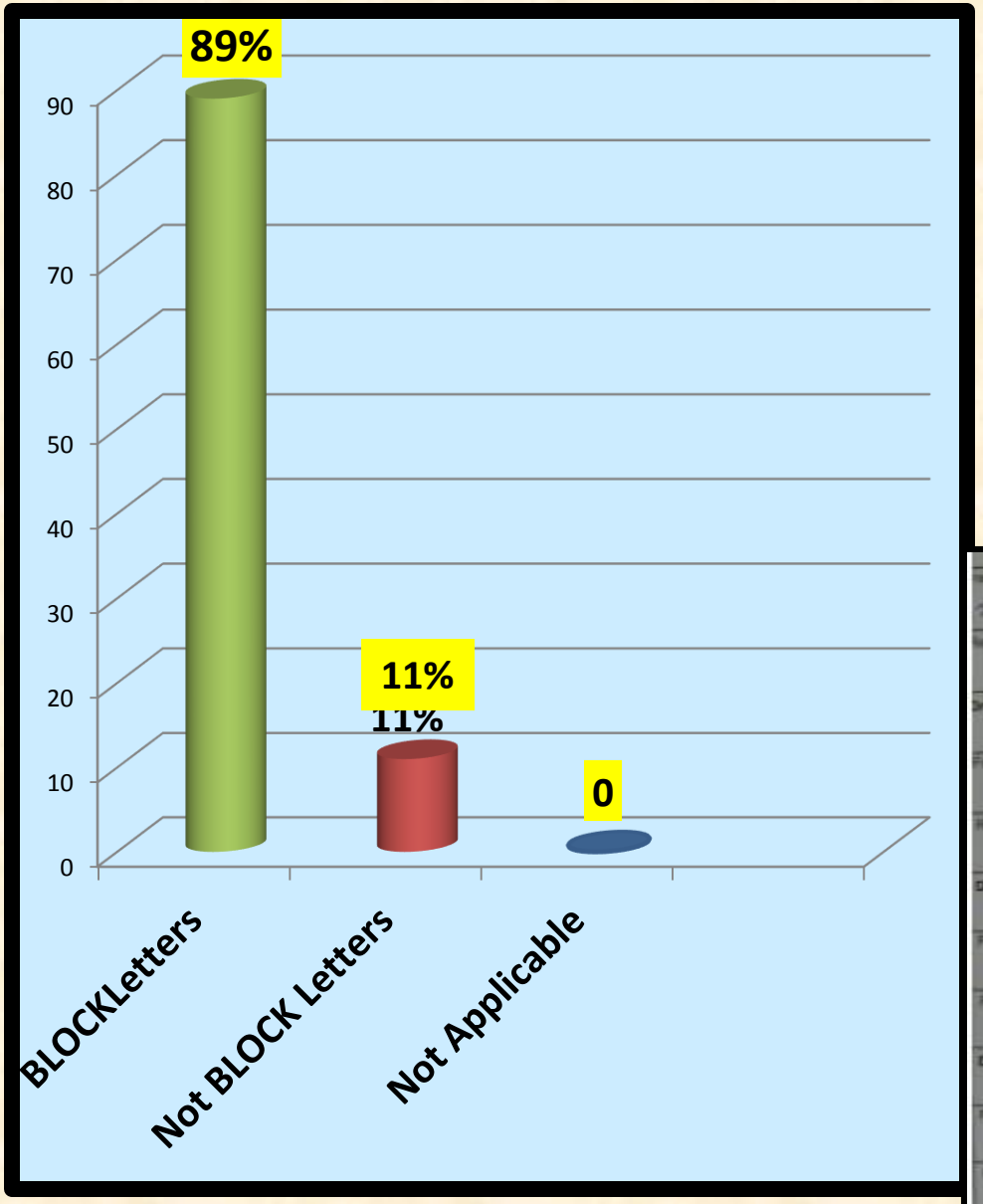
PAGE 2 OF 2

Special Instructions (Planning for procedure/ Surgery / Special investigations /Transfer / Discharge etc)

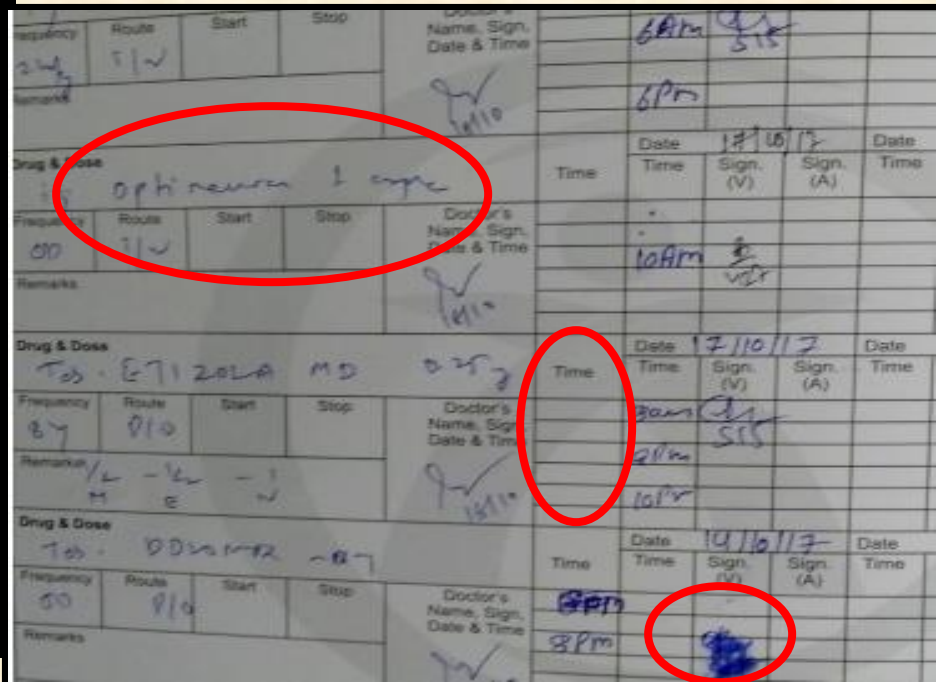
Nursing Handover Report (Morning)	Nursing Handover Report (Evening)	Nursing Handover Report (Night)
Vitals-	Vitals-	Vitals-
Investigations/Procedures/References/NCP-Done/Pending	Investigations/Procedures/References/NCP-Done/Pending	Investigations/Procedures/References/NCP-Done/Pending
Sign with Emp ID	Sign with Emp ID	Sign with Emp ID

Fever (+).
Vitals Stable
Adv.
As charted
Parents

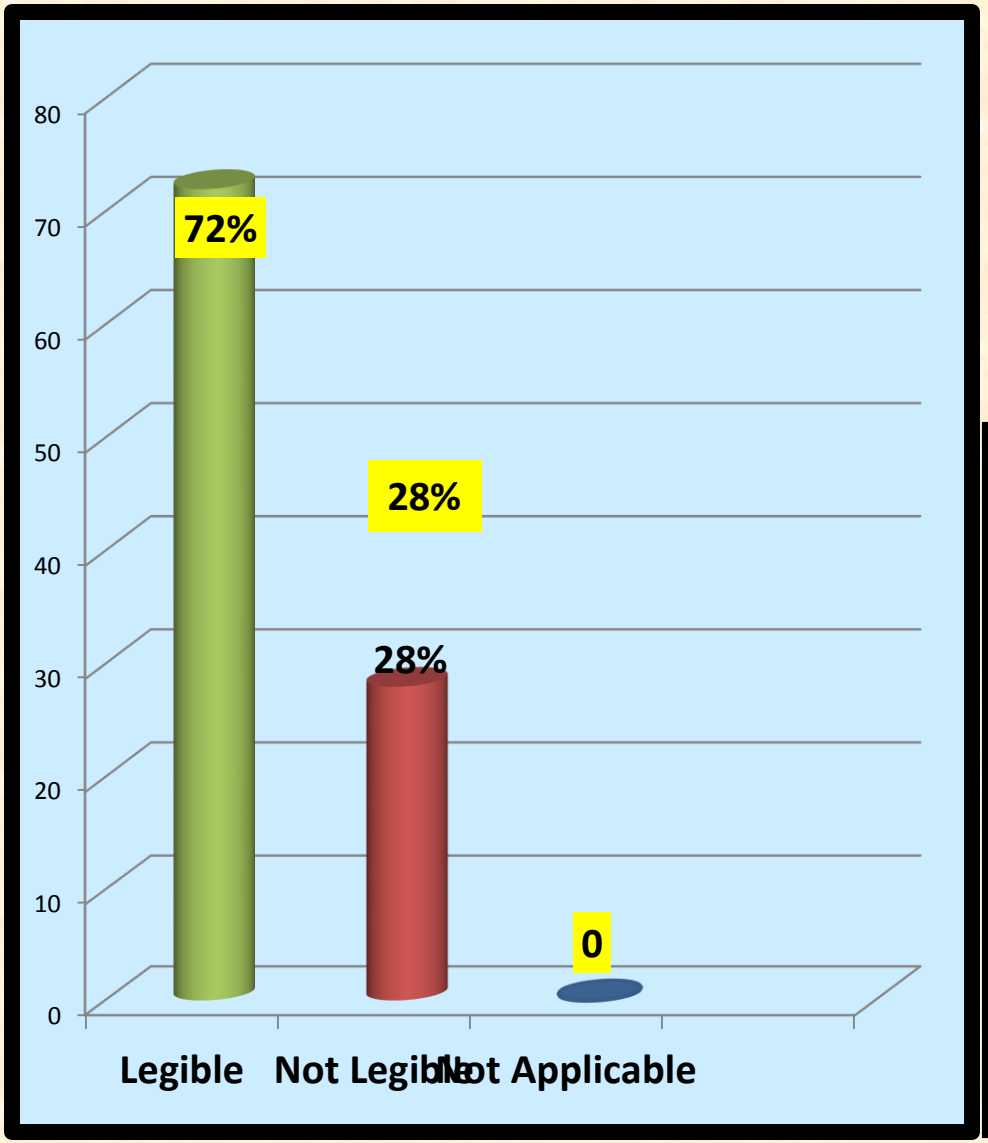
Medications not in BLOCK LETTERS



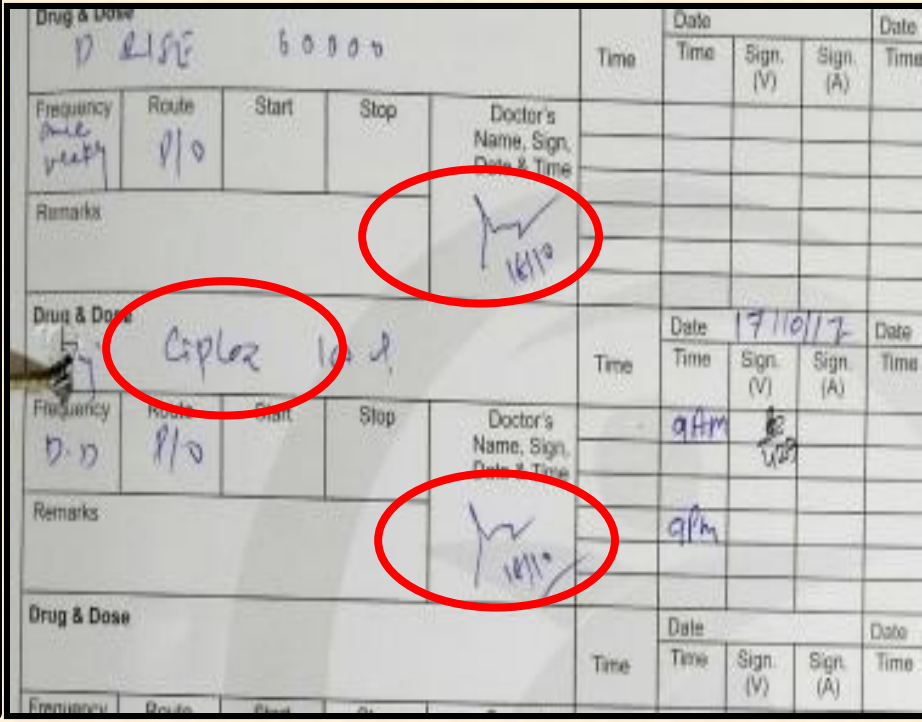
- Adverse drug events are direct consequence of not being able to ensure five Rights
- *Drug, Route, Time, Dose and Patient*
- Standards for these parameters have to be 100% always and every time
- BLOCK LETTERS not compliant in 11 % of Medication Administration Charts



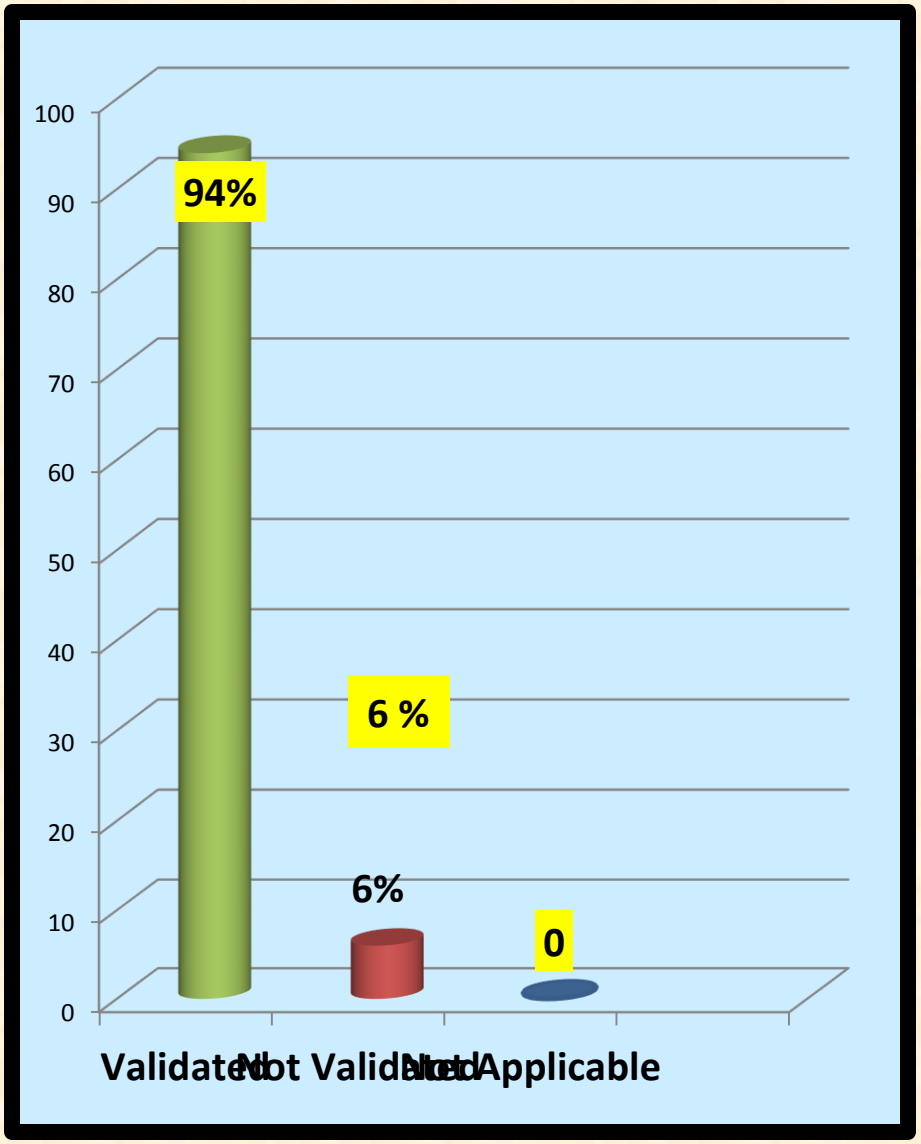
Legibility of Doctor's Signature in the Medication Administration Chart



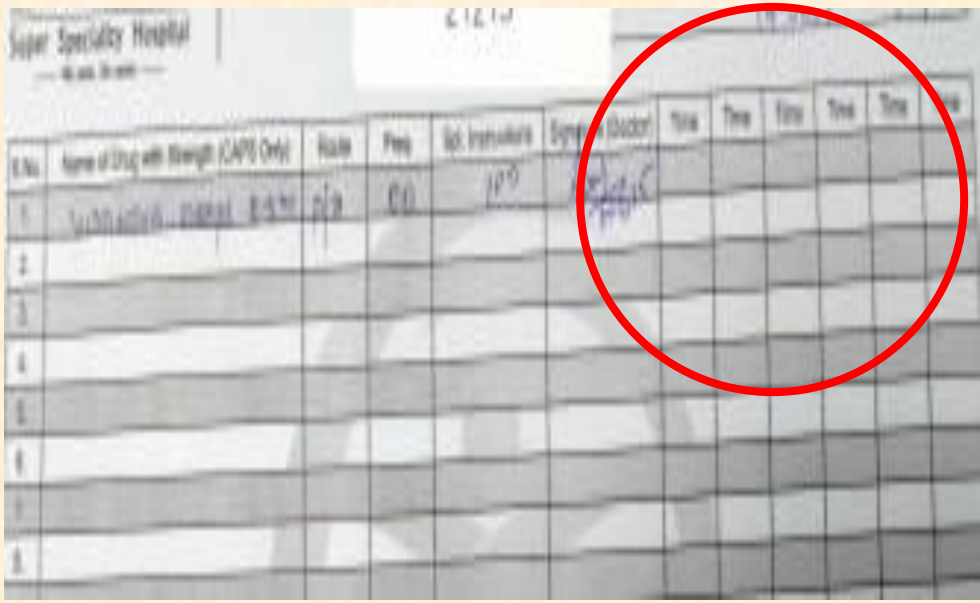
- Signature of doctor not legible in 28% of Medication Administration Charts
- During emergency crucial time may be wasted in consulting concerned doctor & administering the appropriate medicine due to said deficiencies



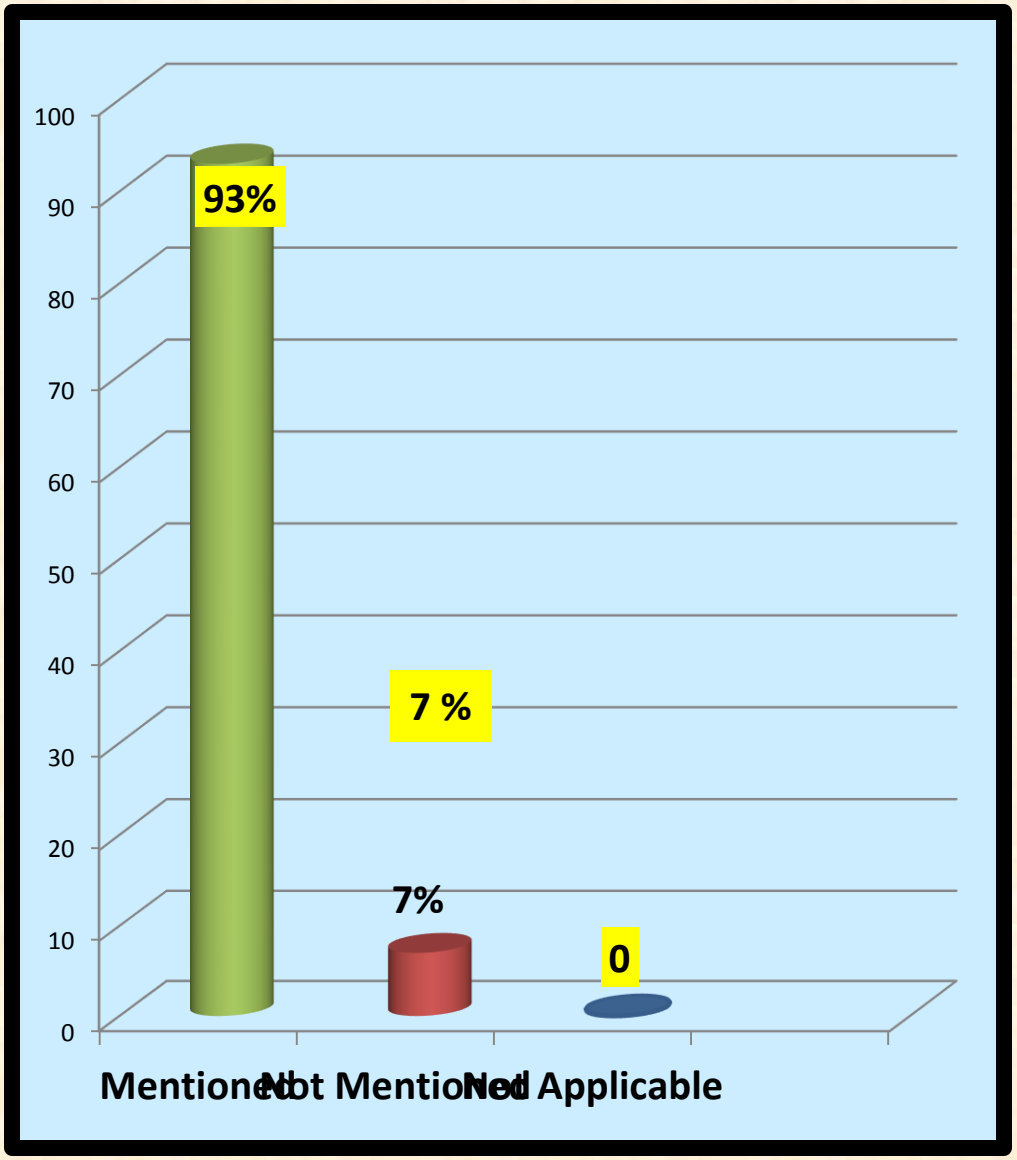
Stopping of Medication not Validated by Doctor



- Medications stopped but not validated by the doctor in 6% cases
- Critical to patient with multiple ailments & being attended to by many doctors
- Stopping medicine without validation may induce error in judgment of the other doc

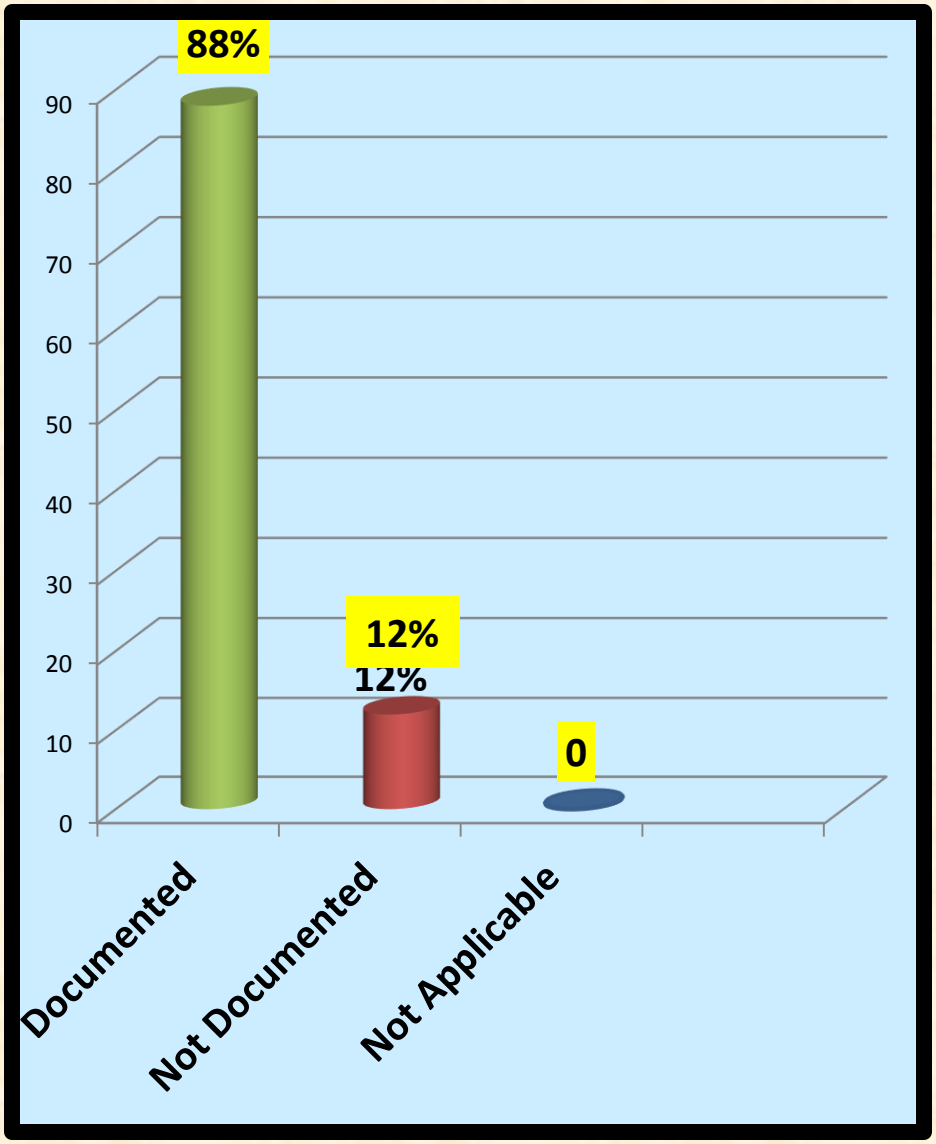


Time of Administration of Medicine in Medication Adm Chart



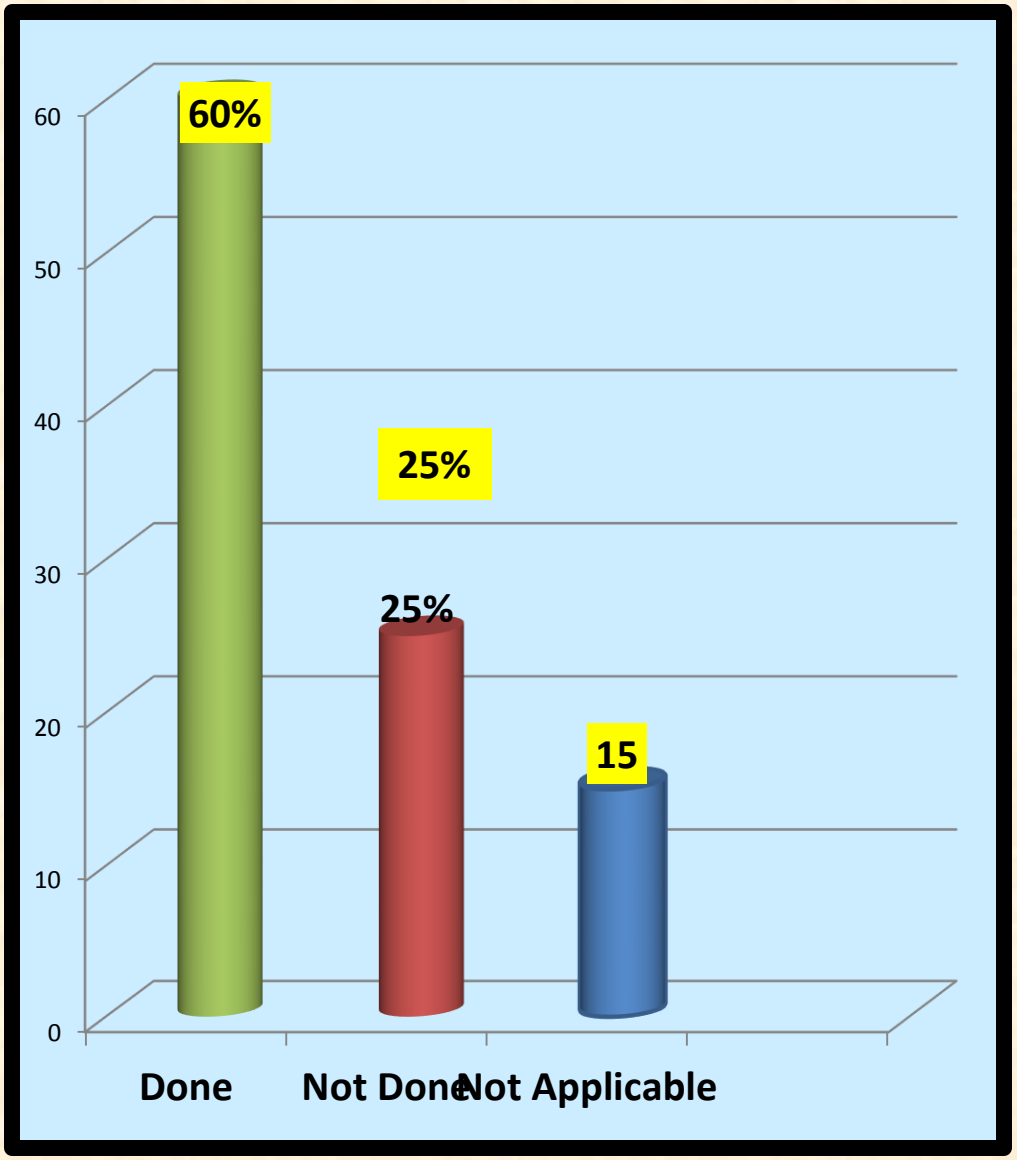
- Deficiency in 7% cases
- May cause over or under-administration of drug
- Threat to patient safety

Date not Mentioned in Medication Administration Chart



- Date of prescription not mentioned in 12% cases
- May cause errors in judgment during review
- Date & Time of medication sets a starting point for beginning of treatment
- Over-dosage due to not knowing details of beginning of medication
- Potential risk to the patient

Nutritional Assessment



- Needs to be done within 24 hrs
- Deficiency observed in 25 % of cases
- Requirement of meeting the nutritional needs differently
- Issue requires separate audit to find out specific deficiencies
- Instant internal audit showed marked improvement in this parameter

IP NUTRITIONAL ASSESSMENT FORM

Date & Time of Admission	Date & Time of Intial Assessment	Date & Time of Re Assessment	Bed No.
24.2.18 5.37pm	25.2.18 8 AM		513

Height (cm)	163	Weight (Kg)	53.7	BMI	20.9 kg/m²

PART A - NUTRITIONAL SCREENING

Screening Point	Scoring Parameters	Score	Awarded Score
A. Has food intake declined over the past 3 months, due to loss of appetite, digestive problems, chewing or swallowing difficulties?	☐ Severe decrease in food intake	0	
	☑ Moderate decrease in food intake	1	1
	☐ No decrease in food intake	2	
B. Weight loss during the past 3 months?	☐ Weight loss greater than 3 kg	0	
	☑ Does not know	1	1
	☐ Weight loss between 1 and 3 kg	2	
	☐ No weight loss	3	
C. Mobility	☐ Bed or chair bound	0	
	☐ Able to get out of chair/ bed but does not go out	1	2
	☑ Goes out	2	
D. Has suffered Psychological Stress or acute disease in the past 3 months?	☐ Yes	0	
	☑ No	2	2
E. Neuropsychological Problems	☐ Severe dementia or depression	0	
	☐ Mild dementia	1	2
	☑ No psychological problems	2	
F. Body Mass Index (BMI)	☐ BMI less than 19	0	
	☐ BMI 19 to less than 21	1	
	☐ BMI 21 to less than 23	2	3
	☑ BMI 23 or greater	3	
	Total Score		11

SCORING INTERPRETATION

12- 14 points	No immediate nutritional intervention required.
8-11 points	Requires nutritional intervention by dietician, in conjunction with physician to improve nutritional status.
0-7 points	Indicates critical need for nutritional intervention.

Note: Mini Nutritional assessment (MNA) Adopted from Nestle Nutrition Institute

DETAILS OF THE PATIENT

(in capitals)	HIMANI SINGH	Gender	☐ M ☑ F
	24303	Age	32

of Advice	☐ OPD	☐ Emergency	☐ Other Location
or Admission	☐ Immediate	☐ Routine	☐ On Priority
n of Admission	☐ Critical care	☐ Day care	☐ Ward*
	Others Details		

ed Date and Time of Admission	5/3/18.
Admit Under Consultant s of the Consultant & Speciality)	Int med I.
ional Diagnosis	PUO.
orbidities	Hypothyroidism.
ed Procedure / Surgery	
cted Date of Procedure / Surgery	2-3 days?
ils of Package (If Applicable)	
or Investigations (If Any)	
tant Details	
pected Length of Stay	2-3 days
U Stay Days	

Advice on Admission

Special Instructions (if any)

Doctors' Signature

Name

DMC No.

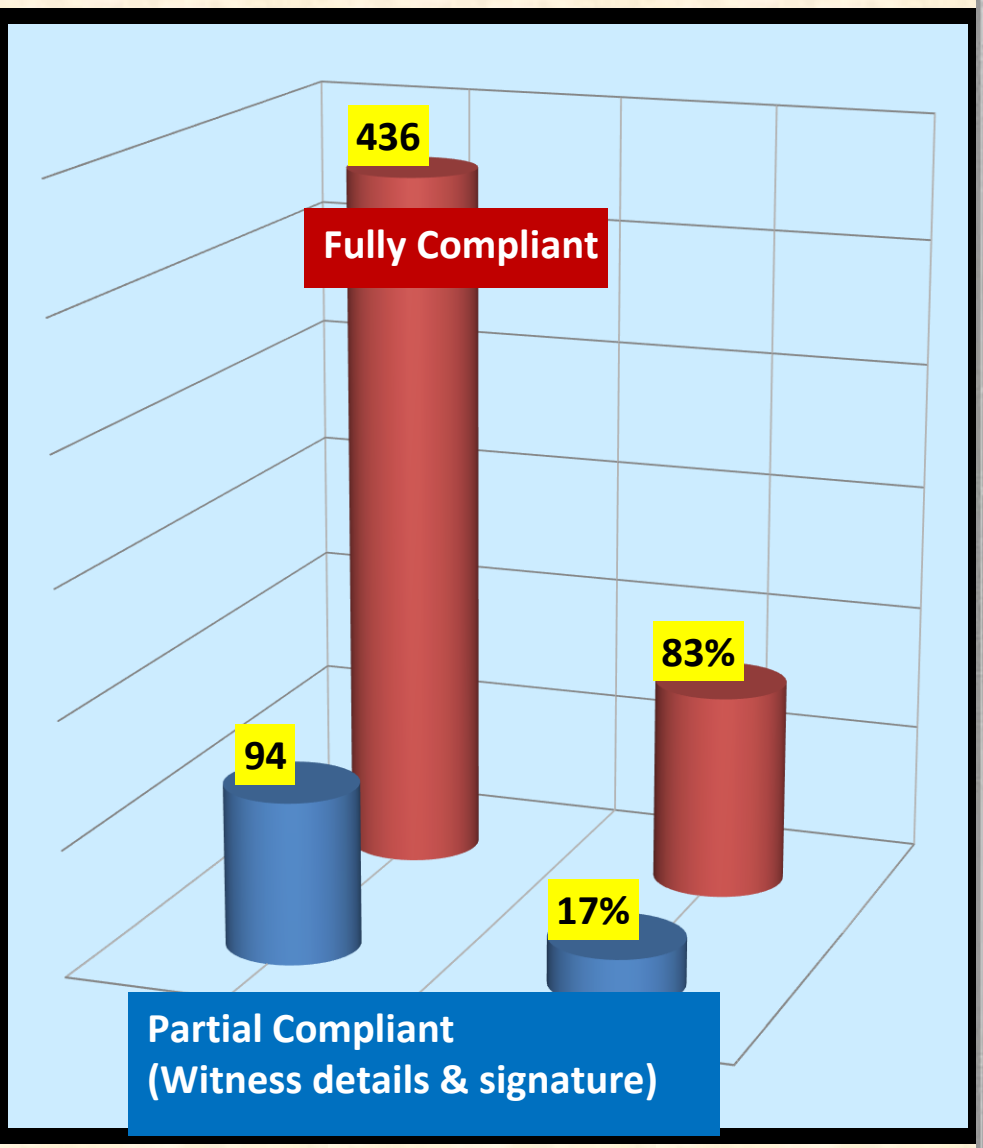
Date & Time

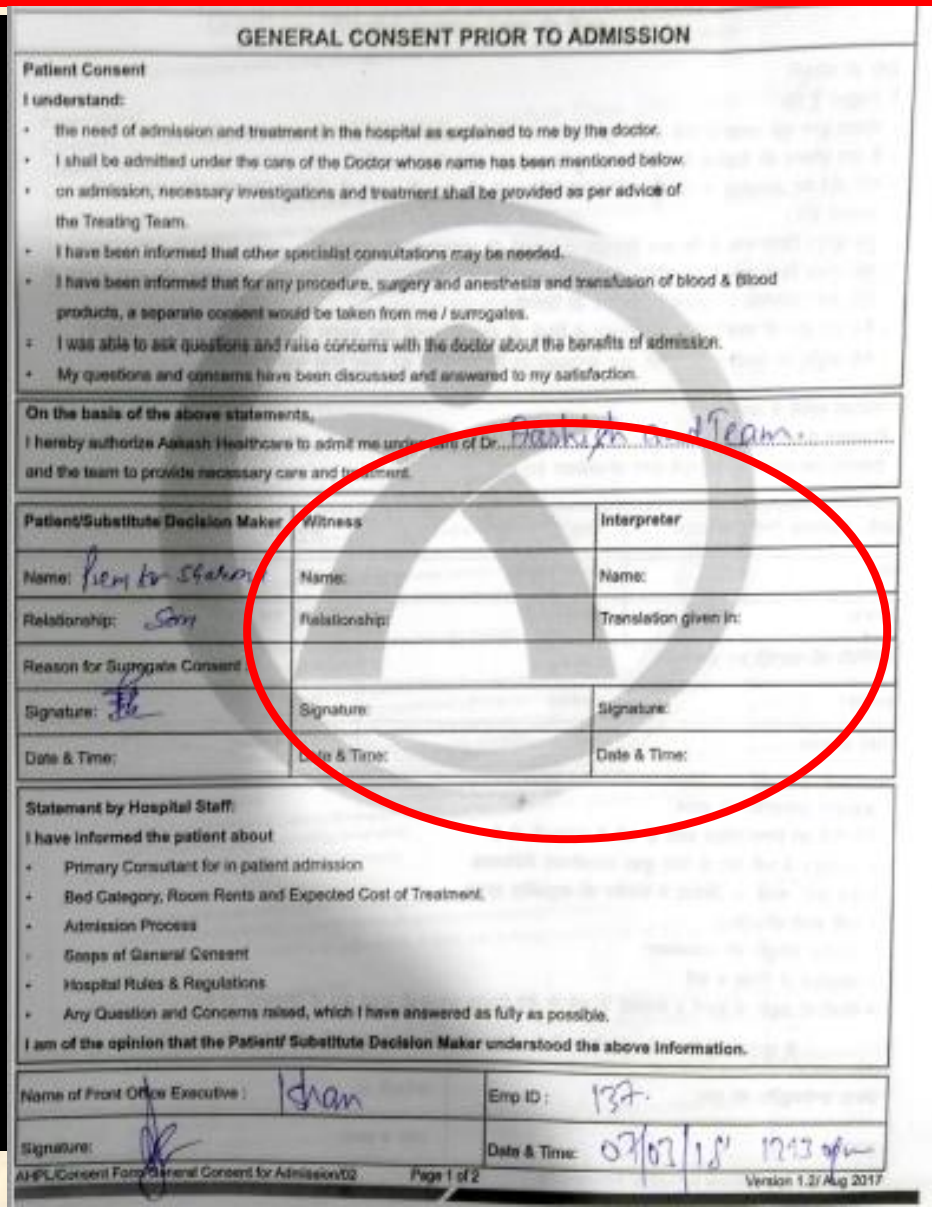
IFORM/MEDICAL/ARF/16

Page 1 of

Version 1.3/ Au

General Consent Form





GENERAL CONSENT PRIOR TO ADMISSION

Patient Consent

I understand:

- the need of admission and treatment in the hospital as explained to me by the doctor.
- I shall be admitted under the care of the Doctor whose name has been mentioned below.
- on admission, necessary investigations and treatment shall be provided as per advice of the Treating Team.
- I have been informed that other specialist consultations may be needed.
- I have been informed that for any procedure, surgery and anesthesia and transfusion of blood & blood products, a separate consent would be taken from me / surrogates.
- I was able to ask questions and raise concerns with the doctor about the benefits of admission.
- My questions and concerns have been discussed and answered to my satisfaction.

On the basis of the above statements,

I hereby authorize Aakash Healthcare to admit me under care of Dr. ... and the team to provide necessary care and treatment.

Patient/Substitute Decision Maker	Witness	Interpreter
Name:	Name:	Name:
Relationship: Son	Relationship:	Translation given in:
Reason for Surrogate Consent:		
Signature:	Signature:	Signature:
Date & Time:	Date & Time:	Date & Time:

Statement by Hospital Staff:

I have informed the patient about

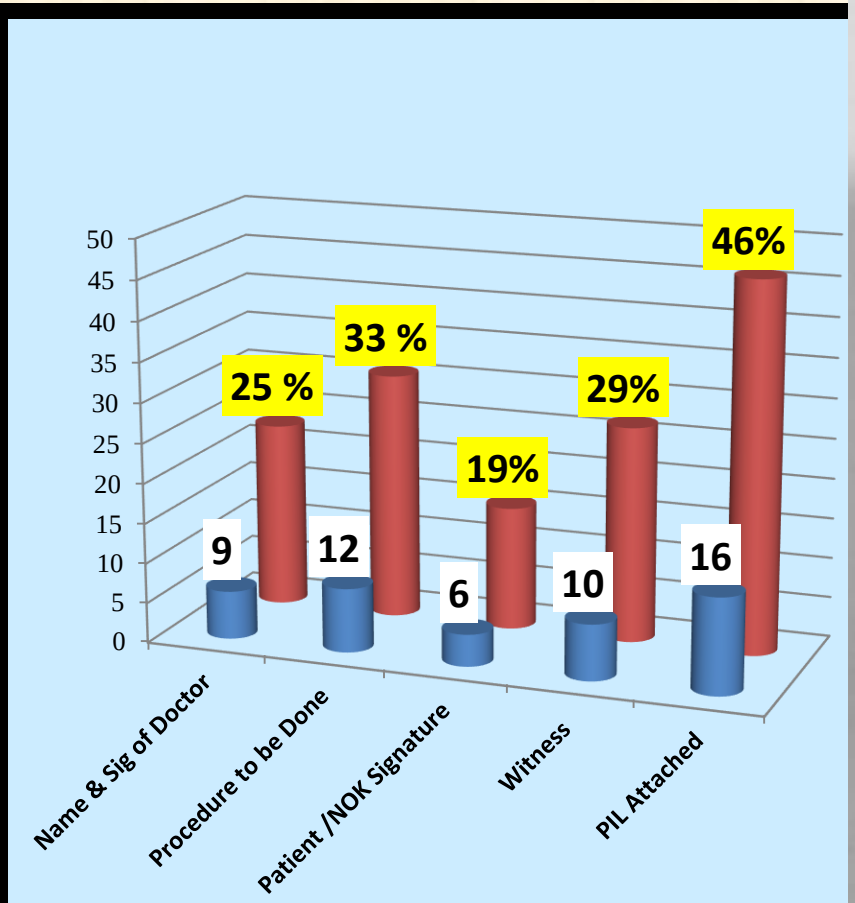
- Primary Consultant for in patient admission
- Bed Category, Room Rents and Expected Cost of Treatment.
- Admission Process
- Scope of General Consent
- Hospital Rules & Regulations
- Any Question and Concerns raised, which I have answered as fully as possible.

I am of the opinion that the Patient/ Substitute Decision Maker understood the above information.

Name of Front Office Executive: Iram	Emp ID: 137
Signature:	Date & Time: 07/07/18 12:13 pm

AHPL/Consent Form/General Consent for Admission/02 Page 1 of 2 Version 1.2/ Aug 2017

Informed Consent Form



- 42 forms (08%) noted with deficiencies

Department

INFORMED CONSENT

Patient Consent

I acknowledge that:

- I have read the attached "Patient Information Literature" with information about the Procedure and other relevant information.
- The doctor has explained my medical condition, the need for the proposed procedure and how it will be performed.
- I understand the benefits, risks and complications of the procedure, including the risks that are specific to me.
- I have been explained about the alternatives available and consequences in case of non treatment.
- I was able to ask questions and raise concerns with the doctor about the procedure.
- My questions and concerns have been discussed and answered to my satisfaction.
- I have given this consent with stable mind, freely, voluntarily and without reservation.

On the basis of the above statements, I hereby authorize Dr. Aashish R. Dave and those he may designate as associates or assistants to perform upon me the procedure Bilateral Total knee Replacement during the course of my hospitalization.

Patient/Substitute Decision Maker	Witness	Interpreter
Name: Bimla	Name: Urvashi	Name:
Relationship: Sey	Relationship: Daughter in law	Translation given in:
Reason for Surrogate Consent :		
Signature: Bimla sharma	Signature: Urvashi	Signature:
Date & Time: 8.2.18	Date & Time: 8.2.18	Date & Time:

Doctor's Statement:

I have explained:

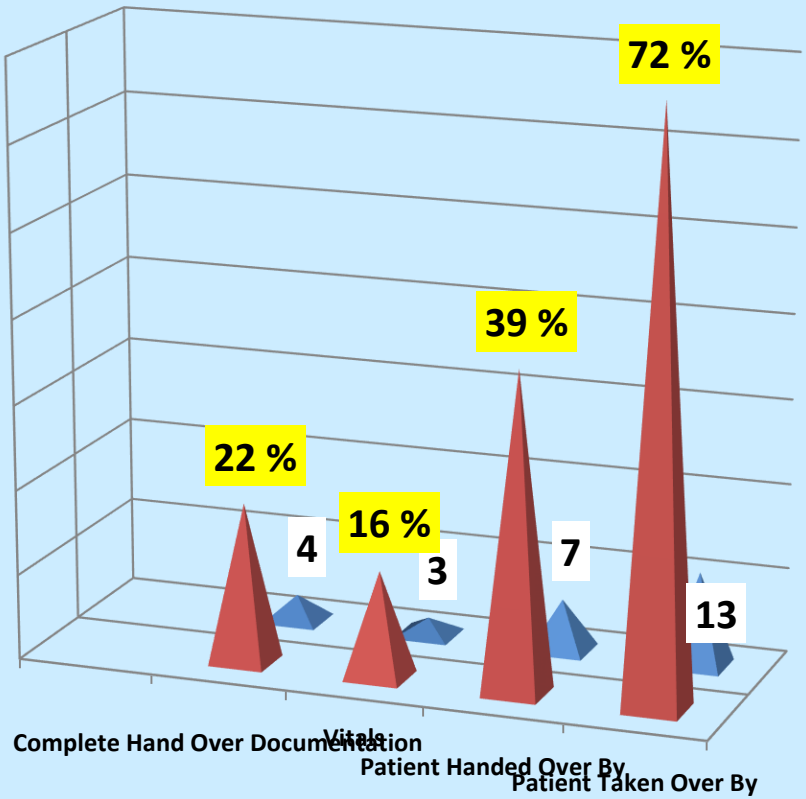
- The patient's medical condition, need for this procedure and how it will be performed.
- The benefits, risks and complications of the procedure, including the risks that are specific to the patient.
- The alternatives available and consequences in case of non treatment.
- I have explained all the information to patient in the language which he / she fully understand.
- I have given the Patient/ Guardian an opportunity to:
- Ask questions about any of the above matters
- Raise any other concerns, which I have answered as fully as possible.
- I am of the opinion that the Patient/ Substitute Decision Maker understood the above information.

Name of Doctor: Dr. Sourabh Shah	Signature: S. Shah
Department: ortho	Date & Time: 08/02/18

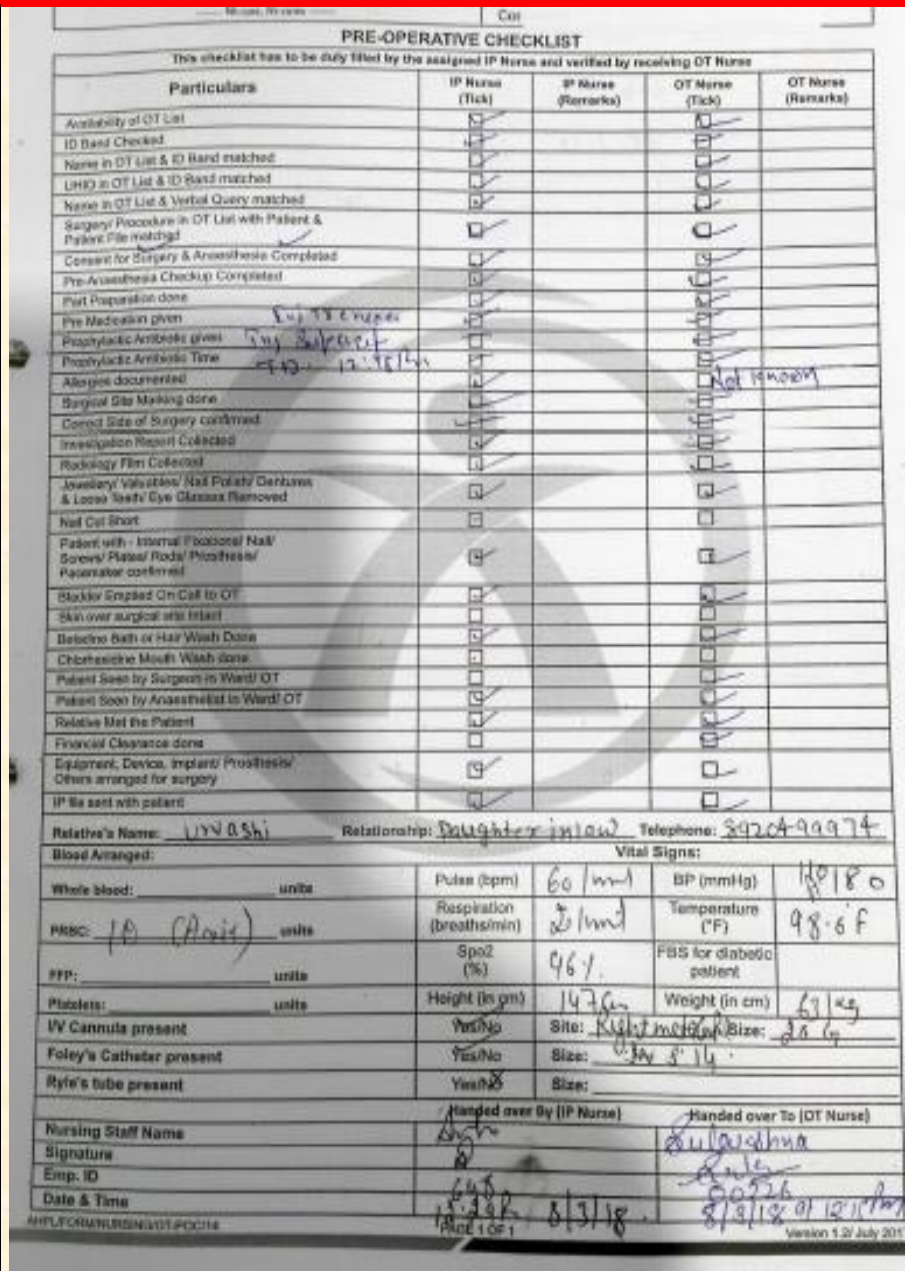
AI/PIL/Consent Form/Common/01 Page 1 of 2 Version 1.1/Jul 2017

Pre Operative Check List

Total Surgical Files - 96



- Out of 96 surgical case files audited,
- 18 Forms (19%) incomplete /deficient



PRE-OPERATIVE CHECKLIST

This checklist has to be duly filled by the assigned IP Nurse and verified by receiving OT Nurse

Particulars	IP Nurse (Tick)	IP Nurse (Remarks)	OT Nurse (Tick)	OT Nurse (Remarks)
Availability of OT List	✓		☐	
ID Band Checked	✓		☐	
Name in OT List & ID Band matched	☐		☐	
UHID in OT List & ID Band matched	☐		☐	
Name in OT List & Verbal Query matched	☐		☐	
Surgery/ Procedure in OT List with Patient & Patient File matched	☐		☐	
Consent for Surgery & Anaesthesia Completed	☐		☐	
Pre-Anaesthesia Checkup Completed	☐		☐	
Part Preparation done	☐		☐	
Pre Medication given	☐		☐	
Prophylactic Antibiotic given	☐		☐	
Prophylactic Antibiotic Time	☐		☐	
Allergies documented	☐		☐	Not known
Surgical Site Marking done	☐		☐	
Correct Side of Surgery confirmed	☐		☐	
Investigation Report Collected	☐		☐	
Radiology Film Collected	☐		☐	
Jewellery/ Valuables/ Nail Polish/ Dentures & Loose Teeth/ Eye Glasses Removed	☐		☐	
Nail Cut Short	☐		☐	
Patient with - Internal Fixations/ Nail/ Screws/ Plates/ Rods/ Prosthesis/ Pacemaker confirmed	☐		☐	
Bladder Emptied On Call to OT	☐		☐	
Skin over surgical site Intact	☐		☐	
Betadine Bath or Hair Wash Done	☐		☐	
Chlorhexidine Mouth Wash done	☐		☐	
Patient Seen by Surgeon in Ward/ OT	☐		☐	
Patient Seen by Anaesthetist in Ward/ OT	☐		☐	
Relative Met the Patient	☐		☐	
Financial Clearance done	☐		☐	
Equipment, Device, Implant/ Prosthesis/ Others arranged for surgery	☐		☐	
IP file sent with patient	☐		☐	

Relative's Name: [illegible] Relationship: Daughter in law Telephone: 8920499974

Blood Arranged:

Whole blood: _____ units

PRBC: 1P (A+ve) units

FFP: _____ units

Platelets: _____ units

Vital Signs:

Pulse (bpm)	60 /min	BP (mmHg)	110/80
Respiration (breaths/min)	20 /min	Temperature (°F)	98.6 F
SpO2 (%)	96%	FBS for diabetic patient	
Height (in cm)	147cm	Weight (in cm)	63 kg

I/V Cannula present	Yes/No	Site: Right metacarpal Size: 20 G
Foley's Catheter present	Yes/No	Size: 14
Ryle's tube present	Yes/No	Size:

	Handed over By (IP Nurse)	Handed over To (OT Nurse)
Nursing Staff Name	[illegible]	Sulakshana
Signature	[illegible]	[illegible]
Emp. ID	[illegible]	[illegible]
Date & Time	8/3/18	8/3/18 01:12 PM

PAGE 1 OF 1

Version 1.2/ July 201

Mrs. RIMLA SHARMA

21427

OT- SURGICAL SAFETY CHECKLIST

Date	Start Time	End Time	Duration of Surgery:

Before Induction of Anaesthesia (Sign in)
(with at least Nurse and Anaesthetist) 1:20 pm

Has the patient confirmed his/her identity, site, procedure, and consent?	Yes ☐ No ☐
Is the site marked?	Yes ☐ No ☐ Not applicable ☐
Is the anaesthesia machine and medication check complete?	Yes ☐ No ☐
Is the pulse oximeter on the patient and functioning?	Yes ☐ No ☐
Does the patient have a: Known allergy?	No ☐ Yes ☐
Does the patient have a: Difficult airway or aspiration risk?	No ☐ Yes, and equipment/assistance available ☐
Does the patient have a: Risk of >500ml blood loss (7ml/kg in children)?	No ☐ Yes, and two IVs/central access and fluids planned ☐

Anesthetist	Surgeon	Staff Nurse
Signature	Signature	Signature
Name	Name	Name
DMC No.	DMC No.	Emp. ID
Date & Time	Date & Time	Date & Time

Before skin incision (Time Out)
(with Nurse, Anaesthetist and Surgeon) 2:20 pm

Confirm all team members have introduced themselves by name and role.	Yes ☐ No ☐
Confirms the patient's name, procedure and where the incision will be made.	Yes ☐ No ☐
Has antibiotic prophylaxis been given within the last 60 minutes? Inj Supacef 1.5gm iv	Yes ☐ NO ☐ Not applicable ☐
Anticipated Critical Events	To Surgeon: What are the critical or non-routine steps? ☐ How long will the case take? ☐ What is the anticipated blood loss? ☐ To Anaesthetist: Are there any patient-specific concerns? ☐
Is essential imaging displayed?	To Nursing Team: Has sterility (including indicator results) been confirmed? ☐ Are there equipment issues or any concerns? ☐ Yes ☐ Not applicable ☐

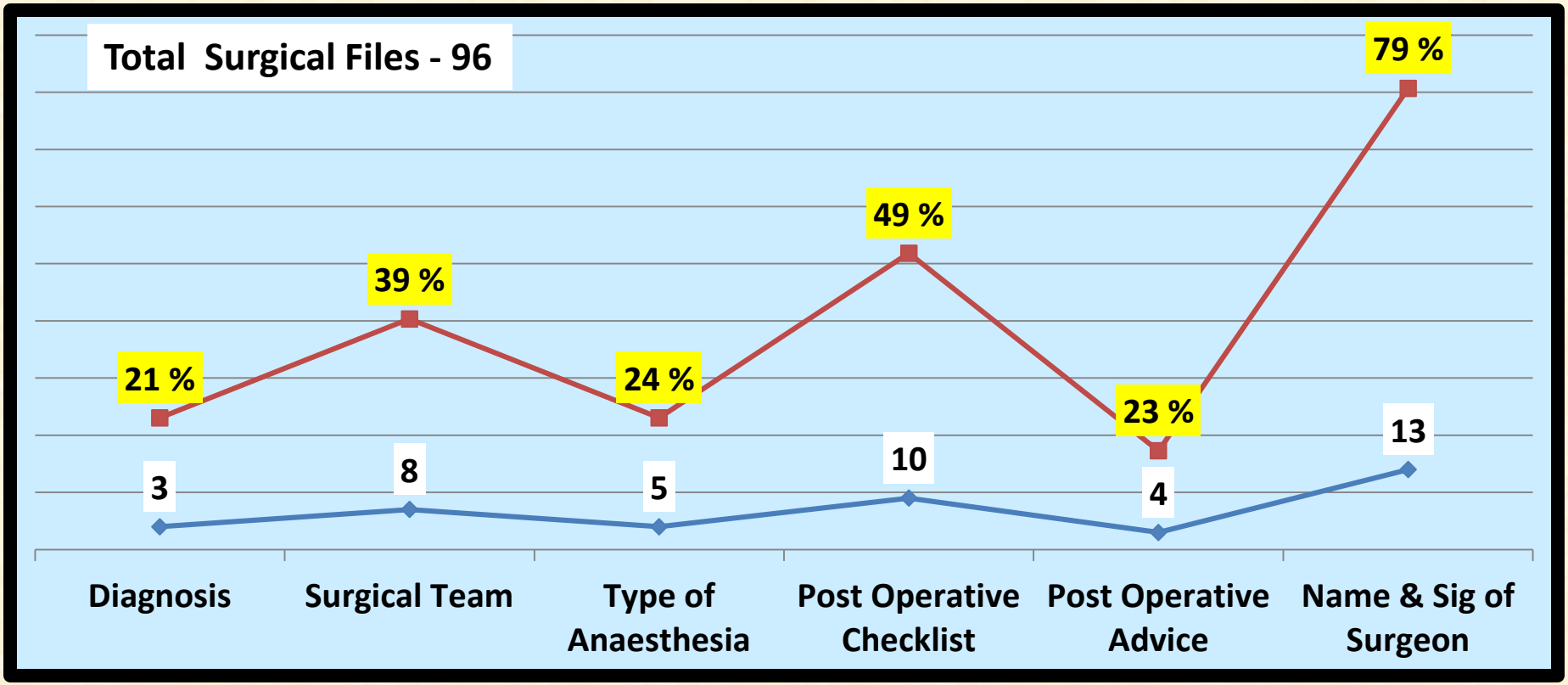
Anesthetist	Surgeon	Staff Nurse
Signature	Signature	Signature
Name	Name	Name
DMC No.	DMC No.	Emp. ID
Date & Time	Date & Time	Date & Time

Before patient leaves Operating Room (Sign -Out)
(with Nurse, Anaesthetist and Surgeon) 3:50 pm

Nurse verbally confirms: THR (R)	The name of the procedure ☐ Completion of instrument, sponge and needle counts ☐ Specimen labeling (read specimen labels aloud, including patient name) ☐ Whether there are any equipment problems to be addressed ☐
To Surgeon, Anesthetist & Nurse	What are the key concerns for recovery & management of this patient? Pain should be controlled by oral analgesics after 2 hrs

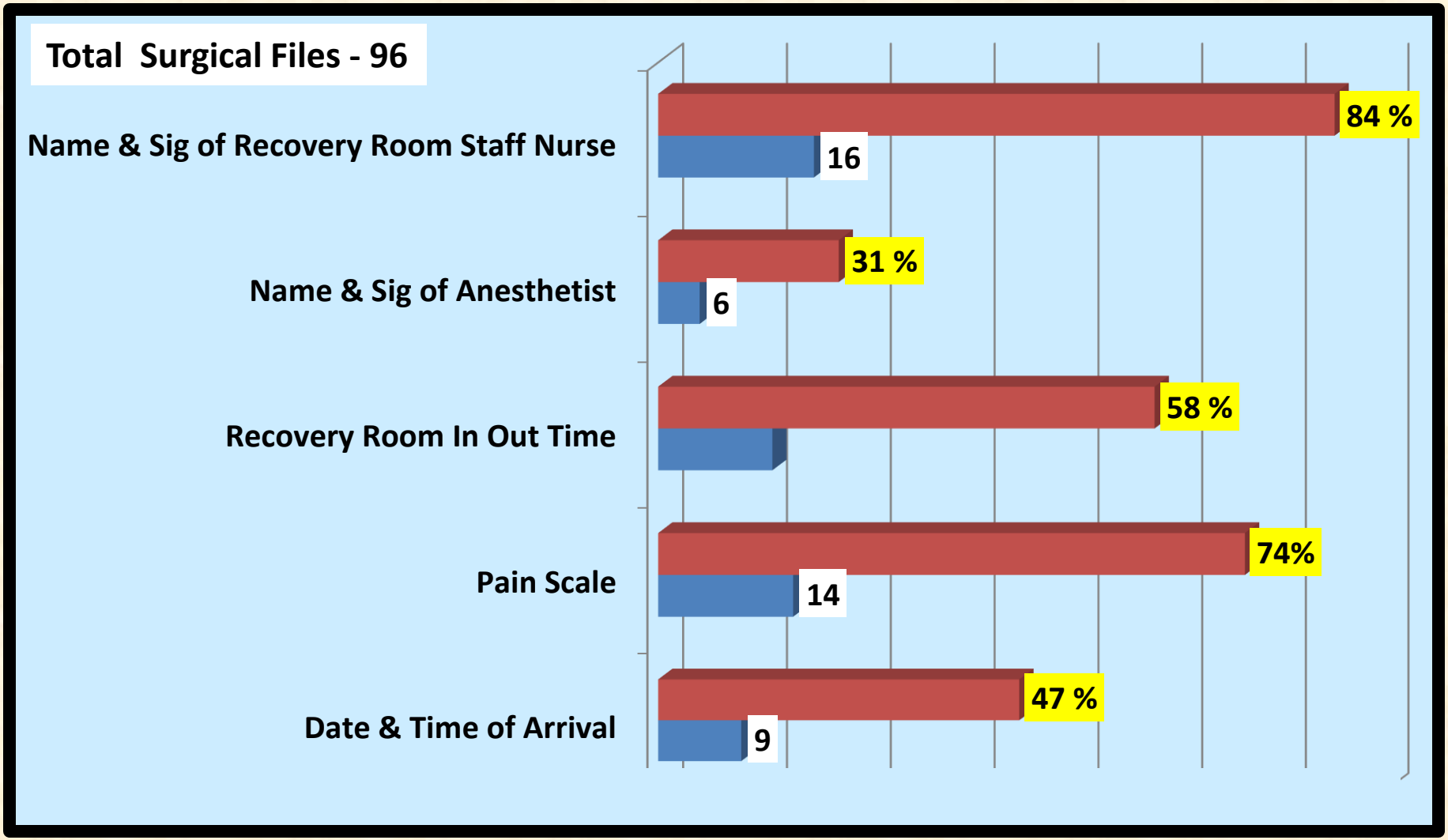
Anesthetist	Surgeon	Staff Nurse
Signature	Signature	Signature
Name	Name	Name
DMC No.	DMC No.	Emp. ID
Date & Time	Date & Time	Date & Time

OT Surgery & Post Surgery Notes



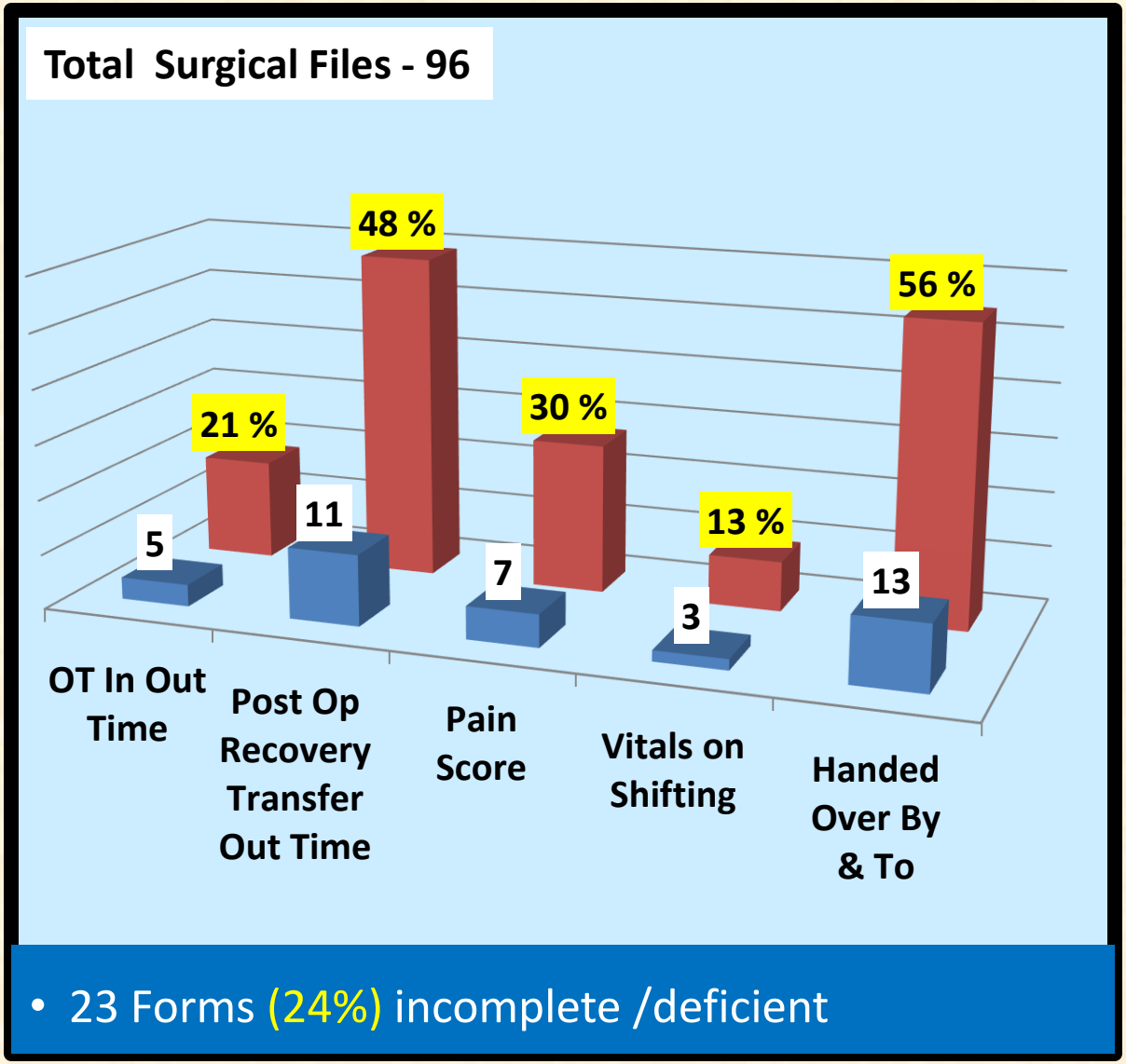
- 22 forms (23 %) forms incomplete and had deficiencies
- Name and signature of surgeon
- Post op check list not complete etc

Monitoring Form for PACU

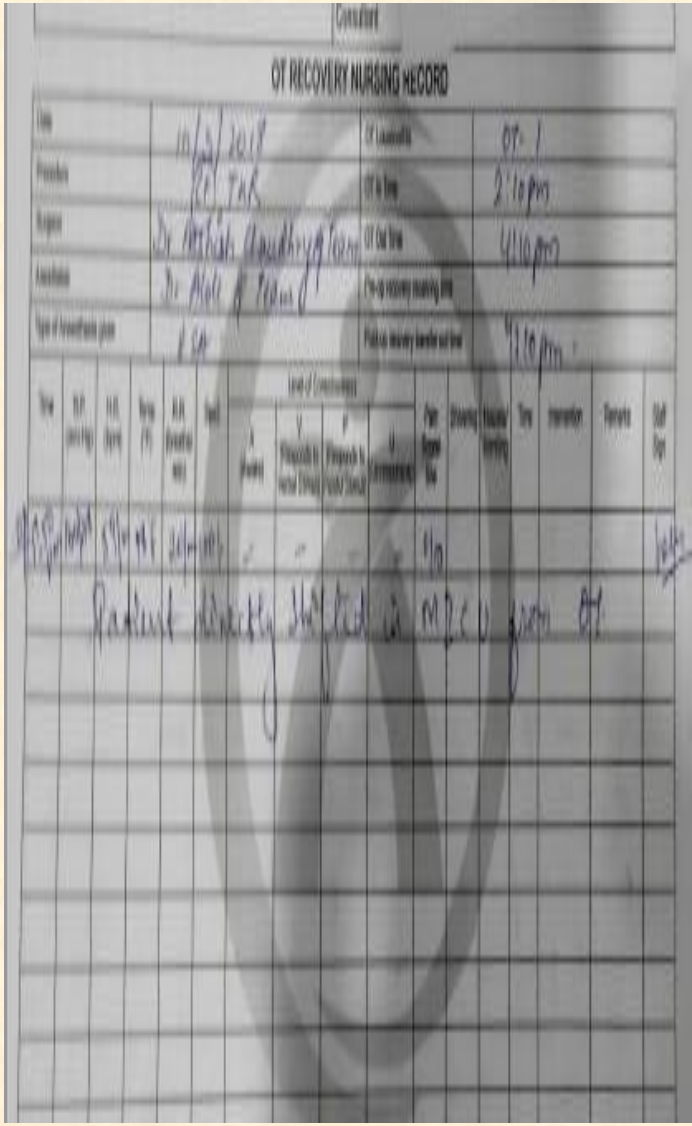


- 19 Forms (20%) incomplete /deficient

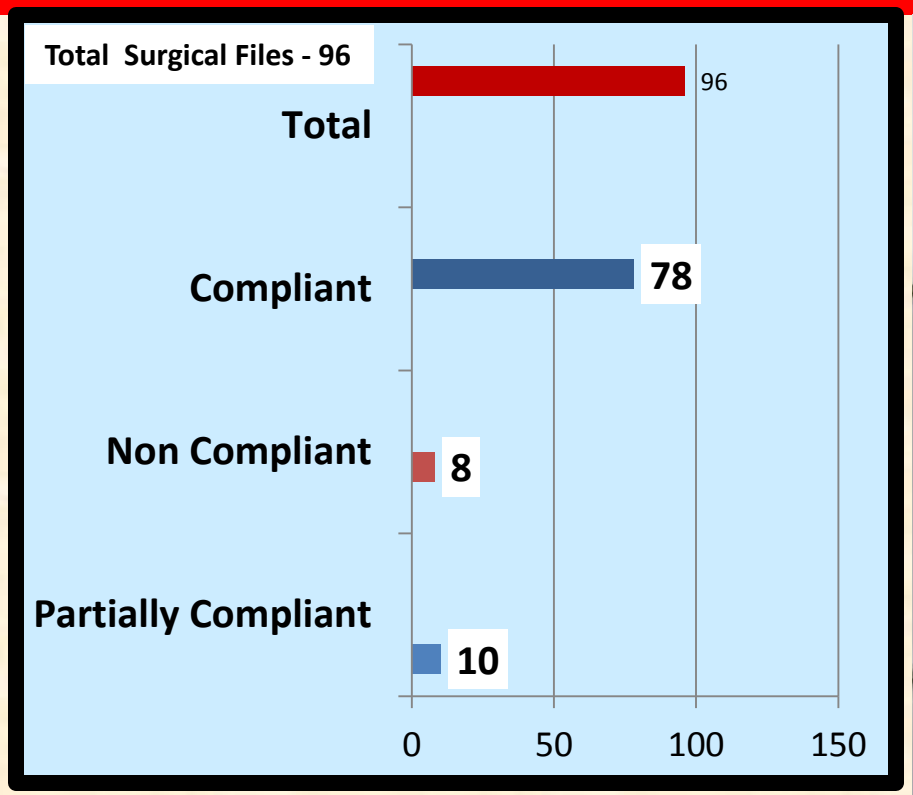
OT Recovery Nursing Record



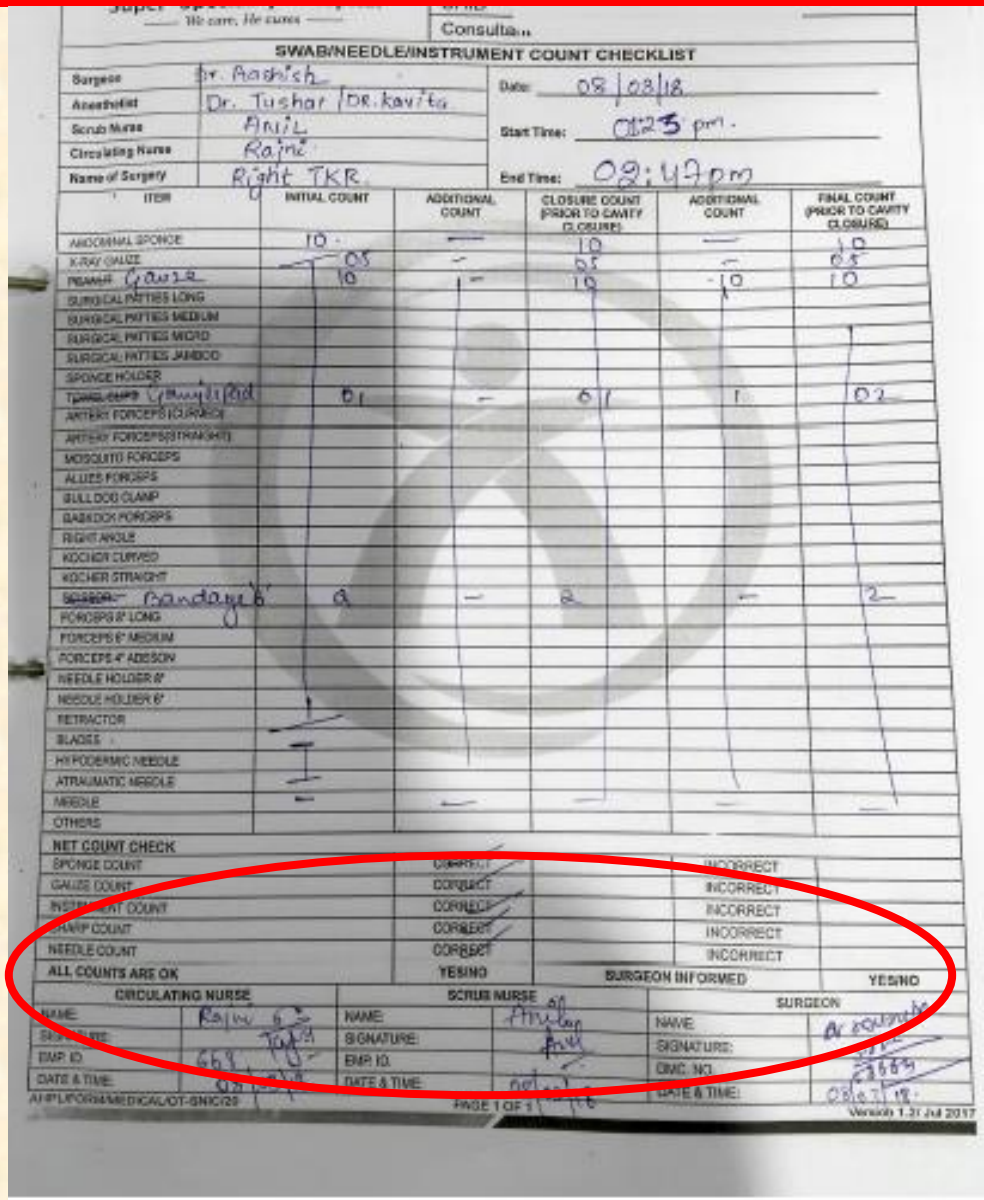
- 23 Forms (24%) incomplete /deficient



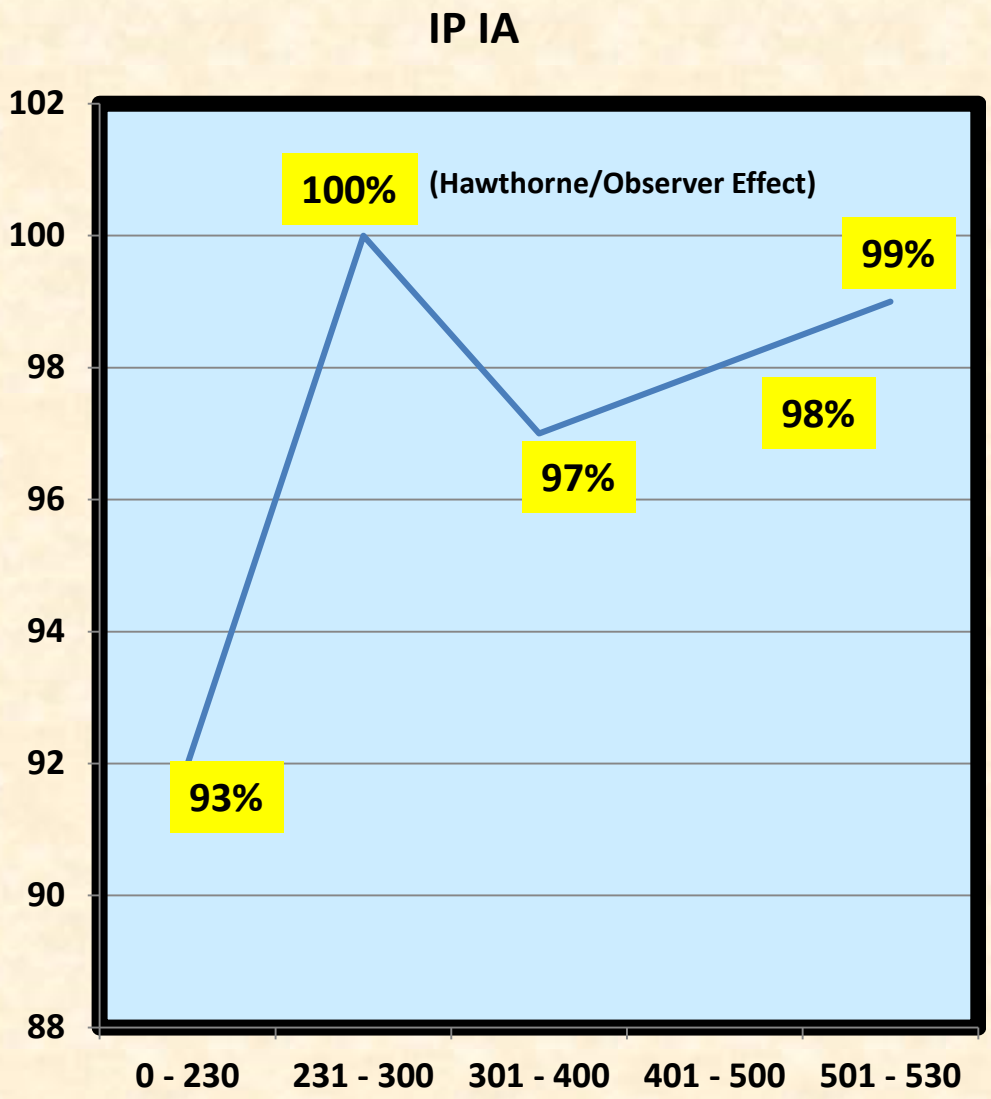
Swab/Needle/Instrument Count Checklist



- 88 files found to have ibid form, out of 96
- 78 forms were fully complete
- 10 forms found partially complete
- Deficiencies like name & sign of circulating nurse, start & end time of surgery, name & sign of surgeon & scrub nurse etc

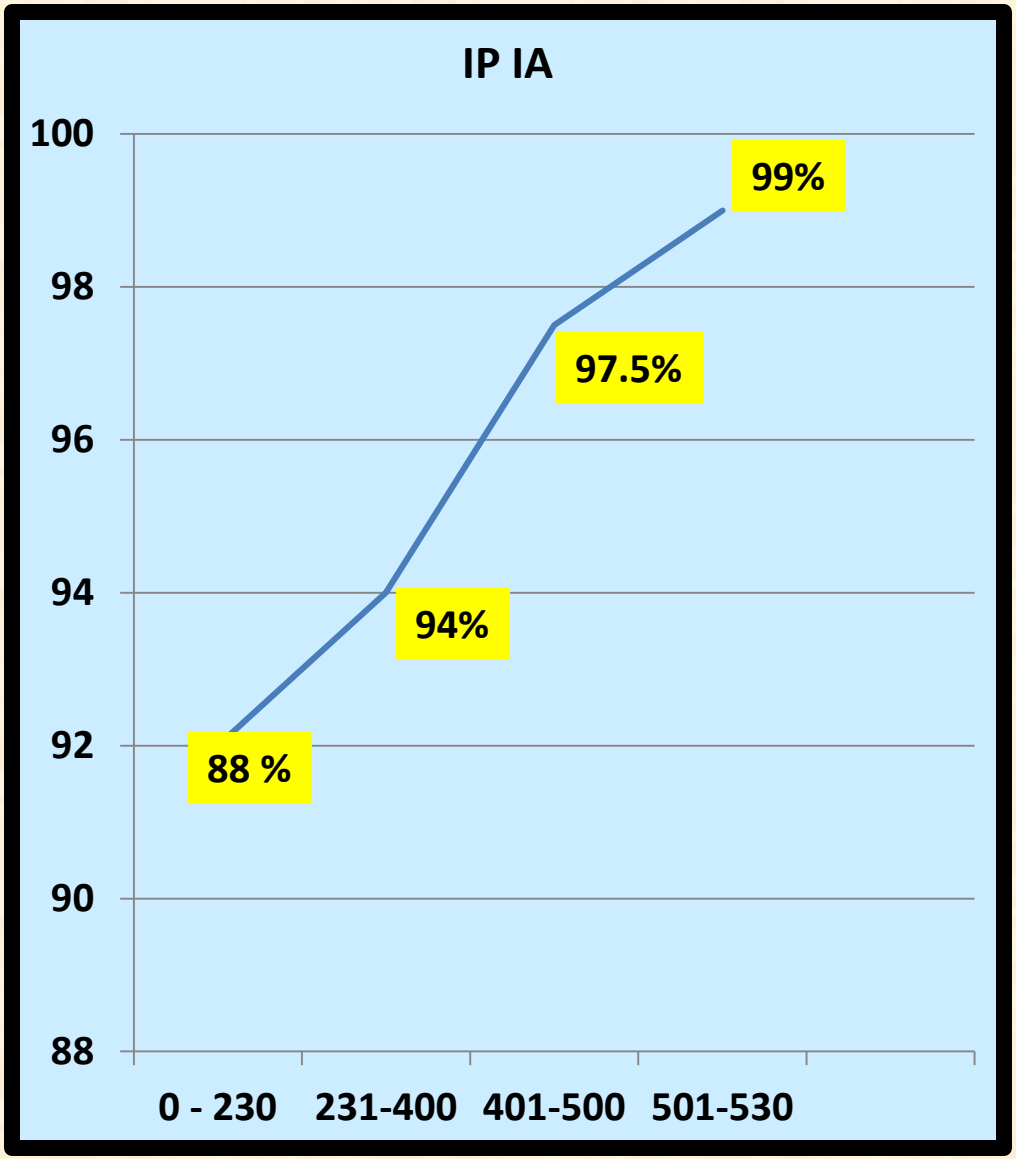


Effect of Internal Audit
IP Initial Assessment(Doc's IA)



- Overall adequacy 78 % due to deficiencies
- 93% achieved for initial 230 folders
- Next 70 samples, improved to 100%, Hawthorne (observer) Effect
- Patient files 301- 400, it was 97%
- Dip likely due to staff getting used to seeing audit continuing, becoming complacent
- Result better than initial 230 results
- Patient files 401 – 500, improved to 98%
- For sample 501 - 530 it was 99%
- Positive change in the basic behavior towards non medical aspects of documentation

Effect of Internal Audit Nutritional Assessment



- Overall in 25 % cases assessment was not done within 24 hrs
- 88 % achieved for initial 230 patient medical documentation folders
- Sample files from 231 -400, improved to 94%
- Improvement in availability of staff, awareness of internal audit and since the hospital shifted to 100% computer entry of the ibid form using computer on wheels
- For sample 401-500, it was 97.5%
- For sample 501 – 530 it improved to 99%
- Positive change in the basic behavior of Nutritionists wrt documentation as per guidelines

Key Findings and Recommendations

Key Findings and Recommendations

Institutionalized /Long Term Measures

- Traditional Approach - Assumed that well trained, conscientious practitioners do not make errors (non use of stamps by 94% of doctors)
- Errors reduce by redesigning systems and processes – using human factors principles
- Audit of Patient medical Documentation - an effort to do the same in a new super specialty tertiary care hospital
- Adaptation of concepts - from other established & successful fields: Internal Audits like in Armed Forces
- Quality improvement review - conduct periodically(self assessment)

Key Findings and Recommendations

- Non standardisation of education – reduction of mistakes through document standardisation
- Continuous Training - guided by deficiencies detected during audit can provide workable solution to fill the gaps in initial medical education
- Limiting the blame & avoid finger pointing – transparency, team spirit
- Collective evolution - of culture & professionalism of staff HCF
- Overlap of all in the patient safety mechanism – monthly Board of Officers(BOO)(Audit Committee)

Key Findings and Recommendations

- Detailed by Quality Department / MS - act as a mirror to 'sharp – end' correction
- Conscious effort to improve patient safety – focus to improve malice of illegible signatures, illegible prescriptions, no use of rubber stamps etc
- NABH Accreditation - fill in this void through internal audit mechanism
- Adoption of other self improvement tools - to improve patient safety & physician defensibility

Key Findings and Recommendations

HCF/Short Term Measures

- Forms & records be filed explicitly as per guidelines
- All columns in forms should either be filled or crossed out or written NA
- Awareness posters at vantage points
- Proactive use of computer on wheels(COW) using speech software
- Minimise cuttings and over writings
- Deficiencies noted be disseminated to concerned staff
- Floor managers be also involved in checking the completion of pt medical documentation

To Conclude……

- Patient Safety should be the reason of all activity in any hospital and there should be constant endeavor by all to achieve this
- The ultimate aim of any healthcare organization should be to have zero tolerance towards patient safety
- Adequate, Clear, Legible, Credible, Accurate and Complete medical records are one of the best remedy for patient safety & defense against litigation and support Physician Defensibility

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