Internship Training
at

Unicare Heart Institute, Surat, Gujarat

(01 Feb - 30 May 2019)

Reviewing Patient Medical Documentation as Means to Enhance Patient Safety as per NABH 4th edition standards

By
Dr. Kavisha Bhatia
PG/17/026

Under the guidance of
Dr Nitish Dogra

Post-Graduate Diploma in Health and Hospital Management
Batch 2017-19

International Institute of Health Management Research,

New Delhi
2019

Reviewing Patient Medical Documentation as Means to Enhance Patient Safety as per NABH 4th edition standards

(Unicare Heart Institute, Surat, Gujarat)

(01 Feb - 30 May 2019)

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

Post-Graduate Diploma in Health and Hospital Management
Batch 2017-19

By
Dr. Kavisha Bhatia
PG/17026

Under the guidance of

DrNitishDogra

DrDogra

Internal Mentor **ExternalMentor**
DrNitishDogra
Associate Professor,
IIHMR, Delhi

DrDevang Desai,
Director,
Unicare hospital

International Institute of Health Management Research,

New Delhi

2019

ABSTRACT:

Aim: To ensure medical records are complete as per the standards set by NABH and identify the areas for improvement. . The accreditation leaves enough scope for adjustments which can be made with regards to the requirements of Patient Safety as per the facilities existing in an organization.**Objective:** The study was conducted to establish role of medical documentation in patient safety to identify the likely non-medical errors by doctors and nurses in patient medical documentation having direct bearing on safety of patient, to utilize internal audit as a possible means to patient safety and to recommend a broad mechanism of internal audit so as to bring behavioral changes in the approach to documentation as means to improve patient safety in a hospital. **Methodology:** The study was carried-out in a cardiac hospital (Unicare heart Institute & research center). It is descriptive cross sectional study design. A sample of 530 patient medical documents was audited for the study.10 medical documents were selected per month from January 2015 to May 2019 and purposive sampling technique was used. For study tool existing patient medical documentation checklist was utilized.**Findings/Results:** To relate various patient medical documents covered aspects (non medical errors) of non-use of stamps, illegible signatures, not mentioning the time and plan of treatment, non counter signature by primary consultants, lack of endorsement of initial assessment and time of admission in the clinician progress notes, prescription of medication in block letters was not done, name and signature of doctor was not legible, nutritional assessment was not carried out within 24 hrs in number of cases etc. Ultimate aim of any healthcare organization should be to have zero tolerance towards patient safety.To **Conclude** the way to the accreditation is through following standardized procedures which are implemented by evolving various forms and documents. These documents are subjected to internal and external audit as per accreditation guidelines. However, the purpose of the documentation should be Patient Safety and physician defensibility.

UNICARE
HEART INSTITUTE & RESEARCH CENTER
(Managed by South Gujarat Cardiac Care Pvt. Ltd.)

(Completion of Dissertation from respective organization)

The certificate is awarded to

Dr. Kavisha Bhatia

in recognition of having successfully completed her
Internship in the department of

Medical Record Department

and has successfully completed her Project on

Reviewing Patient Medical Documentation as Means to Enhance Patient Safety as per NABH 4th edition standards

01 Feb – 30 May 2019

Unicare Heart Institute,Surat

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

We wish her all the best for future endeavors.

Unicare Heart Institute & Research Center
ACME Plaza, B-Wing, 1st Floor,
Near Sosyo Circle,
Behind New Civil Hospital,
Canal Road, SURAT-395002.

Dr Devang Desai,
Director
Unicare Heart Institute,
Surat

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **DrKavisha Bhatia** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at Unicare Heart Institute from 01 Feb to 30 May 2019

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical. The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

PK Panda

DrPradeep K Panda
Dean, Academics and Student Affairs
IIHMR, New Delhi

ND Dogra

Mentor
Dr. NitishDogra
IIHMR, New Delhi

Certificate of Approval

The following dissertation titled **Reviewing Patient Medical Documentation as Means to Enhance Patient Safety as per NABH 4th edition standards**at **Unicare Heart Institute** is hereby approved as a certified study in management carried out andpresented 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.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr Madhulekha Bhattacharya	13/5/19
Dr Nitish Dogra	
Dr Pankaj Talreja.	

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Kavisha Bhatia**, a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision.

She is submitting this dissertation titled "**Reviewing Patient Medical Documentation as Means to Enhance Patient Safety as per NABH 4th edition standard at Unicare Heart Institute** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

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.

Dr Nitish Dogra,

Associate Professor ,

IIHMR,

Delhi

Dr Devang Desai,

Director

Unicare Heart Institute,

Surat

Unicare Heart Institute & Research Center
ACME Plaza, B-Wing, 1st Floor,
Near Sosyo Circle,
Behind New Civil Hospital,
Canal Road, SURAT-395002.

UNICARE
HEART INSTITUTE & RESEARCH CENTER
(Managed by South Gujarat Cardiac Care Pvt. Ltd.)

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr. Kavisha Bhatia, student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at Unicare Health Institute from 01 Feb to 30 May 2019

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.
The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

Dr Devang Desai
Director

Unicare Heart Institute & Research Center
ACME Plaza, B-Wing, 1st Floor,
Near Sosyo Circle,
Behind New Civil Hospital,
Canal Road, SURAT-395002.

Acme Plaza, B-Wing, Near Sosyo Circle, B/H New Civil Hospital, Canal Road, Surat-395002
For Appointments: 8141577444, For Emergency: 8141377444
Reception : 0261-2639700 / 9800, Cathlab Direct No: 0261 - 2639200, Fax : 0261 - 2639500
E-mail : unicareheartinstitute@gmail.com
CIN No : U85110GJ2013PTC073815

SGCPL

॥ हृदयम् ॥

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Reviewing Patient Medical Documentation as Means to Enhance Patient Safety as per NABH 4th edition standards** and submitted by **Dr. Kavisha Bhatia** Enrollment No. **PG17026** under the supervision of Dr Nitish Dogra for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 01 Feb to 30 May 2019
embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Signature

UNICARE
HEART INSTITUTE & RESEARCH CENTER
(Managed by South Gujarat Cardiac Care Pvt. Ltd.)

FEEDBACK FORM

Name of the Student: Dr Kavisha Bhatia

Dissertation Organisation: Unicare Heart Institute

Area of Dissertation: Audit of patient medical record to verify if the outcome is as per standards of NABH 4th edition

Attendance: 100%

Objectives achieved: Yes

Deliverables: Presentation submitted for medical record department according to NABH 4th edition standards

Strengths: Good observation skills and hardworking

Suggestions for Improvement: Needs to be more analytical in her approach

Suggestions for Institute (course curriculum, industry interaction, placement, alumni): None

Signature of the Organisation Mentor (Dissertation)

Date: 24/05/2019
Place: Unicare Heart Institute, Surat

Unicare Heart Institute & Research Center
ACME Plaza, B-Wing, 1st Floor,
Near Sosyo Circle,
Behind New Civil Hospital,
Canal Road, SURAT-395002.

ACKNOWLEDGEMENT

Any attempt at any level cannot be satisfactorily completed without the support and guidance of learned people. I owe a great debt to all the professionals at Unicare Hospital, Surat for sharing generously their knowledge and time, which inspired me to do my best during my summer training.

I would like to express my immense gratitude to **Director** of Unicare Heart Institute **Dr. Devang Desai** for providing support and guidance for learning in hospital and for directing the thoughts, goals and objectives towards the attitude that drives to achieve and other aspects that one as novice needs to be acquainted with. I express my heartfelt gratitude to him for providing me with valuable information and an opportunity for working in his hospital. I would sincerely like to thank him for his immense guidance.

Also I would also like to express my gratitude t for being helpful and guiding me throughout my training and answering the queries that came along the way.

I am glad to acknowledge **Dr Pradeep Panda, Dean(Academic & Student Affairs)** and **Dr.Nitish Dogra (Mentor), IIHMR** for incorporating right attitude in me towards learning and for helping and supporting whenever required. I am grateful to them for giving me an opportunity to learn administrative tricks and styles, so that I come to know how a hospital caters their patients successfully and how a hospital gives quality treatment to patients.

TABLE OF CONTENTS:

LIST OF FIGURES/ GRAPHS:

LIST OF SYMBOL & ABBREVIATION

1. IPD- In Patient Department
2. NABH- National Accreditation Board for Hospitals & Healthcare Providers
3. ICU-Intensive Care Unit
4. CCU- Critical Care Unit
5. CTVS- Cardio Thoracic Vascular Surgery
6. IT-Information Technology
7. HDU – High Dependency Unit
8. OPD-Out Patient Department
9. HAI- Hospital Acquired Infection
10. Doc's IA- Doctor's Initial Assessment
11. Nursing IA- Nursing Initial Assessment
12. NA-Not Applicable
13. Doc's CP- Doctor's Care Plan
14. Nursing CP- Nursing Care Plan
15. MRD- Medical Record Department
16. HIS – Hospital Information System
17. LAMA – Leave against medical advice
18. PC – Partially Complete

About UNICARE

Unicare Heart Institute and Research Center, managed by South Gujarat Cardiac Care Pvt. Ltd. is a joint venture of Sona Cardiac Care and South Gujarat Cardiology Pvt. Ltd.. Unicare Heart Institute and Research Center is committed to provide 24x7 gold standard service to the people of Surat. Beside the state of the art cathalab, the hospital has the facility of ICU for critical cases, high dependency unit for observation of less critical cases, VIP and Deluxe Rooms as well as general ward beds. The hospital has also provision of echo cardiogram, colour Doppler, Stress Test, Pathology Laboratory, Pharmacy, X-Ray and CT Scan facilities-all under one roof round the clock. The hospital also provides the cardiac rehab services. The provision of well equipped cardiac operation theatre and cardiac ambulance is also made. The entire Unicare Hospital is centrally air conditioned.

VISION

It is an endeavour of Unicare Heart Institute and Research Center to develop Surat as a world class medical centre of excellence along with a leading destination for medical tourism in the country. And this upcoming venture Unicare Heart Institute and Research Centre will pave the way for further growth of cardiology care services in the region and provide a gold standard healthcare quality of care to best serve the patients.

MISSION

South Gujarat Cardiac Care Pvt. Ltd.- A venture of South Gujarat Cardiology Pvt. Ltd. & Sona Cardiac Care is committed to offer comprehensive cardiac care services with sensitivity, care, concern for people and professionalism.

CHAPTER 1: INTRODUCTION

Reviewing Patient Medical Documentation as Means to Enhance Patient Safety as per NABH 4th edition standards

INTRODUCTION:

Patient safety is a discipline that emphasizes safety in health care through the prevention, reduction, reporting, and analysis of medical error that often leads to adverse effects. Audit as such is the evaluation of data, documents and resources to check performance of systems so that they meet the specified standards. It is a tool to reveal what is being done at present, and is often then compared with what has been done earlier, or what is the intention to achieve in the future. There is a process followed for the accreditation which leads to the development of various check lists which are standardized. These check-lists form the back-bone for establishing standardized processes in a healthcare organization for ensuring patient safety. The accreditation leaves enough scope for adjustments which can be made with regards to the requirements of Patient Safety as per the facilities existing in an organization.

While being in these areas, a patient may be exposed to various risks which can

affect their safety due to the medical treatment itself or otherwise. The reason for the risk to the patient can be the human error, faulty procedure or malfunction of equipment/facility. Hence the total concept of healthcare has undergone paradigm change to cater for all aspects which affects the patient care. This has led to emergence of standardization in the processes for the safety of a patient. one of the simplest meeting ground for achievement of the Patient Safety Goals can be through the maintenance of **Patient Medical Documentation based on standardization.**

Summary of Standards

IMS 1: Documented policies and procedures exist to meet the information needs of the care providers, management of the organisation as well as other agencies that require data and information from the organisation.

IMS 2: The organisation has processes in place for effective control and management of data.

IMS 3: The organisation has a complete and accurate medical record for every patient.

IMS 4: The medical record reflects continuity of care.

IMS 5: Documented policies and procedures are in place for maintaining confidentiality, integrity and security of records, data and information.

IMS 6: Documented policies and procedures exist for retention time of records, data and information.

IMS 7: The organisation regularly carries out review of medical records.

The process of evolution of the medical documentation in any hospital used to be

based on the past experience of the healthcare organizations. However, these days this uncertain and uneven process of self learning has been replaced by taking the assistance of the accreditation processes which have evolved in the developed countries. In the developed West the accreditation in healthcare started in 1990‘s whereas in our country this was set in motion by establishment of NABH in 2006. There is a process followed for the accreditation which leads to the development of various check lists which are standardized. These check-lists form the back-bone for establishing standardized processes in a healthcare organization for ensuring patient safety. The accreditation leaves enough scope for adjustments which can be made with regards to the requirements of Patient Safety as per the facilities existing in an organization. These adjustments can be made by matching of the existing facilities with the vision/mission statements of the healthcare organization and the laying down of a suitable patient safety definition and the patient safety goals.

There has to be mechanism developed to continuously assess the patient safety parameters, however, in an upcoming accredited healthcare setup, the criteria for comparison may not be available. The past data required may not provide adequate inputs for evaluation which can assist in arriving at logical conclusions regarding the Patient Safety. In such cases, a lot of supervision is required over the processes which are being established so that a professional culture evolves in the outfit. As such, if the healthcare organization is accredited then the processes are followed as per the documented Standard Operating Procedures and every aspect is required to be documented. Hence, if proper Patient Medical Documentation is maintained in an accredited hospital, then its audit itself can act

as one of the indicators for the management to assess continued maintenance of the standards of patient safety.

Medical records department has become an essential department of every hospital. The information from the medical records department can be utilized for monitoring and controlling the quality of patient care, in assessing the performance of the medical staff, in assessing the utilization of the hospital resources and in compiling data for research purposes.

Medical record is personal document and there are many ethical and legal issues surrounding them such as third-party access and appropriate storage and disposal. The maintenance of complete and accurate medical records is a requirement of health care providers. The medical record serves as the central repository for planning patient care and documenting communication among patient and health care provider and professionals contributing to the patient's care. An increasing purpose of the medical record is to ensure documentation of compliance with institutional, professional or governmental regulation.

The **medical record is both an indicator of the quality of care, and a means of improving this quality**. In addition to being a source of information and a means of communication in the care of patients, the medical record is also becoming a document of increasing legal importance.

Figure 1.1 : The Steps of Medical Audit

CHAPTER 2: REVIEW OF LITERATURE

To achieve the goals of patient safety the healthcare organizations should understand why people make errors and in so doing, it must learn from the experiences of developed world without just adopting the accreditation. One must learn from the evolution of the process of patient safety and bring in the conviction of following the norms set in by the standardization. It will be akin to upgrading equipment along with the transfer of technology. Hence, to arrive at the very basics of patient safety, the following stages can be identified from the evolution process of patient safety in the developed
countries:

(a) **Limiting Blame**. The traditional approach assumed that well-trained, conscientious practitioners do not make errors and equated error with

incompetence and regarded punishment as both appropriate and effective in motivating individuals to be more careful. This led to practitioners rarely revealing mistakes, and patients and supervisors were frequently kept in the dark. Low reporting made learning from errors nearly impossible, and legal counsel often supported and encouraged this approach in order to minimize the risk of malpractice litigation. Thinking began to change in the 1990s in response to several kinds of new information.

(b) **Systems Thinking**. This involves reduction of mistakes through design features, standardization and simplification.

(c) **Transparency and Learning**. The idea that adverse events could yield information was applied in health care. Specialists on the subject emphasized that more the error related information was disseminated and shared, better lessons could be implemented all around.

(d) **Culture and Professionalism.** People involved with health care delivery organizations were increasingly encouraged to think in terms of building high-reliability organizations. It involved a culture change and bringing in high level of professionalism wherein the clinicians could disclose all relevant facts to injured parties.

(e) **Accountability for Delivering Effective, Safe Care**. Importance of litigation to prevent ill behaviour and individual accountability for actions and procedures linked to adverse outcomes became embedded in both medicine and law of torts.

(f) Medical field began to establish methods for accountability as the treatments became more effective. Scientific methods were essential in that development, and medical profession has adhered to it.

(g) Due to developments of highly effective and safer health care delivery systems

which commenced focusing on hospitals, standards for these health care delivery systems were understood to be necessary and hence certification of hospitals and other health care delivery systems followed.

(h) Recent realization that health care delivery system and its components also needed to be accountable for learning from errors was harder to tackle. Steps were taken to reform and bring in institutional accountability for safe practices.

Patient Medical Record

Before looking at specific role of medical documentation with respect to patient safety, we need to discuss about the medical record, what it is, how it develops and why it is so important. The medical record is an important compilation of facts about a

patient‘s life and health. It includes documented data on past and present illnesses and treatment written by health care professionals caring for the patient. The medical record must contain sufficient data to identify the patient, support the diagnosis or reason for attendance at the health care facility, justify the treatment and accurately document the results of that treatment.

The **medical record** has four major sections:

(a) **Administrative,** which includes demographic and socioeconomic data such

as the name of the patient (identification), sex, date of birth, place of birth, patient‘s permanent address, and medical record number;

(b) **Legal data** including a signed consent for treatment by appointed doctors and authorization for the release of information;

(c) **Financial data** relating to the payment of fees for medical services and hospital accommodation; and

(d) **Clinical data** on the patient whether admitted to the hospital or treated as an outpatient or an emergency patient.

CHAPTER 3: METHODOLOGY

Methodology of Data Collection:

(a) **Study Area**. The study was carried-out in a cardiac hospital, Unicare Heart Institute, Surat

(b) **Study Design**. Descriptive Cross sectional study design.

(c) **Study Period**. 01 Feb to 30 May 2019.

(d) **Study Population**. Patient Medical Documents in Medical record department were utilized.

(e) **Sample Size**. . A sample of 530 patient medical documents was audited for the study.10 medical documents were selected per month from January 2015 to May 2019.

(f) **Study Tool**. Existing Patient Medical Record Checklist was utilized.

(g) **Sampling Technique**. Purposive Sampling Technique was used.

Procedure.

To have an initial understanding about the Patient Medical Documentation, a checklist was prepared after going through the NABH Guidelines. It was analyzed for the medical aspects.The existing Audit of Patient Medication Documentation of the hospital. Since the MRD Section is the most complete part of any hospital which requires maintenance of all types of Patient Medical Documentation, the data was collected from MRD Section of the hospital. The department selected was basically the one wherein the documentation covers the complete array of medical documentation. Patient files in MRD, Medical Documentation was scrutinized for meeting the Patient Safety requirements and simultaneously understanding how the Quality standards are maintained through Continuous Service Evaluation Methodology. This data was shared with the authorities concerned to be able to reflect upon the areas of improvement with respect to documentation. Simultaneously, the data was compiled for collective analysis of the data.

The Patient Medical Documents were scrutinized as applicable for the following parameters:

1. Discharge Summary
2. CAG –Report
   Diagram
3. PTCA- Report
   Post PTCA order form
   Medical Consumption Report
4. CABG- Report
   Graft Diagram

Operative notes

5. Anaesthesia Chart
6. Consent Form –Consent for admission

   Normal Procedure Consent

   High risk consent

7. Medical Management
8. Physiotheraphy chart
9. Pre CAG/PTCA/CABG Checklist
10. ECG report copy with respective dates
11. 2D Echo report
12. X-Ray report
13. Laboratory reports
14. Pharmacy bills (photocopy)
15. Consumable bills (photocopy)
16. Investigation report sheet
17. Indoor case paper
18. Doctor's observation sheet
19. Treatment sheet- Pharmacy dosages

    STAT drug

20. Patient admission assessment form by nursing
21. Daily intake/output chart
22. Observation sheet- Hourly observation

    Nursing observation

    Nursing during &after procedure

23. Green data sheet

Medical Records

UNICARE CARDIAC INSTITUTE & RESEARCH CENTRE

Name:-		IPD No.	CATH-LAB No.	

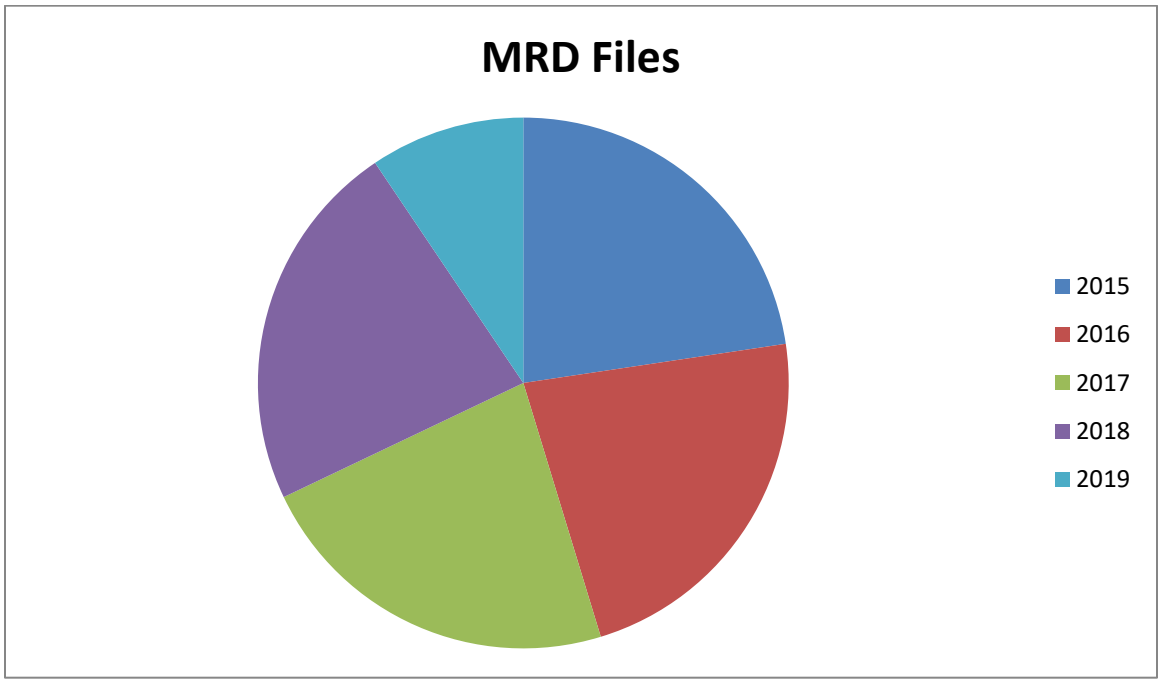
Sr. No.	Details		Data Filled	Date	Name	Sign.	Yes/No
1	All Bills with Receipts (Photocopy)						
2	Discharge Summery						
3	CAG	Report					
		Diagram					
4	PTCA	Report					
		Post PTCA Order Form					
		Sticker's Photocopy					
		Medical Consumption Report					
5	CABG	Report					
		Graft Diagram					
		Operative Notes					
6	Anaesthesia Chart						
7	Consent Form	Consent for Admission					
		Normal Procedure Consent					
		High Risk Consent					
8	Medical Management						
9	Physiotherapy Chart						
10	Pre CAG/PTCA/CABG Check List						
11	ECG Report copy with respective dates						
12	2D Echo Report						
13	X-Ray Report						
14	Laboratory Reports as per DATA CARD						
15	Pharmacy Bills' (Photocopy)						
16	Consumable Bills' (Photocopy)						
17	Investigation Report Sheet						
18	Indoor Case Paper						
19	Doctor's Observation Sheet						
20	Treatment Sheet of	Pharmacy Dosages					
		STAT Drug					
21	Patient Admission Assesment Form by Nursing						
22	Daily Intake / Output Chart						
23	Observation Sheet	Hourly Observation					
		Nursing Observation					
		Nursing During & After Procedure					
24	Green Data Sheet						

Checked By :-		Signature:-	
Date :-			
Remarks:-			

CHAPTER 4: OBSERVATIONS AND ANALYSIS

A total of 530 patient medical documents was audited for the study.10 medical documents were selected per month from January 2015 to May 2019 .

Figure 5.1: Total Medical Record Files Audited



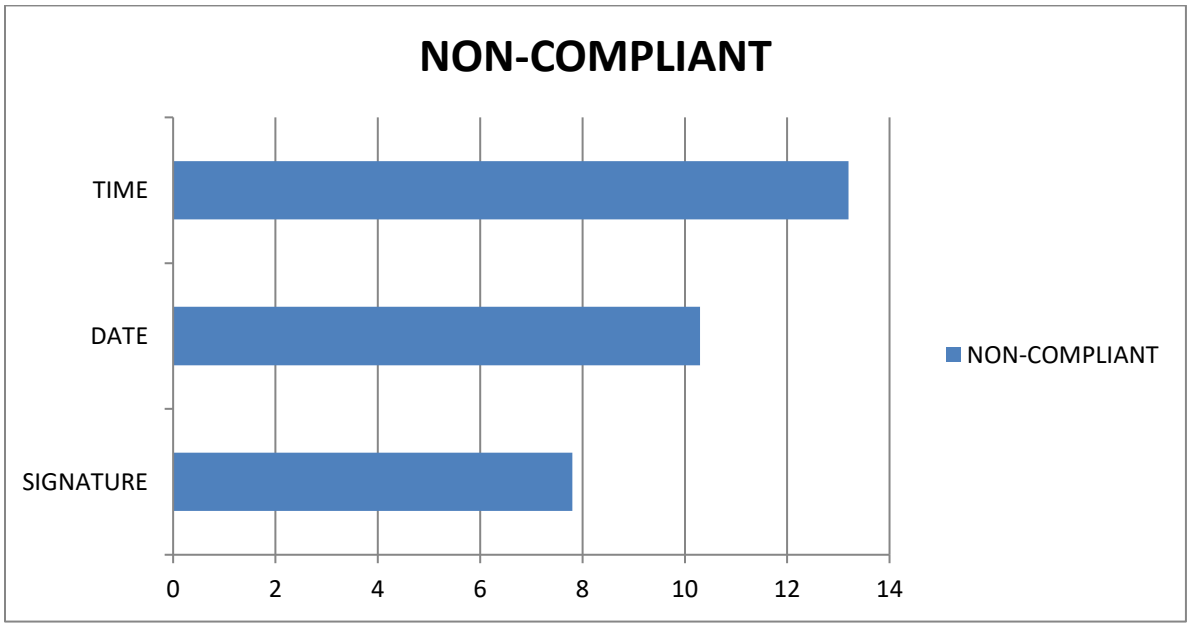
Initial Assessment Form: All the files had initial assessment form. Of the entire form, some were partially filled. The details are as under:

Table 5.2: Indoor Assessment Form

Indoor Assessment Form	Quantity	Percentage
Compliance	364	68.6
Non-Compliance	166	31.3

FIGURE 5.2: Indoor Assessment Form

FIGURE 5.3: SIGNATURE, DATE AND TIME ON IP INITIAL ASSESSMENT FORM



Nursing Observation Sheet:

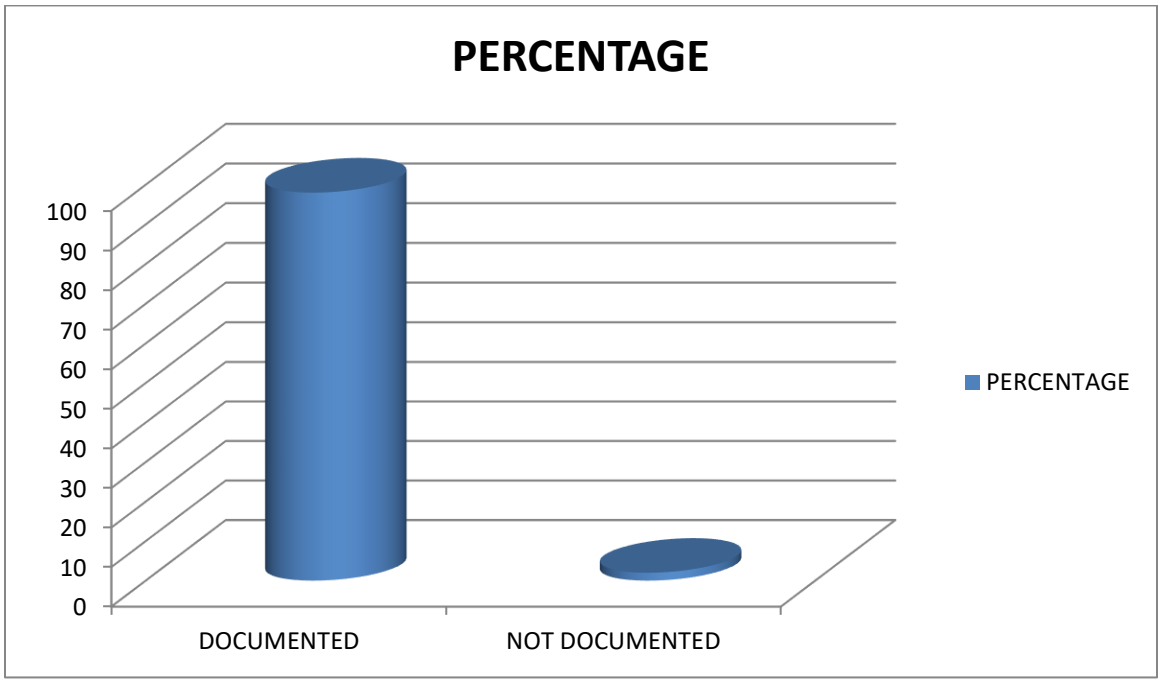
98.0% of the documents have been documented.The general documenting deficiencies noticed in the documentation are as follows:

(a) The column of “Handed Over To” has not been signed in certain documents.

(b) The date and timings were not written clearly.

(c) The entries which are not relevant should be scored out or endorsed with a remark “NA” and not left blank as was done in a few documents.

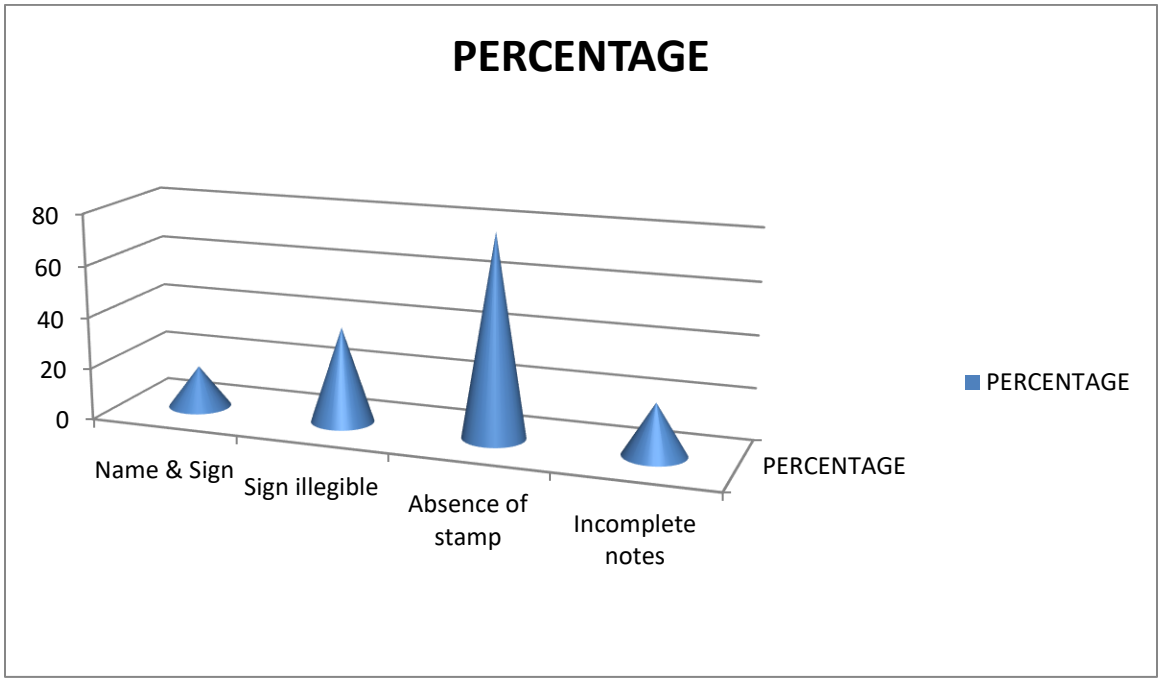
Figure 5.4: Nursing Initial Assessment



Doctor's observation sheet:

- Name & Signature of consultant was not endorsed in 16% of admission request form thereby making the subsequent assessment difficult.
- 37 % of the signatures of doctor are not legible in Doctors Note.
- In the absence of use of stamps by 78 % of the doctor's .
- 20% Doctor's note are incompletely filled and also usage of a lot of abbreviation.

Figure 5.5 Doctor's observation Sheet



As per NABH requirements too, following needs to be followed:

(a) The endorsement by the Consultant at least once in a day.

(b) The use of personal stamp of the doctor along with the signatures.

Treatment sheet- Pharmacy dosages & STAT drug

Treatment sheet is made as per NABH standards to root out all the reasons for adverse drug event. The results of the audit are as under:

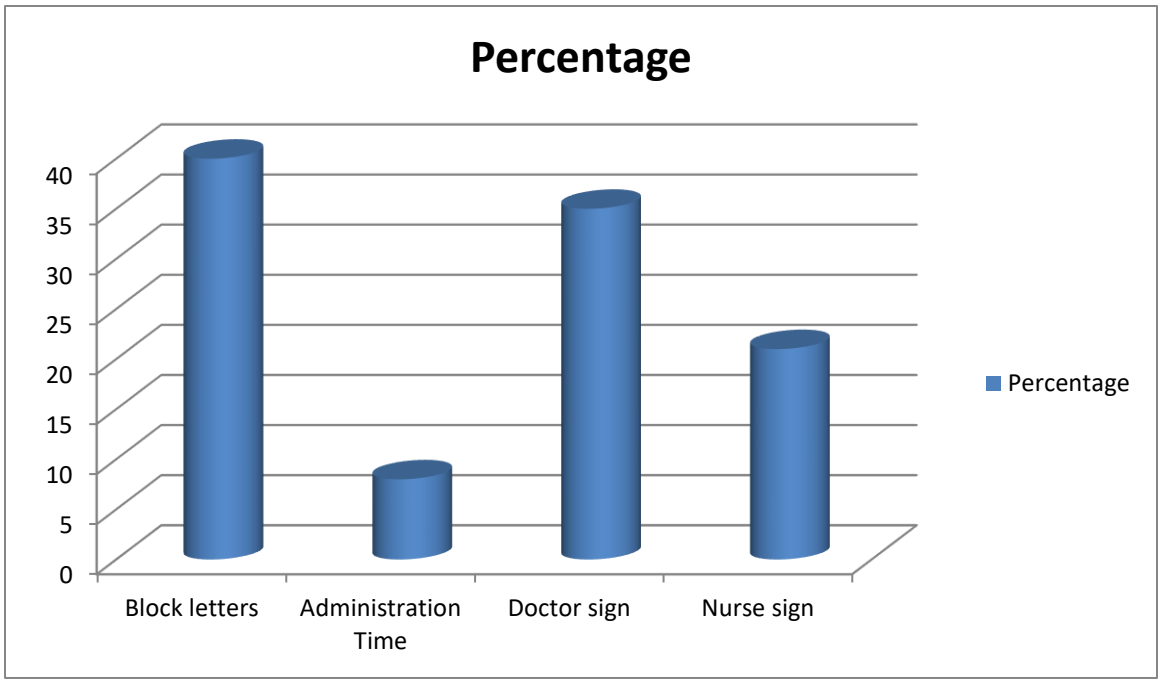
(a) Prescription of Medication in BLOCK LETTERS has not been done in 40 % of Medication Administration Charts

(b)Time of administration of medication is not mentioned in 8 % of the Charts

(c)The signature of doctor is not legible in 35% of Medication Administration Charts.

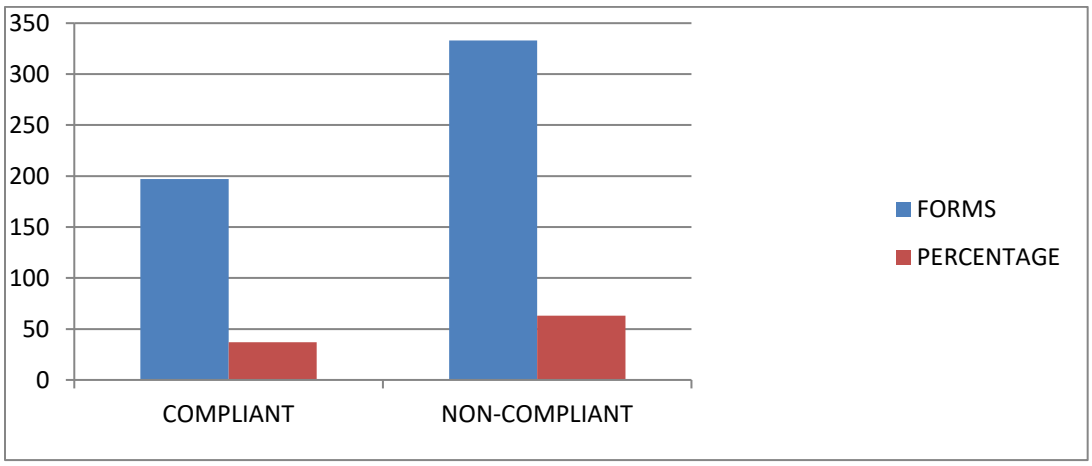
(d)Nursing signatures are not present in 21% of medication chart.

FIGURE 5.6 Treatment sheet- Pharmacy dosages & STAT drug



General Consent Form. All the medical records had general consent form. However it was noted that 63% of them did not have the details and signature of witness.

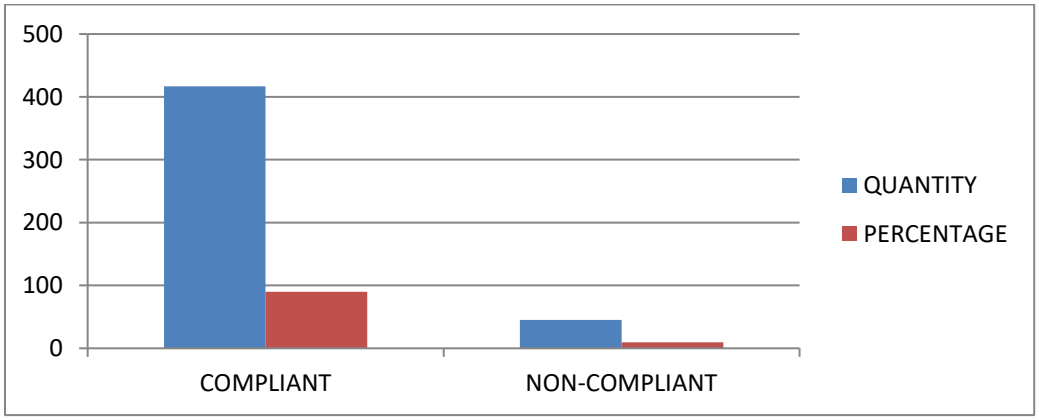
FIGURE 5.7 : General Consent Form



Procedure Consent Form. There were a total of 462 medical records with procedure consent. Of these, 417 were completely filled and rest had few deficiencies like:

- Witness sign was missing.
- Time was not mentioned in form.

FIGURE 5.8 : Procedure Consent Form

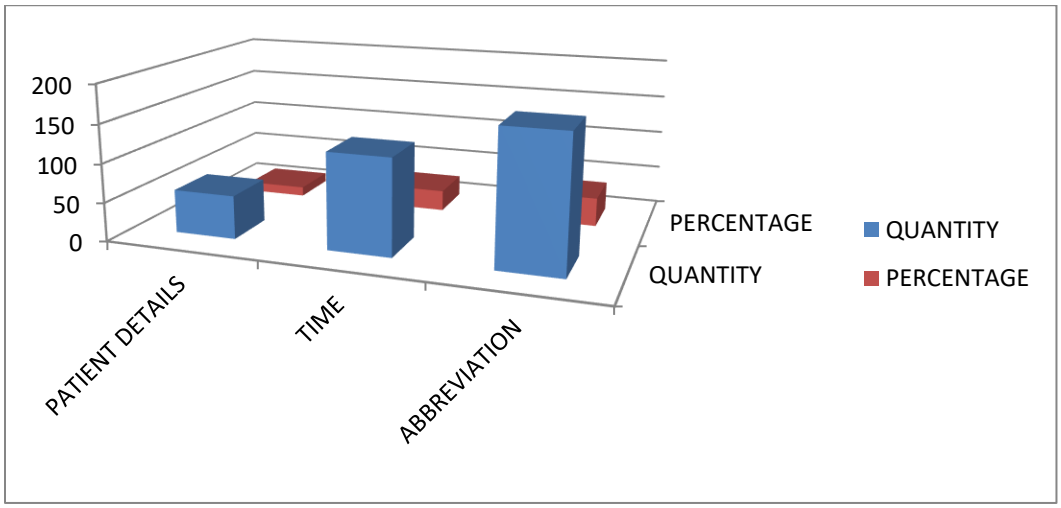


CAG –Report & Diagram

Of the total of 462 procedure files all had report and diagram but there were few deficiencies like:

- Patient full details like age, cath no were not filled in 56 forms
- Time was not mentioned in 124 forms.
- Many abbreviations were used on reports- 172 forms

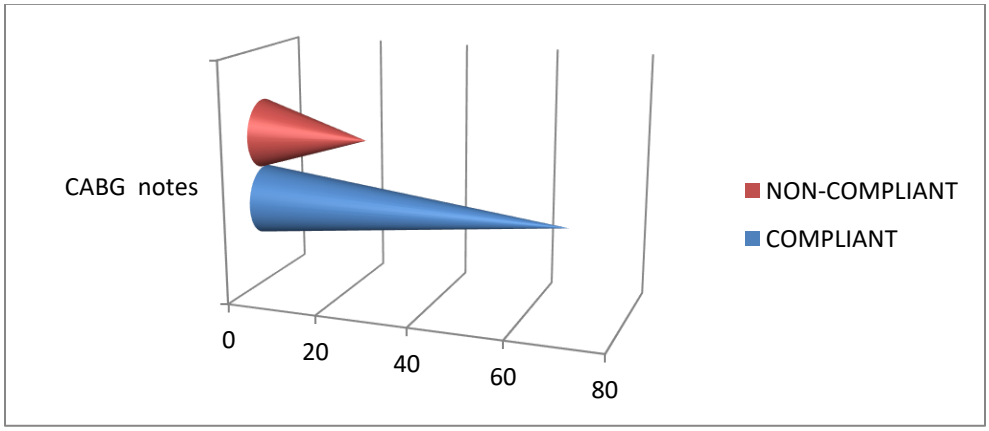
Figure 5.9: CAG- report



CABG Surgery & Post Surgery Notes. All 92 surgical cases had surgery and post surgery notes. However 24 of the notes were not complete in all respects as per the checklist developed for audit. Few deficiencies noted are:

- Without the name and signature of the Surgeon,
- Partially filled post operative checklist.

Figure 5.10: CABG surgery



CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

Medical Record Department is responsible to keep all the completed patient's records into its custody. The department staff is responsible for accurately arranging the medical record files according to the category of the patient's records. Smooth retrieval of the data in the time of need is also the responsibility of the patient.

1. Accuracy of the medical record:

- Each medical record should have the IPD number of its own.
- In the time of preparation of medical record file, time, date, patient's name must be written on it.
- Other than the authorized personnel, patient's file must not be accessible to every one.
- All the patients' documents should be attached in the file.
- A checklist must be made by the hospital authority, which shows the possible documents should be there within the file.
- After patient's discharge, the authorized person must complete the medical record file as per the checklist.
- Within the medical record department, the medical record files must be segregated and kept separately as OPD Record, IPD Record, and MLC record, death
- The MRD staff about the completeness of the medical ercord must do rechecking.
- Disciplinary action must be taken against the staff, who did not complete the medical record before dispatching the file to the MRD.
- Medical record of the patients must be arranged in a chronological order.

2. Components of medical records:

- Reasons for admission, diagnosis and plan of care of the patient.

- Detail information about operative and other procedures performed on the patient.
- Date of transfer, reasons for transfer and name of the receiving hospital if the patient is transferred to other hospital.
- A copy of discharge summary, signed by the authorized and qualified person.
- A death certificate, in case patient died in the hospital.
- A copy of clinical autopsy report performed on the dead patient.
- A copy of medications used by the patient during hospitalization.
- Duties performed by nurses on the patient during patient's hospitalization with date and time in the nurse's reports.
- Diet chart prepared by the dietitian for the patient during the period of hospitalization.

3. Confidentiality of the medical records:

- Medical record of the patient must not be the easy access to the outside persons other than the authorized hospital personnel.
- A doctor cannot share patients' records until it is absolute necessary like
  - ❖ Court order
  - ❖ Consulting with other physician for treatment
  - ❖ When the records of the patients is the need of the common public.
  - ❖ With patient's consent
- Computerization of the patient's records which, ensures the confidentiality, security and integrity of the patient's data.
- Any non-adherence of the confidentiality policy, a disciplinary action makes by the hospital against the guilty person.

4. Retention of medical records:

- Retention policy of medical records in the hospital is depending upon the types of medical records. As per the rules-

- OPD Records-5 years
- IPD Records-7 yrs
- MLC Life time
- Death Life Time

5. Disposal of Medical Records

- At the end of Calendar year, a list of IP No. is taken based on the Admission date before 5 years (MLC and death Files not included in the list).The list contains IPD NO, patient name and admission date. This list is sent to Medical Director/Chief Operating Officer for Verification and Signature of consent for disposal of Medical Records
- Public Notification i.e advertisement is provided in newspaper after consent for disposal of medical records is obtained. After receiving the consent all the case-file should be sent for shredding.

RECOMMENDATIONS:

- The medical records shall be reviewed and audited periodically and used as a tool for quality improvement of clinical services. A medical audit committee is composed for this who shall audit the records on monthly basis.
- Appropriate sample of the medical records shall be selected for audit. The sample should be based on statistical principles and representative of all records. Adequate mix of active and discharge cases shall be kept in sample
- The medical audit findings shall be kept confidential and circulated only to the care providers.
- Physicians anonymity shall be maintained in medical audits
- Based on the findings in medical audit, committee shall take appropriate corrective and preventive actions.

TABLE 6.1: Description

S. No.	Activity	Responsibilities
1.	To conduct the medical audit once a six months	Director
2.	To decide the number of files to be audited (Sample size) based upon following statistical process • Population size = Total patient treated or are being treated as in-patients in last one month • Sample size = 5 % of the population size (at least one file from each specialty shall be included) • Systematic random selection: Through computer generated random numbers (selection on basis of IP numbers)	Director Administrator
3.	Sample selection and stratification • Files of all the cases with death discharges (Not to be included in sample size) • Files of all cases who underwent an adverse clinical event during the stay (Not be included in sample size) • 25% - Active files, 75% - Discharged files • At least 1 file from every specialty shall be included	Director Administrator
4.	No. of files in sample size is to be randomly selected and retrieved from MRD, and from inpatient areas in case of active files	Members
5.	The files selected for audit shall be equally distributed to members of the committee or other consultants. Decision for distribution shall lie with Director. No auditors are allowed to audit their own cases.	Director

6.	The audit checklist shall be distributed amongst members who have to audit the records	Members
7.	Composition of audit team may be altered at the discretion of the Director to allow fair representation to all consultants	Director
8.	The files to be audited as per the checklist and as per their own understanding of the case and medical practice	Members
9.	Following points shall also be checked during review • Completion of various components of medical files, i.e. whether all entries are made and all necessary forms are attached in the records • Proper endorsement of name, date, time and sign of the person who made entries • Legibility of the entries • Adequacy and fulfillment of minimum requirements of assessment notes as per the subjective, objective, assessment and plan (SOAP) note methodology.	Members
10.	Complete the medical audit checklist and write your remarks. Be elaborative while writing the audit observation. Justified and adequacy of treatment should be focused while auditing	Members
11.	Call the meeting of committee, to discuss the findings of audit and corrective/preventive measures.	Director
12.	Each member shall present his/her audit findings in committee meetings. Based on this committee shall discuss and decide preventive actions or quality improvement actions	Members Director Administrator

	Anonymity of the clinicians shall be maintained while presenting the audit findings	
13.	If all audit presentation cannot be completed, call for a second meeting. Do not compromise the functioning for time shortage	Director, Members
14.	Major findings of the audits of each case, brief description of the discussions and decision taken shall be recorded in minutes of meeting format	HR manager
15.	The minutes of meeting shall be reviewed and approved by Director before circulation	Director Administrator
16.	Minutes shall be circulated to all the consultants and to medical director. The minutes shall be kept confidential and should not be revealed to any other	All members
17.	Completed checklist and a copy of the minute shall be kept in committee file as record	HR manager
18.	A repeat meeting shall be called to monitor and to discuss the action taken on decisions	Director

CHAPTER 6: CONCLUSION

The shifting of gears in the private healthcare sector in our country to woo business from developed countries has led to abrupt adaptation of the accreditation standards which were evolved in the developed countries after due research. This has led to an accreditation system in healthcare sector in our country which is not evolved indigenously and is largely based on the developed countries. Nevertheless, the accreditation has by and large led to the standardization of medical care in our country also. The way to the accreditation is through following standardized procedures which are implemented by evolving various forms and documents. These documents are subjected to internal and external audit as per accreditation guidelines. However, the purpose of the documentation should be Patient Safety and physician defensibility rather than being just be guided by the requirement of accreditation and legal framework only. After the study, it has emerged that the internal audit of the Patient Medical Documentation can assist in positively influencing the behavior of the doctors and nurses towards documentation and hence patient safety and physician defensibility in a hospital.This type of internal audit of the Patient Medical Documentation should be strengthened to bring back the focus of a hospital to patient safety which otherwise has shifted to the completion of documents from the point of view of fulfilling the legal requirement only.

1.To retrospectively evaluate clinician's conformance to the norms and standards of the modern medical practice
2.To aid in improving quality of clinical care by highlighting opportunities for improvement

Different departments shall be given access to required module and the system shall be secured by assigning individual password

Medical records shall be kept under supervision of authorized personnel like Medical supervisor to ensure security and confidentiality

Audits shall be conducted at periodic intervals to check for effective management of data.

Policy and procedure documents, if stored electronically shall be subject to security, confidentiality and integrity of information.

Medical records are confidential documents and shall be kept confidential. Any request for access to information in medical records shall be duly scrutinized for proper and legal selection.

The physical form of medical records is the property of the hospital and the information contained within it is the property of patient.

Information in the medical record shall be accessible only to following as per law

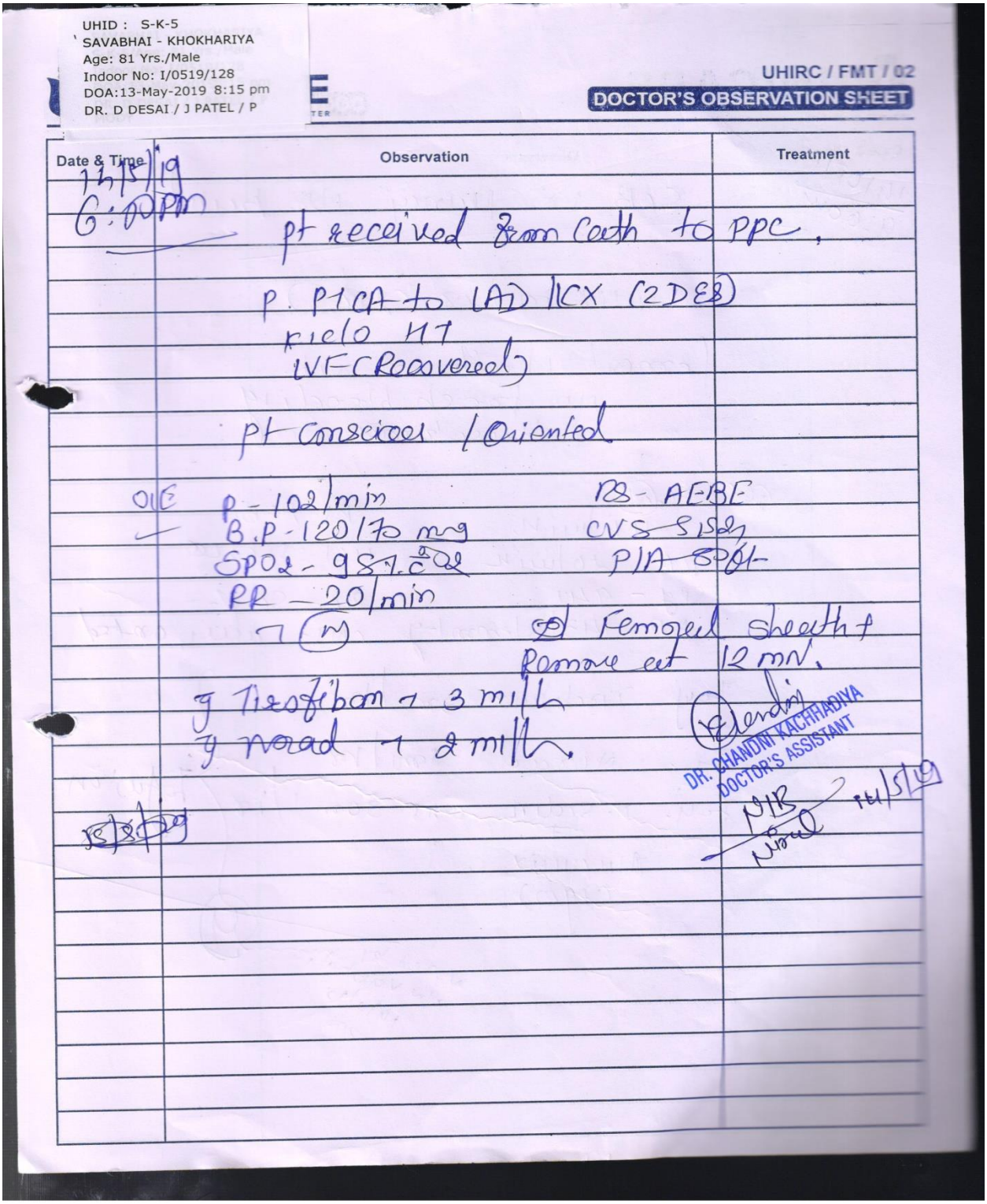
1. To the patient
2. To the healthcare provider who are directly involved in provision of care to the patient
3. To the court of law if asked for
4. To third party payer
5. To any other person only after valid consent from the patient

BIBLIOGRAPHY / REFERENCES

- National Accreditation Board for Hospitals and Healthcare Providers (NABH), Accreditation Standards for Hospitals, 4th Edition
- Dr. Steevens Hospital, Dublin, A Practical Guide to Clinical Audit, Quality and Patient Safety Directorate, , 2013
- Medical Records Department Operations Policy (2010),
- Medical Records Manual: A Guide for Developing Countries, ISBN 92 9061 005 0 © World Health Organization 2002, updated 2006
- National Accreditation Board for Hospitals and Healthcare Providers (NABH), Accreditation Standards for Hospitals, 3rd Edition
- Quality Council of India, National Accreditation Board for Hospitals and Healthcare Providers, Standards for Hospital, 1st Edition 2005
- MRD Protocol, www.mgri.ac.in/pdf

APPENDIX:

DOCTOR' OBSERVATION SHEET



UHID : S-K-5
SAVABHAI - KHOKHARIYA
Age: 81 Yrs./Male
Indoor No: I/0519/128
DOA:13-May-2019 8:15 pm
DR. D DESAI / J PATEL / P

UHIRC / FMT / 02
DOCTOR'S OBSERVATION SHEET

Date & Time	Observation	Treatment
14/5/19 6:00 PM	pt received from cath to PPC.	
	P. P1CA to LAD |CX (2DES)	
	Rt clo HT	
	LVF (Recovered)	
	pt Conscious / Oriented	
O/E	P - 102/min	RS - AE-BE
	B.P - 120/70 mm	CVS - S1S2
	SpO2 - 98% @ 2L	P/A - SOFT
	RR - 20/min	
	(N)	② Femoral sheath removed at 12 mn.
	① Tirofiban @ 3 ml/h	
	② Nicad @ 2 ml/h.	
15/5/19		Chandini DR. CHANDINI KACHHADIYA DOCTOR'S ASSISTANT
		MB Nicad 14/5/19

Date: 06-04-2019 01:25 PM
Lat: 21.1762349 Long: 72.8257934

UHIRC / FMT/ 10

UNICARE
HEART INSTITUTE & RESEARCH CENTER

NURSE'S OBSERVATION SHEET

IDENTIFICATION

THAKORBHAI HIRABHAI PAT
THP-1/Age: 68 Yrs./Male
Indoor No: I/0419/64
DOA:05-Apr-20195:59 pm
DR. D. DESAI / DR. J. PATEL
DR. P. MODY

Name of Patient : ____ Age/Sex ____ IP No. ____
Category : PPC ...: 203 Doctor's Name : Dr. D. Desai
Diagnosis : ____ Assigned Nurse : Tinkal NAME:

Date & Time	Observations	Signature
5/4/19 6PM	Pt came from Janak hospital, Vyara, c/o chest pain, vein flow positive present over left & Right hand, Inj- Norad 2 ml/hr running, PTS ECG taken, RBS checked, monitor attached, BP - 77/59 mmHg, Inj Norad 4ml/hr IV started, Inj - 0.45 NS 20ml/hr IV started, consent done for TPI, preparation done	S/N Tinkal
	Pt had vomiting, Inj- Perinorm 1 amp IV stat given, Blood sample collected & send for CAG profile at concept lab, valuable Handover to relative, consent taken for HIV test, Hi-RISK consent taken,	S/N Tinkal
5/4/19 6:45 pm	Pt shifted to cathlab, Handover given to cathlab staff c file	S/N Tinkal
5/4/19 6:50 pm	Pt Received from PPL in cue for CAG + TPI by Dr. D. Desai pt is conscious and oriented, Pulse present at left hand peripheral pulse present	Alesh
5/4/19 6:52 pm	Procedure CAG + TPI started 6F arterial and venous sheath inserted via RFA RFV no sign of hematoma and bleeding	Alesh
5/4/19 7:00 pm	Procedure CAG + TPI over 6F arterial sheath present via RFA RFV no sign of hematoma and bleeding	Alesh
5/4/19 7:10 pm	6F arterial sheath suture done and dressing done pt shifted to ... Hand over given to on duty staff	Alesh

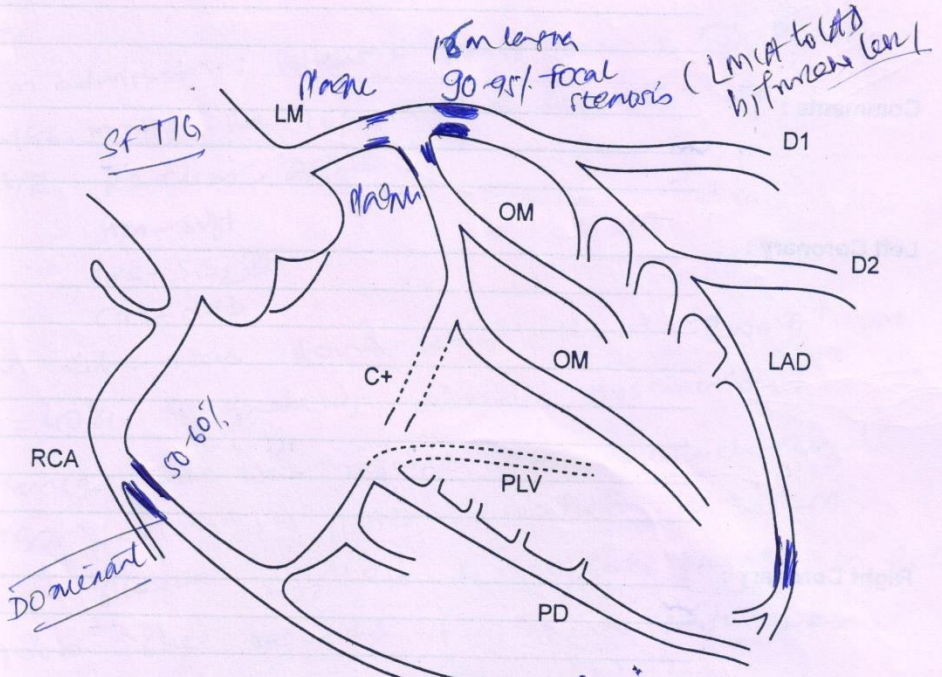
UNICARE
HEART INSTITUTE & RESEARCH CENTER

UHIRC / FMT / 13

REPORT OF CORONARY ARTERIOGRAPHY

UHID : SCP-1
SHANTABEN CHHIBABHAI PAT
Age: 59 Yrs./Female
Indoor No: I/0519/94
DOA:10-May-2019 7:50 pm
DR. D DESAI / J PATEL / P

TIME:
Date : 11/5/19
Cath No.: 12789



ACS, UA. critical LAD lesion.
Adv. - PTCA to LAD [1 DES]
16 mm length
Ostial, Bifurcation lesion

Ref - Echo correlation

Ao-P
LV-P
LVED-P
CO

Dr. Devang Desai
Interventional Cardiologist
DM(Cardiology), M.D.(Med)
FSCI (India), FSCAI (USA) FACC (USA)
Reg. No. G-17060 (MBBS)/G-5005 (MD)

UHIRC / FMT / 30

UNICARE
HEART INSTITUTE & RESEARCH CENTER

CONSENT TO SURGICAL OPERATIONS AND OTHER PROCEDURES

Acme Plaza, B-Wing, Near Sosyo Circle, Next to Unique Hos...
Phone : 0261-2639200/9700/9800, E-mail : unicare...

UHID : SSS-2
SALIM S SHEKH
Age: 55 Yrs./Male
Indoor No: I/0519/175
DOA:18-May-2019 12:54 pm
DR. D DESAI / J PATEL / P

Admitting Consultant : Dr. D Desai	Name
Consultant Performing Procedures : Dr. D Desai	Age/Sex
	Category PPC Floor 2nd
Date : 18-5-19	Bed No. 203

1) I authorise to perform upon ____________ for
(Myself or name of Patient)

the following procedure (s) For CAG F CAG

under the direction of Dr. / Team of Doctors Dr. D. Desai
(Name of Doctor)

2) The doctor has fully explained to me the kind of procedure in detail that he / she will perform and has answered my questions about my condition and the procedure to my satisfaction. The doctor has also explained the risks involved in the procedure and I understand these risks and am willing to undergo the procedure. This I consent to my own free act and will.

3) The doctor has also explained other alternate methods of treatment to me and I have decided to undergo the procedure, including the administration of blood products, If necessary, as the best means of trying to correct my condition.

4) I understand that during the course of this procedure the doctor may find other unhealthy conditions in me that may need corrections, which may not have been previously discussed with me. I therefore also authorise the doctor to perform such other procedure which he / she may find necessary to do in order to improve or correct these conditions.

5) The doctor has also explained that, in performing the procedure he / she may use assistants, such as hospital residents or other physicians, Surgeon, Anaesthetists and nurses and he / she has my consent to do so.

6) No guarantee have been given to me by my doctor about the results of the procedure, and I also understand that there are times when more than one procedure may be necessary to complete the treatment of my condition. I also understand that these procedures may be performed over a period of months.

7) I consent to the observing, Photographing or televising of the procedure to be performed, including appropriate portions of my body, for medical, scientific or educational purposes provided my identity is not revealed by the pictures or by descriptive text accompanying them.

8) I consent to the disposal by hospital authorities of any tissues or part that may be removed during the procedure.

9) I also agree to Co-Operate full with my doctor and to follow, to the best of my ability, his / her instruction and recommendations about my care and treatment.

10) This has been explained to Me in my own language and I have understood if fully.

	DOCTOR	PATIENT / PATIENT RELATIVE	RELATION WITH PATIENT	WITNESS
SIGN	[signature]	Parvez	SON	[signature]
NAME	Dr. D Desai	Parvez		[signature]

Date & Time : 18-5-19 at 1pm

REGULAR PRESCRIPTIONS			DRUG CHART SHEET								Drugs Not Administered & Reason
Date			14.5.19		15.5.19						
Time			Checked by	Given by	Checked by	Given by	Checked by	Given by	Checked by	Given by	
7. DRUG (Approved Name): TAB DOLO											
Dose: 650	Route: P/O	Frequency: 1-0-1									
Doctor's Signature: M		Start Date: 14/05									
8. DRUG (Approved Name): TAB MUCOMIX											
Dose: 600	Route: P/O	Frequency: 1-0-1									
Doctor's Signature: M		Start Date: 14/05									
9. DRUG (Approved Name): INJ. LASIX											
Dose: 20mg	Route: IV	Frequency: 1-0-0									
Doctor's Signature: M		Start Date: 14/05									
10. DRUG (Approved Name): RBS (8) hrly											
Dose	Route	Frequency									
Doctor's Signature		Start Date									
11. DRUG (Approved Name): T. MODEP AF											
Dose: 5/50	Route: P/O	Frequency: 1-0-0									
Doctor's Signature: M		Start Date: 15/5									
12. DRUG (Approved Name)											
Dose	Route	Frequency									
Doctor's Signature		Start Date									

Date	Dr. Name	Sign.	Duty Nurse Name				Time
14/5/19	Dr D. Desai	D		Tinkal			8 am to 2 pm
15/5/19	Dr D Desai	D	Vaishali				2 pm to 8 pm
			vaishali				8 pm to 8 am