Summer Internship Report

At

Max Smart Super Speciality Hospital, Saket
(April 22 to June 21 - 2024)

“

“Medical documentation compliance- a review of discharge summary as per NABH standard requirement “ .

A Report

By

Mr. AAKASH KUMAR CHAHAR

PGDM (Hospital and Health Management)

2023-2025

International Institute of Health Management Research, New Delhi

Certificate of Approval

The Summer Internship Project of titled "**"Medical documentation compliance- a review of discharge summary as per NABH standard requirement"** at "**Max Smart Super Speciality Hospital, Saket"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of Post Graduate Diploma in Health and Hospital Management for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed, or conclusion drawn therein but approve the report only for the purpose it is submitted.

Dr. Ratika Samtani

Name of the Mentor

Designation

IIHMR, Delhi

FEEDBACK FORM

(Organization Supervisor)

Name of the Student: Aakash Kumar Chahar

Summer Internship Institution: Max Smart Super Specialty Hospital, Saket, New Delhi

Area of Summer Internship: Medical Quality

Attendance: Aakash is quiet punctual in his conduct.

Objectives met:
Completes all the tasks assigned timely and good at communication & clarifications when required.

Deliverables:
Discharge Summary Project.

Strengths:
Communication, Pro-active approach towards work, Positive attitude, when required can go extra mile for work, Sincere, Data Analysis

Suggestions for Improvement:
Can work on learning structured methodology to approach any task.

Signature of the Officer-in-Charge (Internship)

21/06/24.

Date: 21/06/2024.

Place: New Delhi

FEEDBACK FORM

(IIHMR MENTOR)

Name of the Student: Aakash Kumar Chahar

Summer Internship Institution: Max Smart Super Speciality Hospital Saket, New Delhi

Area of Summer Internship: Quality Department

Attendance: 98%

Objectives met: completes all the task assigned timely & good at communication

Deliverables: Discharge Summary Project

Strengths: Pro- active approach towards work, Positive attitude, Data Analysis

Suggestions for Improvement:

Signature of the Officer-in-Charge (Internship)

Date: 5/7/24

Place: New Delhi

ACKNOWLEDGEMENT :

First and foremost, I would want to express my gratitude to Ratika Samtani, my mentor, for her patience, support, excitement, and extensive knowledge throughout my summer internship study and research. Her guidance was very beneficial to me while I was doing my research and writing my report.

I couldn't have asked for a better mentor and adviser for my summer internship.
I would want to express my gratitude to my parents and the instructors at IIHMR, Delhi, for their amazing encouragement and support in seeing my research through to completion.

I am extremely thankful the team of max hospital and especially my mentor in the hospital , Ms Kanika Bhatt , Quality manager of max super smart speciality hospital , Saket in helping throughout my summer internship work and shaping it in fruitful work.

Table of Contents

Acronyms/Abbreviations:

NABH :- NATIONAL ACCREDITATION BOARD FOR HOSPITALS

IPD:- IN -PATEINT DEPARTMENT

OPD:-OUT-PATEINT

LAMA:- LEAVE AGAINST MEDICAL ADVICE

DAMA:- DISCHARGE AGAINST MEDICAL ADVICE

MLC:- MEDICO -LEGAL CASE

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OVERVIEW :

A reputable multispecialty hospital that has established its own quality standards inside the medical system is the Max Smart Super Speciality Hospital in Saket, which is situated in south Delhi. With over 250 beds for patient assistance, it is a part of the Gujarmal Modi Hospital and Research Centre for Medical Sciences.

Our patients receive top-notch care at our NABH-accredited hospitals.
The goal of Max Smart Super Speciality Hospital, Saket is to give patients the best possible care from the moment of admission until their discharge, supported by more than 300 renowned specialists, a dedicated nursing team, and cutting-edge medical equipment.

Centres of Excellence :

- Cancer Care / Oncology
- Cardiac Sciences
- Neuro Sciences
- Liver Transplant And Biliary Sciences
- Orthopaedics
- Nephrology
- Kidney Transplant
- Bone Marrow Transplant
- Bariatric/Weight Loss Surgery
- Minimal Access / Laparoscopic Surgery
- Eye Care / Ophthalmology
- Robotic Surgery

AMENITIES :

1. World-Class Facilities:
2. Specialized Departments:.
3. Patient-Centred Care:
4. Innovative Treatments and Research:
5. Community Engagement:
6. Innovative Treatments and Research:.
7. Community Engagement:

Specific Objectives:

1. Enhance Patient Experience:
2. Expand Specialized Services:
3. Promote Medical Research:
4. Strengthen Quality Standards:
5. Community Outreach and Education: .
6. Sustain Financial Health:

Accreditations:-

- The Quality Council of India's National Accreditation Board for Hospitals & Healthcare Providers, or NABH, is a constituent board that was established to create and manage an accreditation program for healthcare organizations. The board's organizational design aims to meet the interests of its members and establish industry standards for the health sector. All stakeholders, including the government, business community, and consumers, support the board while granting it complete operational autonomy.
- In 2003, Joint Commission International released its first set of laboratory accreditation standards. In order to meet the demands of the growing number of JCI-accredited facilities, JCI has since undergone constant evolution to stay up to date with trends in the laboratory business. In order to find new laws and commonly-accepted practices, JCI regularly updates its laboratory accreditation standards and performs an international review. One of the fundamental ideas of The material is anchored on professional knowledge, consumer feedback, current scientific facts, and best practice suggestions for defining standards and the accreditation process. JCI provides two distinct laboratory accreditation programs to meet the various requirements of various laboratory environments and local laws:
- Based on ISO 15189:2022 and the Joint Commission International Accreditation Standards for Laboratories, Fourth Edition, the laboratories have been accredited. Medical labs: Standards for proficiency and quality

Review of Literature

Critical Review of Discharge summaries at a Tertiary care ophthalmic centre of New Delhi, India

Dr. Anant Gupta, Dr. Shakti Kumar Gupta, Dr. Nishant Sharma Corresponding Author: Dr. Anant Gupta .

I. INTRODUCTION :

A discharge summary is a summary of a patient's information prepared during inpatient care and given before or after their departure from the hospital. It should be completed by the physician in charge during admission and should include details such as the reason for hospitalization, significant findings, procedures performed, care, treatment, and services provided, the patient's condition upon discharge, and information provided to the patient and family. Accurate completion of all relevant parts of a discharge report is necessary for patient records, clinical governance, and good medical practice.

Inadequate or delayed information exchange between healthcare providers can have a substantial influence on patient safety, treatment continuity, satisfaction with patient-physician relationships, and resource use. Until the timeliness and accuracy of hospital discharge communication are improved, patients with complex medical issues who require early post-discharge follow-up care may be treated by their primary care physician before the physician is informed about the hospitalization, pending test results, and specific follow-up needs.

The audit of discharge summaries from Indian ophthalmic institutes has received little scholarly attention, and the contents of these summaries have received even less. It is imperative to observe and recommend modifications to the medical record of a tertiary level ophthalmology centre to ensure fullness. A study was conducted to compare discharge summaries to industry standards and critically assess them at a tertiary eye care facility in India.

II. Materials and Methods

A six-month hospital-based retrospective record study was conducted from July to December 2016 at an apexcenter for Ophthalmic Sciences in India. The study estimated that 40% of discharge summaries were incomplete due to not disclosing most criteria. 150 samples were required, and 25 discharge summaries were randomly selected from each unit. The reports were accessible online through the hospital's software. International organizations support discharge summary criteria, which vary by area. The hospital must ensure legal protection and documentation is done. The Indian agency, NABH, recommends specific standards for discharge summaries, while the JCI recommends specific standards for the JCI. The UK also has its own guidelines for discharge summaries.

III. OUTCOMES:

A study examined 150 discharge reports using specific criteria. The reports contained information about admission and discharge dates, admission specialty, and physician signatures. Hospital problems were mentioned by 74% of patients, and the condition at discharge was mentioned in 59%. The prognostic parameter for the disease was given in 66% of instances. 95% of the reports had physician information, but the physician's name was absent from patients whose surgeries were cancelled. Only 31% of files contained unresolved issues. More than 90% of cases included information about hospital care, investigations, medications, diagnosis, and ICD 10 code. Parameters missing from the reports included complementary and alternative medicine, nutrition, religious and cultural ideas, support for family members, palliative care, and contact information.

ABSTRACT

Introduction: The attending physician of a hospitalized patient prepares a document known as a discharge summary. It includes an overview of the patient's diagnosis at admission, the diagnostic procedures carried out, the therapy they received while in the hospital, the clinical course of their stay, the prognosis, and a discharge plan with a time frame for follow-up.

Techniques:

1. Active study and quasi-experiment design of the study.
2. Research area: The 250-bed Max Smart Super Speciality Hospital
3. sampling size: Two months' worth of inpatient medical data comprised of a systematic random sampling. There were 150 case sheets in the sample.
4. Data gathering Between April 22 and June 21, 2024, I carried out a pre- and post-intervention study at the Max Smart Super Speciality Hospital in Saket, Delhi.

Outcome: 84% of the 11 items in the pre-audit 16 % of the discharge summaries were not completed. 3.2% of the post-audit discharge summary was incomplete, compared to 96.8% of full cases.

In conclusion, with significant ramifications for patient safety and care quality, reviewing discharge summaries is an essential part of quality assurance in healthcare transitions. Healthcare companies can enhance care coordination, advance patient-cantered care, and ultimately improve patient outcomes by giving discharge auditing top priority and funding ongoing quality improvement programs.

SYNOPSIS

Project Details

1) Duration of Project: a) Date of Internship Start (22/04/2024)

b) The day on which the internship ends (21/06/2024)

2) Topic: Reviewing the discharge summary in accordance with the NABH standard requirement for medical documentation compliance .

3) Goal of the Project

The following are the project's goals:

1. Raise patient safety and continuity of care 2. Boost the quality and accuracy of discharge summaries 3. Identify areas where documentation procedures need to be improved

4. Verify adherence to legal and regulatory standards Analyse the success of programs or interventions meant to raise the calibre of discharge summaries.

4) The approach that will be used

1. Active study with a quasi-experiment design.

2. Research area: The 250-bed Max Smart Super Speciality Hospital

3. sampling size: Two months' worth of inpatient medical data comprised of a systematic random sampling. The sample size was 150 case sheets from every hospital department.

4. Data collection: From May to June of 2024, we carried out a pre- and post-intervention study at the Max Smart Super Speciality Hospital in Saket, Delhi.

5) A brief project summary (must be properly certified by the industry guide)

Pre-intervention: In accordance with NABH guidelines, hospital administration examined every discharge summary of IPD services that was available for May 2024 to ensure that it included all 11 components.

Post-intervention: In accordance with NABH guidelines, hospital administration assessed all discharge summaries of IPD services that were accessible as of June 2024 to ensure that they included all 11 components.

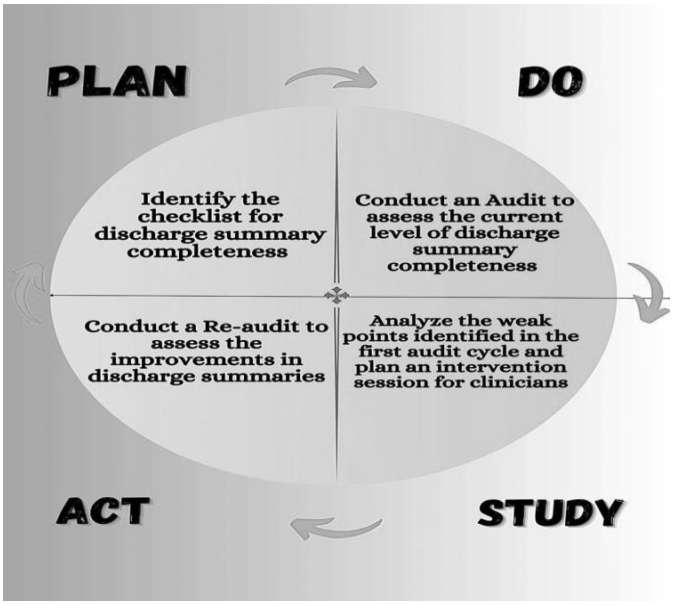


Figure 1.1 PDSA Cycle

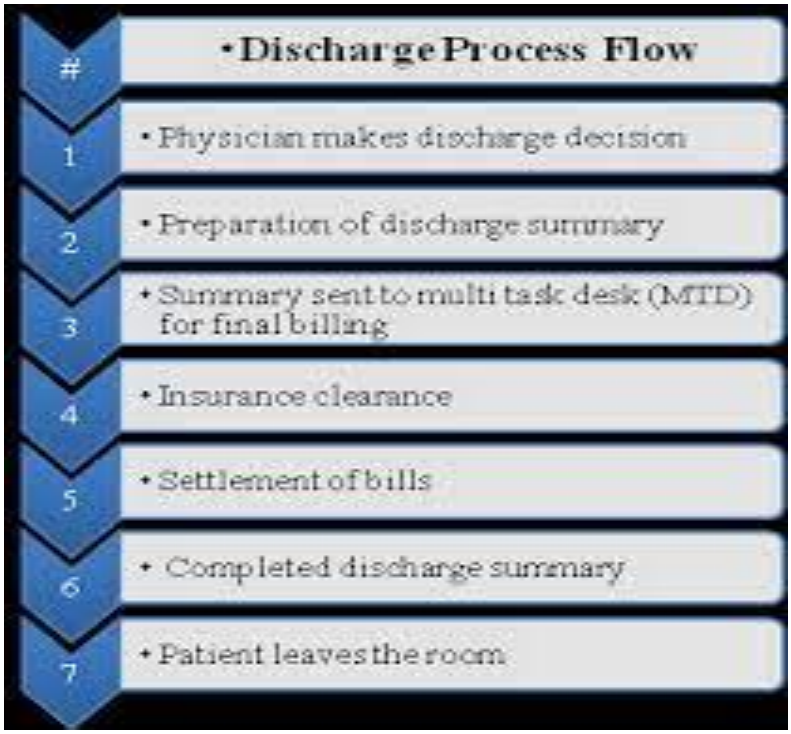


Figure 1.2 Discharge Flow Process

Medical documentation compliance- a review of discharge summary as per NABH standard requirement

Introduction:

Introduction: The attending physician of a hospitalized patient prepares a document known as a discharge summary. It includes an overview of the patient's diagnosis at admission, the diagnostic procedures carried out, the therapy they received while in the hospital, the clinical course of their stay, the prognosis, and a discharge plan with a time frame for follow-up. It is a written account of the patient's treatment record that details the patient's successes and setbacks, the reasons for their release from therapy, and suggestions for additional services. It is created and added to the patient's permanent medical records upon her release from a medical facility. A summary of the patient's medication modifications during her hospital stay, together with a record of her symptoms, physical examination, lab results, and radiographic examinations, should all be included. discharge as well as suggestions for aftercare. It should be shared with or discussed with her outpatient primary care physician for the best possible patient care.

The following six elements need to be mentioned in the patient's discharge summary:

1. The principal reason for the patient's hospitalization, or the chief complaint

• The patient's medical history, including details on their health upon hospital admission, such as the results of their initial diagnostic assessment

2. Principal findings or diagnosis • Primary diagnoses - diagnoses made at admission or discharge

3. Hospital operations and treatments; hospital courses or events; hospital consultations (medical, surgical, or other specialty); hospital procedures (surgical, invasive, non-invasive, diagnostic, or technical);

4. The state of the patient's discharge

• Records of the patient's state of health at the time of discharge

5. Instructions for the patient and their family (if applicable)

• A list of all prescriptions prescribed at admission and discharge

• nutritional instructions – suggested nutritional intake

• Activity orders – the patient's degree of activity upon hospital discharge

• Physical or physiotherapy

• Medical follow-up plans – appointment times and dates or a specified period of time for medical follow-up

6. Signature of attending physician: The attending physician's signature, either in person or electronically.

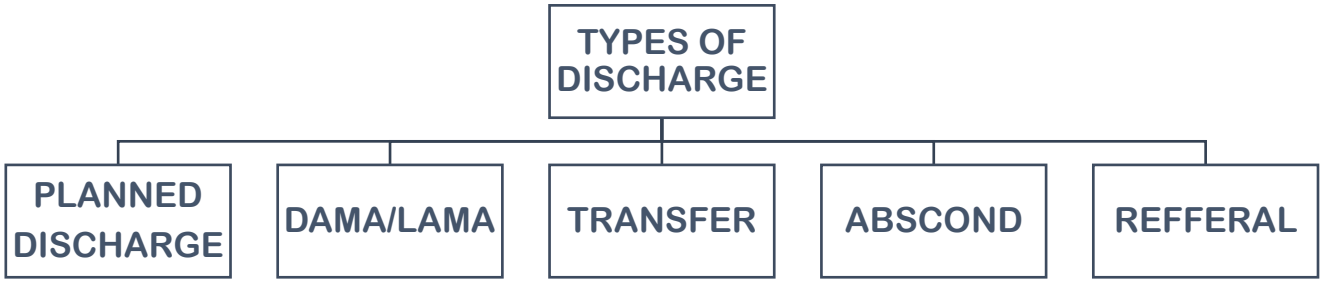
Discharge is scheduled with at least 24 hours' notice. The planning process will involve creating a draft discharge summary, paying back prescriptions, and educating patients about ongoing care. Unexpected releases are reduced.

The purpose of documenting the discharge procedures is to guarantee collaboration between several departments, including accounts, and to ensure that the discharge documents are completed on time. The organisation is responsible for ensuring that the police are notified in medico-legal cases (MLCs). The attending physician ought to discuss the implications of this action to the tolerant attendant. The grounds for departing against medical advice (LAMA) could be covered in the written guidance in order for the organization to take any necessary corrective or preventive action. Discharge is scheduled with at least 24 hours' notice. The planning process will involve creating a draft discharge summary, paying back prescriptions, and educating patients about ongoing care. Unexpected releases are reduced.

The organization establishes the time required for release; this time may be based on a pay mix or other factors, such as cash, insurance, or corporate. The organization must adhere to this timeline, and any delays in the discharge process are tracked. Improvement tasks are carried out and the causes of the delays are determined. When the treating physician certifies that the patient is ready for discharge, that's when the timer starts to run. The patient is ready to be released. The moment the patient gets out of bed is the endpoint.

TYPES OF DISCHARGE:

Figure 1.2



1. Planned Discharge: This is a hospital discharge that has been prearranged. It usually happens when the patient is stable enough to leave the hospital after their treatment plan has been finished. A scheduled discharge enables plans to be made for any further follow-up care or support services that may be required.

2. Discharge against Medical Advice/Leave against Medical Advice, or DAMA/LAMA: This is when a patient decides to go from the hospital before the medical staff suggests that they be discharged. Patients who refuse medical advice run the danger of receiving insufficient care, which could aggravate their health or cause problems. In addition to documenting this choice, healthcare professionals may also offer the patient advice regarding associated hazards.

3. Transfer: The term describes the motion of a patient moving between medical facilities. When a patient needs specialized care or services that the current facility does not offer, a transfer may take place. Examples include moving a patient to a rehabilitation center for more healing or from a local community hospital to a larger tertiary care facility for more advanced care.

4. Abscond: When a patient leaves the hospital without medical advice and without alerting the medical personnel, this is referred to as an abscond. It sounds like DAMA/LAMA, but it could also mean a more abrupt

or covert departure. The patient's health may be at danger if they disappear because they might not have gotten the required care or instructions for continued care.

5. Referral: In the context of discharge, a referral usually entails making recommendations or making arrangements for the patient to obtain services or care from a different medical facility or practitioner. A patient may be referred to a professional for extra assessment or treatment, to community resources for continuous assistance, or to a social worker or counsellor for further help with their medical need.

The aim of a hospital discharge summary audit project may differ based on the particular objectives and specifications of the project. Nonetheless, a few shared goals could be:

1. Boost discharge summaries' correctness and compliance: Make sure that any essential patient data, such as diagnosis, treatment plans, prescriptions, directions for follow-up care, and any other relevant information, is appropriately captured in discharge summaries.

2. Promote patient safety and care continuity: By making certain that discharge Summaries are thorough, error-free, and guarantee that patients' care transitions from the hospital to other settings are seamless.

3. Determine which aspects of documentation procedures need to be improved: Develop ways to resolve frequent flaws or weaknesses, such as missing information, inconsistent formatting, or mistakes, in discharge summaries through the audit process.

4. Verify regulatory compliance: Verify that discharge summaries adhere to the regulations and specifications set out by accrediting organizations, including those pertaining to medicolegal situations and LAMA cases.

5. Improve workflow procedures and documentation efficiency: Simplify the discharge summary documentation process to lessen the workload for healthcare professionals in terms of paperwork while maintaining the completeness and quality of discharge summaries.

In general, a discharge summary audit project's goal is to raise patient safety, continuity of treatment, and general healthcare quality by improving the efficacy, accuracy, and quality of discharge summaries.

Methodology

1. Active Study with experimental quassi was the study design.
2. Study area: A 250-bed facility called Max Smart Super Speciality Hospital.
3. Sampling size: Two months' worth of inpatient medical data comprised of a systematic random sampling. 150 case papers from every hospital department made up the sample size.

The following documents were evaluated for documentation completeness: Discharge Summary: Details about the patient's demographics, date of admission, date of discharge, diagnosis, procedure name and date, if applicable, investigation, special needs, urgent care options, emergency contact number, signature, date, and time.

4. Data collection: At the Max Smart Super Speciality Hospital in Saket, Delhi, between MAY, we carried out a pre- and post-intervention study. d June of 2024.The discharge case files from the two months that were accessible in the medical record area served as the primary source of the data. We used a quantitative strategy to gather data. Surveys and observations were employed as methods. Using a handful of the quality indicators as benchmarks, an organized checklist (Audit Tool) was created.
5. Data Analysis: After being collected, the data were input into a Microsoft Excel spreadsheet. Statistics were also performed using Microsoft Excel.
6. Intervention

Pre-intervention: In accordance with NABH standards, hospital management solely examined all discharge summaries of inpatient services that were accessible as of May 2024 to ensure that they included all 11 items.

Post-intervention: The completeness of every discharge statement for inpatient services that was accessible in June 2024 was checked.

hospital administration exclusively uses the 11-item discharge summary template in accordance with NABH guidelines.

7.Eligibility and rejection standards:

Study inclusions: All files including discharge summaries for May and June of 2024 discharges were included in the study.

Exclusion: All discharge reports from LAMA and medicolegal cases met the exclusion criteria.

DISCHARGE SUMMARY CRITERIA

S.NO	CRITERIA	Complete	Absent
1.	Discharge Summary - Demographics Details		
2.	Discharge Summary – DOA		
3.	Discharge Summary – DOD		
4.	Discharge Summary – Diagnosis		
5.	Discharge Summary – Name of procedure (where applicable)		
6.	Discharge Summary – Date of procedure		
7.	Discharge Summary - When to obtain urgent care		
8.	Discharge Summary - Lab Investigations		
9.	Discharge Summary - Special Care Needs		
10.	Discharge Summary - Emergency Care Contact		
11.	Discharge Summary - Signature , Date and Time		

S.NO	CRITERIA	Complete	Absent
12.	Discharge Summary - Demographics Details		
13.	Discharge Summary – DOA		
14.	Discharge Summary – DOD		
15.	Discharge Summary – Diagnosis		
16.	Discharge Summary – Name of procedure (where applicable)		
17.	Discharge Summary – Date of procedure		
18.	Discharge Summary - When to obtain urgent care		
19.	Discharge Summary - Lab Investigations		
20.	Discharge Summary - Special Care Needs		
21.	Discharge Summary - Emergency Care Contact		
22.	Discharge Summary - Signature , Date and Time		

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Discharge Summary Urology

Patient Demography Details :

Name	: [redacted]	**Patient ID**	: [redacted]
DOB	: [redacted]	**Age/Gender**	: [redacted]
DOA	: [redacted]	**Ward**	: [redacted]
Address	: [redacted]		

IP No.	: [redacted]
Primary Consultant	: [redacted]
Secondary Consultant	: [redacted]
Mobile No.	: [redacted]

Date and Time of Discharge : 15 JUN, 2024 11:50

Diagnosis:

Right Paratesticular Tumor

Presenting Complaints:

Right testicular pain - intermittent x 2-3 years
Swelling and hardness x 2 years

History of Present Illness:

Mr. Gaurav Vishal, 51 years old gentlemen, presented to Urology OPD with above mentioned complaints. On evaluation, MRI Pelvis (03/06/24) revealed a large benign mesenchymal tumor of right paratesticular region displacing the right testis.Patient and his family member were counselled in detail regarding the above mentioned findings and clinical diagnosis and its plan of management.
He was advised surgery (Right Paratesticular Tumor Excision). After proper counselling regarding the diagnosis and proposed plan of treatment and it's known complications, all necessary pre operative workup and written informed consent, he was planned for surgery (Right Paratesticular Tumor Excision). Now admitted here for the same.

Past Medical History:

Hypertension

Allergies:

No known drug allergies

Course in Hospital:

For post-hospital care at home, call Max@Home at 8744 888 888 (24x7 helpline).Services include Critical Care@home, Nursing Healthcare Attendant, Physio-therapy, X-Ray, Sample Collection, Medicine Delivery, Medical Equipment and more.

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(Gujarmal Modi Hospital and Research Centre for Medical Sciences
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Regd. Office: Mandir Marg, Press Enclave Road, Saket, New Delhi - 110 017
For medical service queries or appointments, call: +91-11 7121 2121
Fax: +91-11-2696 3801
www.maxhealthcare.in

Patient Name : Gaurav Vishal
SSN No. : 670471058

MAX Healthcare

Medications During Stay:

1) AUGMENTIN 1.2GM VIAL VIAL 1.2gm IV BID(08&20HRS)
2) CREMAFFIN PLUS 225ML * SYRUP 30 ML PO QHS(DAILY 10:00PM)
3) ESOMEPRAZOLE 40MG UD VIAL VIAL 40MG/1VIAL IV QAM(06HRS)
4) NORMAL SALINE UD 0.9% 500ML PLASTIC BTL 120ML/HR IV CONTINUOUS
5) ONDANSETRON 2MG/ML 4ML UD AMP INJ,SOLN 8MG IV PRN SOS IN CASE OF NAUSEA/VOMITING, SOS/PRN FOR VOMITTING. Max Dosage - 32 MG / DAY SOS/PRN FOR VOMITTING. Max Dosage - 32 MG / DAY
6) PARACETAMOL UD 1GM VIAL VIAL 1GM IV Q8H(6,14&22 HRS)
7) TRAMADOL 100MG/2ML 2ML UD AMP INJ,SOLN 100MG IM PRN HIGH ALERT MEDICATION,HIGH ALERT MEDICATION HIGH ALERT MEDICATION,HIGH ALERT MEDICATION
8) URIMAX 0.4MG CAP,ORAL 1CAPSULE PO QDAILY(10HRS)

Medications on Discharge:

- Tab Augpen LB 625 mg one tab thrice daily (after meals) for 7 days
- Tab Pantocid 40mg one tab once daily (before breakfast) for 7 days
- Tab Signoflam one tab three times a day (after meals) for 5 days
- Tab Chymoral forte one tab twice daily (before meals) for 5 days
- Tab Crocin 650mg one tab SOS in case of high grade fever
- Cap Urimax 0.4 mg one cap at bed time for 3 weeks
- Syp Cremaffin 30ml once daily (SOS) in case of constipation
- Continue your regular medicine for Hypertension as advised by the physician

Advice:

- Normal diet
- Adequate oral fluid intake (2 liters/day)
- Rest for 3 days
- Collect Biopsy report from OPD after 7 days
- Wear scrotal support for 2 weeks
- Abstinence for 1 month
- Dressing review on Monday (17/06/24) in Urology OPD at 11am
- Avoid straining/constipation/lifting heavy weights/strenuous physical activities for 1 week

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He was admitted with the plan for aforementioned procedure and all relevant investigations were done. After PAC clearance and informed written consent, Right Paratesticular Tumor Excision was done under Spinal Anesthesia on 13/06/2024, which patient the tolerated well and tissue was sent for histopathology. In the post operative period, he had difficulty in passing urine and developed acute urinary retention. He was put on an indwelling catheter. Per urethral catheter was removed on post-operative day two and patient was voiding satisfactorily. Now he is being discharged in stable condition with following advice.

On Examination:

Stable

Condition on Discharge:

Stable

Lab Results:

All relevant investigations attached along with discharge summary.

Surgery:

Right Paratesticular Tumor Excision done under Spinal Anesthesia on 13/06/2024

Name of Surgeon : Dr. Anjani Kumar Agrawal
Anesthetist : Dr. Kamal Fotedar
Assistant Surgeon : Dr. Pankaj
Scrub Nurse : Reema

Findings:

5x5 cm encapsulated pararatesticular tumor seems arising from proximal vas deferens ,separate from right testis which is small and hypoplastic

Procedure :
Patient positioned in supine position. Area painted and draped. 5-6cm right inguinal incision made, dartos layer incised, right testicular mass along with right testis delivered. Cord structures identified and looped , right paratesticular tumor removed from right hypoplastic testis. Right testis fixed with scrotal dartos hemostasis confirmed. Dartos closure done with absorbable suture.,. Skin closure done with nylon 3-0. 14fr foley's catheter introduced and balloon inflated with 10cc saline. All aseptic dressing done.

Histopathology:
Right Paratesticular Tumor

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Fax: +91-11-2696 3801
www.maxhealthcare.in

SSN No.: 6704710**59** Patient Name : Gaurav Vishal

Follow Up Advice:

- Follow-up in Urology OPD with Dr Anjani Kumar Agrawal on Monday (17/06/24) with prior appointment.

- In case of high grade fever / frank blood in urine / severe abdominal pain / vomiting or any other bothersome symptoms or complaints please contact emergency : 011-71212121.

- In case of any query or appointment, please contact : 011-71212121.

I ARCHANA VERMA have understood and have been given an opportunity to clarify my concerns in the language I/we understand & hereby acknowledge receipt of the discharge summary.

Patient/Attendant Archana Nurse Sangeeta

/es/ Vikas Sharma
Resident Medical Officer
Signed: 15 JUN, 2024 11:47

/es/ Anupam Bhargava
Cosigned: 15 JUN, 2024 14:25
for Anupam Bhargava

Entered Date : 14 JUN, 2024 12:37
Prepared By: Vikas Sharma

SSN No.: 6704710**58** Patient Name : Gaurav Vishal

For post-hospital care at home, call Max@Home at 8744 888 888 (24x7 helpline).Services include Critical Care@home, Nursing Healthcare Attendant, Physio-therapy, X-Ray, Sample Collection, Medicine Delivery, Medical Equipment and more.

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RESULT & DISCUSSION

Proportion of Discharge Summaries Pre-audit and Post-audit and Feedback Intervention

		PRE-INTERVENTION		POST-INTERVENTION	
S.No	CRITERIA	COMPLETE	ABSENT	COMPLETE	ABSENT
1.	Discharge Summary - Demographics Details	73	2	75	0
2.	Discharge Summary – DOA	75	0	75	0
3.	Discharge Summary – DOD	75	0	75	0
4.	Discharge Summary – Diagnosis	75	0	75	0
5.	Discharge Summary – Name of procedure (where applicable)	58	17	73	2
6.	Discharge Summary – Date of procedure	57	18	74	1
7.	Discharge Summary - When to obtain urgent care	60	15	74	1
8.	Discharge Summary - Lab Investigations	50	25	57	18
9.	Discharge Summary - Special Care Needs	55	20	71	4
10.	Discharge Summary - Emergency Care Contact	59	16	75	0
11.	Discharge Summary - Signature , Date and Time	67	8	75	0

We evaluated pre- and post-audit scores, as well as the total and composite discharge summary scores for each of the 11 Discharge Summary categories, in order to evaluate the audit's impact. 150 case documents from various departments made up the sample. Discharge Summary: Details about the patient's

demographics, date of admission, date of discharge, diagnosis, procedure name and date, if applicable, investigation, special needs, urgent care options, emergency contact number, signature, date, and time.
Of the 11 elements in the discharge summary, 84% were finished during the pre-audit, and 16% were not.

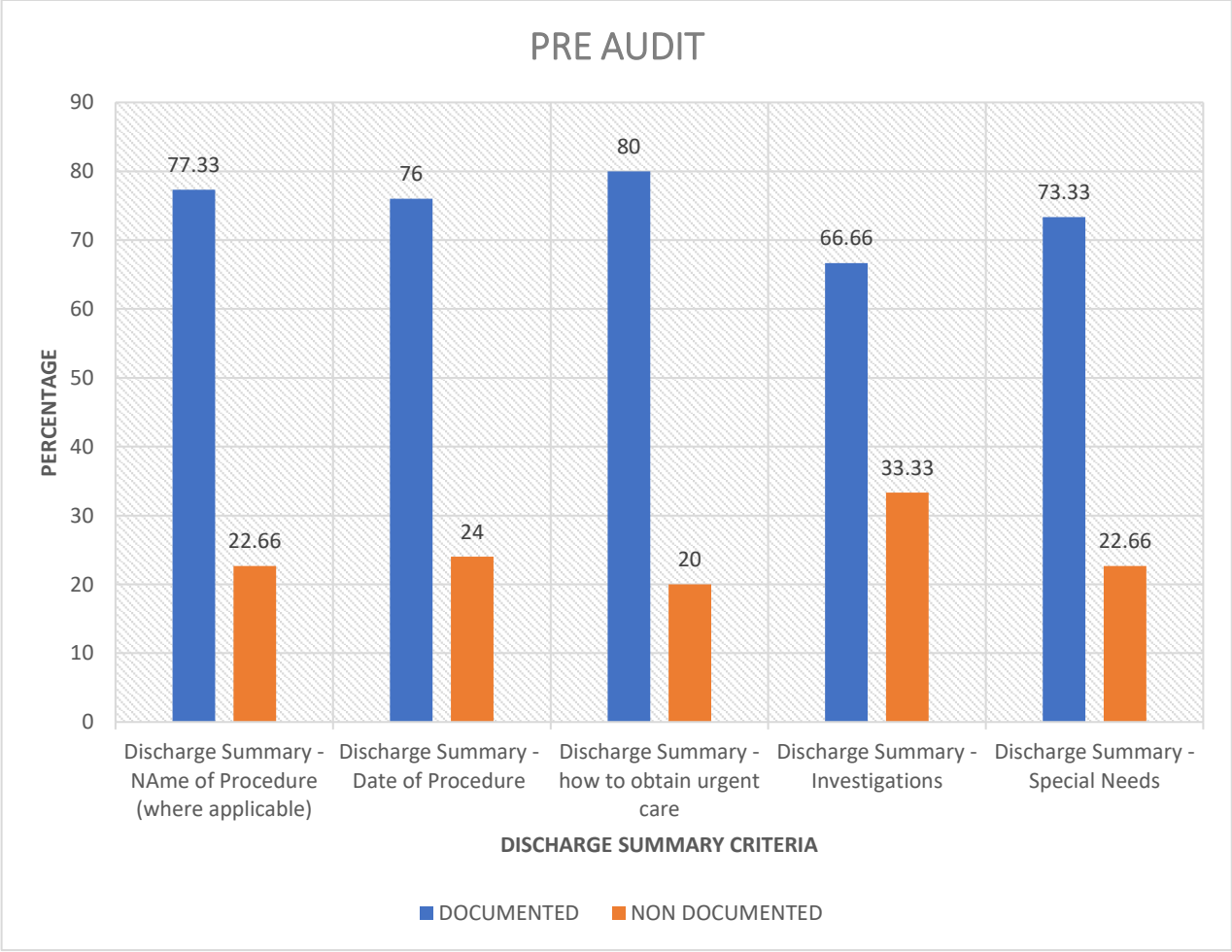
Discharge summary demographics details: 97.33 percent; admission date: 100%; discharge date: 100%; diagnosis: 100%; procedure name or surgery, if applicable: 77.3%; procedure date: 76%; how to get urgent care: 80%; investigation: 66.6%; special needs: 73.33 percent; emergency Contact number (78.66), signature (89.33%), and date and time

Compliance Measures:
Information about Demographics: patient demographics including name, age, gender, and contact details are included.

- Name of Diagnosis: Clearly identify and document the primary diagnosis or reason for hospital admission.
- Dates of Admission and Discharge: Precise documentation of the day and time of patient admission and discharge.

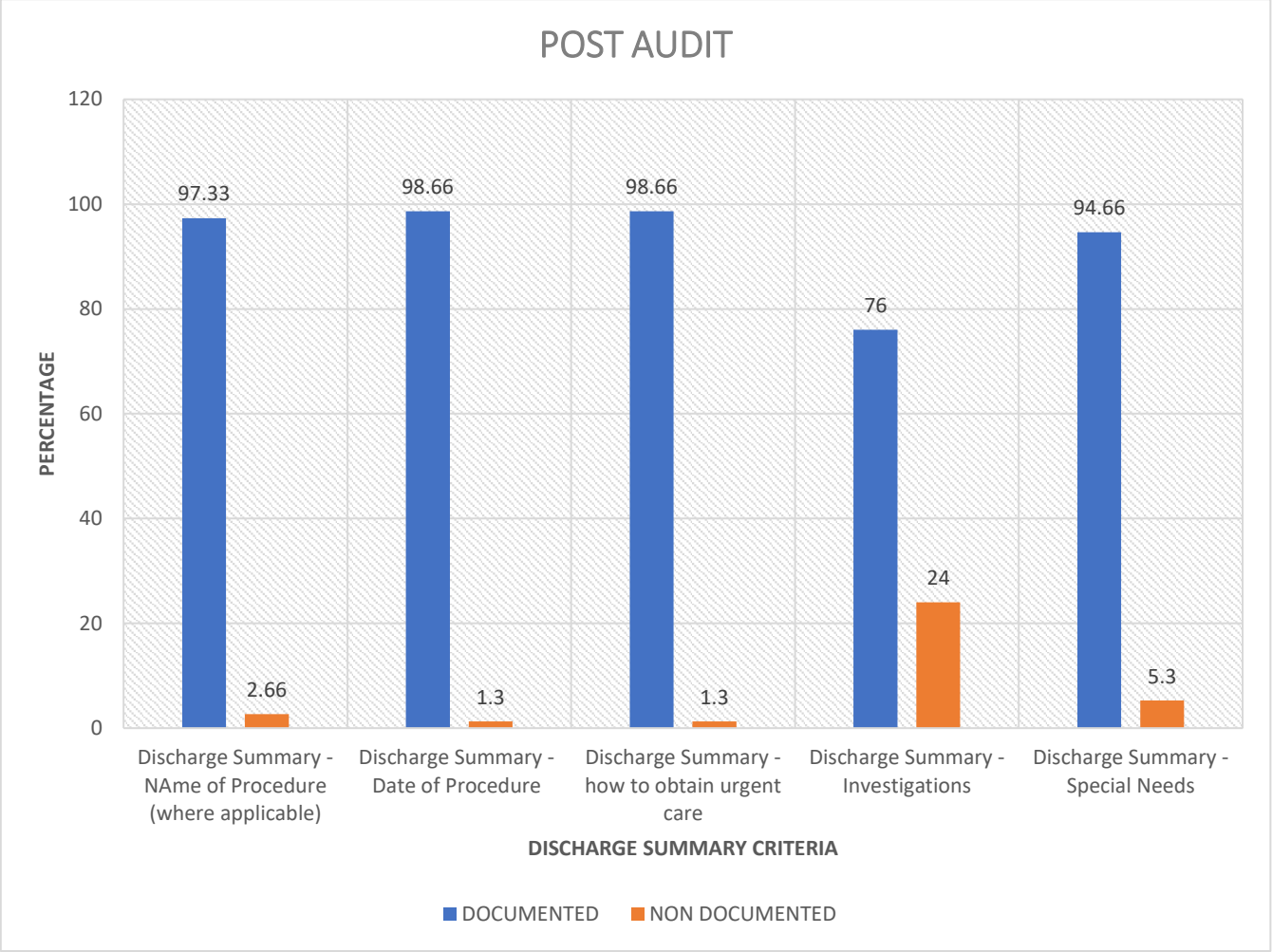
Reasons for Non-Compliance:

- Name of Procedure: Any procedures carried out during the hospital stay are not properly documented.
- Date of Procedure: The time and date of the procedures performed are not documented.
- Instructions for Obtaining Urgent Care: No guidance on where to go for urgent care after being discharged.
- Investigations: Not recording diagnostic procedures or inquiries carried out while the patient was in the hospital.
- Special Needs: Lack to give information about post-discharge accommodations or special needs.

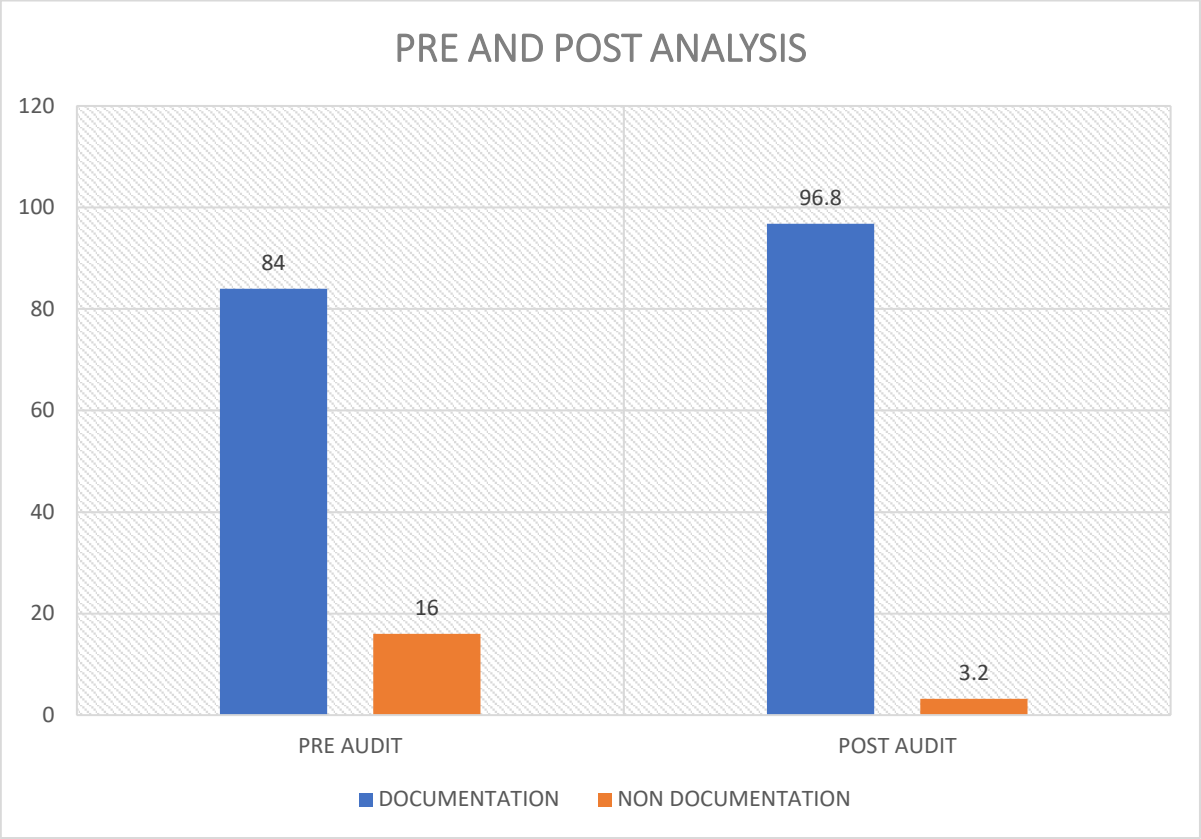


During the post-audit, 96.8% of the 11 items in the discharge summary were completed, with 3.2% being incomplete.

Discharge Summary Demographics Details(100%), Date of Admission(100%), Date of Discharge(100%), Diagnosis(100%), name of Procedure / Surgery where applicable(97.33%), date of procedure(98.66%) , how to obtain urgent care(98.66%), investigation(76%) , Special Needs(94.66%), Emergency Contact Number(100%), Signature , Date and Time(100%)



Our findings show that audit sessions enhanced the completeness of discharge summaries by 12.8% and the reduces the absent criteria by 12.8%.



Pre-Intervention Analysis: The analysis conducted prior to the implementation of targeted interventions indicated a notable lack of compliance with multiple essential components of the discharge summary paperwork. Typical inadequacies were insufficient urgent care instructions, missing procedure information, and a deficiency in the documenting of special needs and investigations.

Implementing the Intervention:

Employee Education: In-depth training sessions were held to inform medical professionals of the significance of precise and comprehensive discharge summary documentation. The necessity of including all necessary components—procedures, urgent care guidelines, investigations, and specific needs—was highlighted.

Standardized Templates: By implementing discharge summary templates with defined parts for every necessary component, thorough documentation is made easier and the chance of omissions is decreased.

Implementing frequent audits and peer reviews to track compliance to documentation standards and pinpoint areas in need of improvement is one way to improve quality assurance.

Post Intervention Analysis: There has been a significant decrease in discharge summary noncompliance since the intervention. Significant improvements have been made to the documentation of specific needs, investigations, and directives for urgent treatment. Even while procedure documentation improved, there were still some gaps—albeit smaller ones.

RECOMMENDATION: Based on our observations made during the audit, it appears that this department is operating efficiently. The procedure should continue as is, but it can be strengthened and improved if they adhere to the regulations.

- Employee Instruction and Development: Healthcare practitioners should get thorough training on discharge summary documenting best practices, with a focus on the significance of timeliness and completeness.
- Process Standardization: To guarantee uniformity and effectiveness between departments, establish standardized workflows and templates for the development of discharge summaries. Using Technology: To ensure correct and timely documentation, invest in electronic health record (EHR) systems that provide discharge summary templates and built-in prompts.
- Measures of Quality Assurance: To find errors and take immediate corrective action, conduct routine audits and peer reviews of discharge summaries.
- Interdisciplinary Collaboration: To guarantee a smooth transfer of care and the interchange of relevant patient data, promote cooperation and communication between the inpatient and outpatient care teams.
- Final verdict : To sum up, the project on discharge summaries has played a pivotal role in enhancing patient care and maintaining continuity of care. We promote continuity of care and reduce error risk by precisely recording the patient's medical history, treatment plans, and follow-up instructions. We have highlighted the value of comprehensive documentation, lucid communication, and centered around patients medical treatment. We will keep improving our procedures going ahead to guarantee that discharge summaries are done on time, accurately, and completely. For the benefit of our patients, we are committed to continuously improving our practices and upholding the highest standards of patient care.
- With significant ramifications for patient safety and care quality, auditing discharge summaries is an essential part of quality assurance in healthcare transitions. Healthcare companies can enhance care coordination, advance patient-cantered care, and ultimately improve patient outcomes by giving discharge auditing top priority and funding ongoing quality improvement programs.

R**EFERENCES :**

https://nabh.co/#:~:text=National%20Accreditation%20Board%20for%20Hospitals%20%26%20Healthcare%20Providers%20(NABH)%20is,accreditation%20programme%20for%20healthcare%20organisations

https://www.jointcommissioninternational.org/what-we-offer/accreditation/accreditation-programs/laboratory/?utm_campaign=2412_jci_labaccred&utm_source=google&utm_medium=cpc&ref=twcpc&gad_source=1&gclid=CjwKCAjw65-zBhBkEiwAjrqRMDtXu7to6AtstfvzarSnU_tT_2vN8bzQJACES1KoagVceioQktvp9xoCXNwQAvD_BwE

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https://www.academia.edu/41542957/Critical_Review_of_Discharge_summaries_at_a_Tertiary_care_ophthalmic_centre_of_New_Delhi_India

ANNEXURE:

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
1	UHID																
2	PATIENT NAME																
3	CONSULTANT NAME																
4	DATE OF AUDIT																
5	DATE OF ADMISSION																
6	DATE OF DISCHARGE																
7	Face Sheet - Gaurdian Signature																
8	Face Sheet - PCC Signature																
9	Face Sheet - Doctor Signature																
10	Face Sheet - Final Diagnose																
11	Face Sheet - Name of Procedure (where applicable)																
12	Admission Request Form - Provisional Diagnosis																
13	Admission Request Form - Doctor Name and Signature																
14	Admission Request Form - PCC Name and Signature																
15	Discharge Summary - Demographics Details																
16	Discharge Summary - DOA																
17	Discharge Summary - DOD																
18	Discharge Summary - Diagnosis																
19	Discharge Summary - Name of Procedure (where applicable)																
20	Discharge Summary - Date of Procedure																
21	Discharge Summary - how to obtain urgent care																
22	Discharge Summary - Investigations																
23	Discharge Summary - Special Needs																
24	Discharge Summary - Emergency Care contact																
25	Discharge Summary - Signature, Date and Time																
26	LAMA Summary - DOA																
27	LAMA Summary - DOL																
28	LAMA Summary - Diagnosis																
29	LAMA Summary - how to obtain urgent care																
30	LAMA Summary - Emergency Care contaxt																
31	LAMA Summary - Signature, Date and Time																
32	LAMA Form (ALL CONTENT NEEDS TO BE FIILED)																
33	Generic Informed Consent - Name of the procedure mentioned																
34	Generic Informed Consent -Risk of the procedure mentioned																
35	Generic Informed Consent -Benefits of the procedure mentioned																
36	Generic Informed Consent -Alternatives of the procedure mentioned																
37	Generic Informed Consent -Possible problems related to recovery																
38	Generic Informed Consent -Possible results of non treatment																
39	Generic Informed Consent - Likelihood of success																
40	Generic Informed Consent - Signature, Name, Date and Time of Decision Maker (Patient however if patient is minor/ unresponsive/sedated then Signature of Next of Kin will be applicable)																

	A
41	Generic Informed Consent - Signature, Name, Date and Time of Witness
42	Generic Informed Consent - Signature, Name, Date and Time of Doctor
43	Informed Consent of Procedure- Name of the procedure mentioned
44	Informed Consent of Procedure -Risk of the procedure mentioned
45	Informed Consent of Procedure -Benefits of the procedure mentioned
46	Informed Consent of Procedure -Alternatives of the procedure mentioned
47	Informed Consent of Procedure-Possible problems related to recovery
48	Informed Consent of Procedure -Possible results of non treatment
49	Informed Consent of Procedure - Likelihood of success
50	Informed Consent of Procedure - Signature, Name, Date and Time of Decision Maker (Patient however if patient is minor/ unresponsive/sedated then Signature of Next of Kin will be applicable)
51	Informed Consent of Procedure - Signature, Name, Date and Time of Witness
52	Informed Consent of Procedure - Signature, Name, Date and Time of Doctor
53	Anaesthesia Consent - Name of the procedure mentioned
54	Anaesthesia Consent -Risk of the procedure mentioned
55	Anaesthesia Consent - Type of Anaesthesia Documented
56	Anaesthesia Consent - ASA Classification documented
57	Declaration by the Patient/ Gaurdian/Close Relative
58	Anaesthesia Consent - Risk Stratification - Signature of the patient
59	Anaesthesia Consent - Signature, Name, Date and Time of Decision Maker (Patient however if patient is minor/ unresponsive/sedated then Signature of Next of Kin will be applicable)
60	Anaesthesia Consent - Signature, Name, Date and Time of Witness
61	Anaesthesia Consent - Signature, Name, Date and Time of Doctor
62	PAC - Signature of Anaesthetist
63	Blood Transfusion Consent - Mention of medical Condition
64	Blood Transfusion Consent -Type of Blood Component ticked
65	Blood Transfusion Consent - Risk of BT ticked
66	Blood Transfusion Consent - Patient specific Risk
67	Blood Transfusion Consent -Benefits of the procedure mentioned
68	Blood Transfusion Consent-Alternatives of the procedure mentioned
69	Blood Transfusion Consent- Possible problems related to recovery
70	Blood Transfusion Consent -Possible results of non treatment
71	Blood Transfusion Consent - Likelihood of success
72	Blood Transfusion Consent - Signature, Name, Date and Time of Decision Maker (Patient however if patient is minor/ unresponsive/sedated then Signature of Next of Kin will be applicable)
73	Blood Transfusion Consent - Signature, Name, Date and Time of Witness
74	Blood Transfusion Consent - Signature, Name, Date and Time of Doctor
75	HIV Consent - Signature, Name, Date and Time of Decision Maker (Patient however if patient is minor/ unresponsive/sedated then Signature of Next of Kin will be applicable)
76	HIV Consent - Signature, Name, Date and Time of Witness
77	HIV Consent - Signature, Name, Date and Time of Doctor
78	HIV Consent - Post test Counselling - Doctor Signature, Name Date and Time
79	HIV Consent - Post test Counselling - Patient Signature, Name Date and Time
80	Pre - Operative Checklist - Name, Signature, Date and Time of Ward Nurse
81	Pre - Operative Checklist - Name, Signature, Date and Time of Nurse TL
82	Pre - Operative Checklist - Name, Signature, Date and Time of Pre-Op Nurse
83	CPRS - Daily RMO progress notes (minimum twice daily)
84	CPRS - Daily Consultant team progress notes (minimum twice daily)
85	Surgical Safety Checklist- Name & Sign of Nurse
86	Surgical Safety Checklist- Name & Sign of Anaesthetist
87	Surgical Safety Checklist- Name & Sign of Surgeon
88	Trigger Tool Checklist- Date,Time & Sign of Nurse
89	Trigger Tool Checklist- Date,Time & Sign of Anaesthetist
90	Trigger Tool Checklist- Date,Time & Sign of Surgeon
91	Immediate Post-Op Observation- Sign Duty Nurse
92	Immediate Post-Op Observation- Sign JR/SR/Consultant
93	Discharge Process Checklist - Handover Details
94	Discharge Process Checklist - Name, Initials, Sign, Date and Time of Staff
95	Discharge Process Checklist - Name, Initials, Sign, Date and Time of TL
96	Discharge Process Checklist - Name and Sign of Attendant
97	Non-OT Procedure Safety Cheklistlist (as applicable) - Name & Sign of Nurse
98	Non-OT Procedure Safety Cheklistlist (as applicable) - Name & Sign of Doctor
99	Non-OT Procedure Safety Cheklistlist (as applicable) - Name & Sign of Anaesthetist
100	NEO NATAL RESUSCITATION SHEET
101	ZERO LINE ECG-I
102	ZERO LINE ECG-II(After 10 Min for Death cofirmation)
103	CRISIS NOTES
104	IMPLANT STICKER
105	Pre Cath Lab Checklist
106	Cath Lab Nursing Log
107	Post Procedure Monitoring Sheet
108	Discharge Process Checklist/Family Education Sheet
109	INTAKE-OUTPUT CHART
110	TRANSFUSION MEDICINE RECORD & STICKER
111	RESTRAINT OBSERVATION CHART
112	remark
113	

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