Summer Internship Report

At

AAKASH HEALTHCARE SUPER SPECIALITY HOSPITAL

(1st May 2024 to 28th June 2024)

" Medical audit of patient record documentation at Aakash Healthcare, a multispecialty hospital "

A Report

By

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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 audit of patient record documentation** at "**Aakash Healthcare Super Speciality Hospital** " 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.

Anuradha

Name of the Mentor Anuradha Bhardwaj

Designation Assistant Professor.

IIHMR, Delhi

FEEDBACK FORM (Organization Supervisor)

Name of the Student: Priyanka Dinesh Singh

Summer Internship Institution: Aakash Healthcare Super Speciality Hospital

Area of Summer Internship: Quality Department

Attendance: 100%

Objectives met: Daily medical audits. Making MOM, Comparitive Data Sheet. Actively Participated in NABH audit.

Deliverables: Medical Audit of Patient Record Documentation

Strengths: Active Participation, Punctual, Sincerity

Suggestions for Improvement: Learn More Technical Skills

Signature of the Officer-in-Charge (Internship)

Date: 4/7/24

Place: New Delhi

(Completion of Summer Internship from respective organization)

The certificate is awarded to

MS. Priyanka Dinesh Singh

In recognition of having successfully completed his/her
Internship in the department of

Quality Department

and has successfully completed her Project on

" Medical audit of patient record documentation "

1/05/2024 – 28/06/24

Aakash Healthcare Super Speciality Hospital

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

We wish him/her all the best for future endeavours .

4/7/24

Organization Supervisor

for

Head-HR/Department Head

ACKNOWLEDGEMENT

First and foremost, I would like to sincerely thank my mentor, **Dr. Anuradha Bhardwaj**, for her unwavering backing during my summer internship study and research, as well as for her patience, encouragement, excitement, and vast knowledge. Her advice was really helpful to me as I was conducting my study and preparing my report. For my summer internship, I could not have asked for a greater mentor and adviser.

I want to thank the **teachers at IIHMR, Delhi**, as well as **my parents**, for their wonderful support and encouragement in helping me finish my research. I want to thank the individuals at the institute in particular for their time and kind attention. My gratitude and acknowledgement also extend to my fellow classmates for their contributions to the project's development and to those who volunteered their skills to assist me.

Acronyms / Abbreviations

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

INTRODUCTION

1.In 1988, Mr. J.C. Chaudhry, the Chairman of Aakash Institute, began instructing 12 pupils in a single institute. After 30 years of dedication and success, Aakash is now a well-known brand with more than 150 locations nationwide that graduate more than 1,25,000 students year into successful careers in engineering and medicine.

2. Aakash Healthcare is a cutting-edge healthcare facility and a subsidiary of the Aakash Group. facilities, as well as the city's first smart hospital. They provide the finest possible healthcare to everyone thanks to their patient-centric policy, knowledgeable physicians, and caring team. The parent organization made a clear decision to focus on healthcare because this industry will help the institute's massive global alumni network.

3. Dr. Aashish Chaudhry had an idea for a smart orthopaedic clinic in November 2011 for the residents of Dwarka, New Delhi, the largest residential colony in Asia. Due to his moral and open medical procedures, the clinic flourished. Today, Dr. Chaudhry is a well-known orthopaedic surgeon who has successfully completed countless orthopaedic surgeries that have restored mobility and agility to the disabled.

4. Aakash Healthcare is a super specialty hospital that provides unparalleled healthcare services and has cutting-edge technology and state-of-the-art infrastructure. The founder and director of Aakash Healthcare, Dr. Aashish Chaudhry, wants to establish Aakash as the most favoured healthcare provider build a reputation for offering high-quality, reasonably priced, and compassionate medical care. With a skilled medical staff and cutting-edge equipment, they guarantee a quick recovery.

5. Infrastructure Highlights

- 230 Beds in Phase 1
- 70 Bedded Medical and Surgical Critical Care Unit.
- 24x7 Cardiac Emergency & Trauma Services.
- 15 Bedded Dialysis Unit.
- Advanced Neonatal ICU.
- Ward Bed Options - Suite, Deluxe, Twin Sharing and Economy.

- 8 Modular OTs.
- Flat Panel Cath Lab
- State-of-the-art diagnostic equipment's that include - 3.0 Tesla MRI, 128 slice CT scan, Flat panel C-Arm, and 4-D Ultrasound to name a few.
- Automated Waste & Laundry Management System for efficient waste management.
- Pneumatic Chute System.

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

Vision

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

Mission

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

Values

9. Aakash Healthcare values define their organization and their ethos and what they stand

for: **ICARE.** These values are:

I: Integrity
C: Compassion
A: Accountability
R: Respect
E: Excellence

Organization Profile

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

a) Cardiology and Cardiac Surgery.

b) Orthopaedics and Joint Replacement.

c) Neurology.

d) Pulmonology.

e) Oncology.

f)Urology Sciences.

g) Clinical Nutrition.

h) Plastic and Cosmetic/Reconstructive Surgery.

i)Dentistry.

j)Endocrinology.

k) ENT, Hearing and Speech.

l)Internal Medicine.

m) Ophthalmology and Refractive Surgery.

n) Trauma and Emergency (24 × 7).

o) Obstetrics & Gynaecology.

p) Physiotherapy.

q) Health Check.

r) Blood Bank and Transfusion Medicine.

s) Dermatology.

t)Mental Health and Behavioural Sciences.

u) Radiology.

v) Critical Care.

Details about the patient

11. **Hospital Facilities**

(a) **Rooms:** Aakash Healthcare has many types of rooms, which are listed below:

The Aakash Healthcare **Suite** features an integrated eating facility, full-time nursing staff, a housekeeper, a small refrigerator, a TV, a microwave, Wi-Fi connectivity, and two lockers for personal possessions and safekeeping.

(i) **Deluxe:** The Aakash Healthcare Deluxe room features an attendant bed, Wi-Fi connectivity, a TV, a small refrigerator, two lockers for personal possessions and safekeeping, an integrated dining area for the attendant, and full-time nursing staff.

(iii) **Single Room:** At Aakash Healthcare, a single room has a TV, a small refrigerator, Wi-Fi, a bedside attendant, a locker for personal items, and an integrated dining area.

(iv) **Twin Sharing:** Twin sharing rooms at Aakash Healthcare has a bed for attendant, a TV and a locker for personal belongings.

(v) **Multi Bedroom:** Multi bedroom at Aakash healthcare has chairs and a locker for personal belongings and essentials.

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

(c) **Laundry Services:** Provision of Laundry services have been catered for in the hospital.

(d) ATM.

(e) **Lounge for visitors:** Easy chairs have been provided on the 2nd floor

(f) **Internet Access:** Wi-Fi is available throughout the building.

(g) **Travel Desk:** A travel desk is available at Aakash Healthcare.

(h) **Pharmacy:** Aakash Healthcare features a ground-floor pharmacy open around-the-clock where customers can receive prescription drugs whenever they need them.

(i) A space for meditation and prayer.

MEDICAL QUALITY DEPARTMENT

12. During the Internship period I was attached with the Quality Department of Aakash Healthcare, Dwarka. The organization of Quality Department comprises of One Manager and Two Executives.

13. While Being with the Quality team of the Aakash Healthcare, I was provided with the opportunity to be a part of the NABH audit. Regular audits of Patient Medical Documents. I had to visit the hospital's IPs, ICUs,

and MRD for the audit to check the patient medical documents. In the most basic sense, auditing is the assessment of information, records, and resources to ensure that systems perform as planned and adhere to predefined standards. It is a tool to show what is being done right now, and it is frequently compared to what has already been done or what the goal is for the future.

A hospital's quality department is essential to making sure that the medical services it offers meet to the utmost requirements for patient care, safety, and efficacy. The following are some essential tasks that the Quality Department usually completes:

1. **Quality Assurance (QA)**
2. **Patient Safety**
3. **Risk Management**
4. **Data Analysis and Reporting**
5. **Staff**
6. **Collaboration and Communication**

All things considered, the Quality Department is essential to the hospital's culture of excellence, safety, and ongoing improvement, all of which improve patient outcomes.

The details of Patient Medical Documentation Audit are Under:

(a) **Patient Medical Audit Checklist:** The detailed checklist (Appendix - A) as used to formulate the audit format form.

(b) **Patient Medical Audit Format**: The standard format (Appendix - B) was used for the audit of the Patient Medical Documentation.

(c) **Sample Size**: Total number of Patient Medical Documentation folders audited was 661 (Appendix - C).

14. The table below describes how the data was assessed in detail:

Sr. No	Name of Ward/ICU/MRD	Appendix
1	IPD – 4^{th},5^{th},6^{th} floor	D
2	ICU's – 2^{nd} floor	E
3	MRD Section	F

Recommendations

15. Here are some suggestions that might significantly enhance patient medical documentation that are based on general data analysis and observations made during department visits:

a) **Studies of training-cases.** It is common to make typing errors when documenting a formatted document. Additionally, records are occasionally produced solely for auditing purposes, which distorts the true image of the standard of care. Therefore, to emphasize the significance of accurate and appropriate recording, senior staff members may discuss professional experiences that might be used to instruct students on the value of patient medical documentation.

b) **Medical Staff Education**. Regular training on the legal implications of proper documentation should be provided to medical workers. To emphasize the importance of properly signing patient medical paperwork, it is also important to draw attention to the negligence component.

c) **Establishing Quality Circles.** To share the experience of those working on the ground with one another and benefit all stakeholders, Quality Circles (**QCC)** should be organized among resident doctors, nursing staff, housekeeping, etc.

(d) **Assign Helpers** to each department to make sure that the paperwork is completed and stays focused on patient safety.

(h**) As the initial stage** of the documentation audit, involving functional staff in the audit of all departments. This can be accomplished by selecting individuals from non-medical and medical departments to conduct audits monthly. This could encourage staff members' assessments and result in behavioral improvements.

Other Key Learnings

a) Recognized how different administrative departments operated on a daily basis.

b) discovered the steps involved in buying medication from a drugstore.

c) familiar with the hospital's policies and the HR division.

d) familiar with the hospital's policies and the HR division.

e) Recognized the hospital's biomedical waste management policy.

f) developed specialized knowledge regarding the project study carried out.

g) A hospital administrator has a dynamic, adaptable, and challenging profession.

h) Patient satisfaction and quality assurance are continual processes.

i) Lower levels of patient satisfaction are caused by a lack of skilled technical labour or by multitasking the labour force that is available.

j) Easy post-installation maintenance is achieved by include the Comprehensive Annual Maintenance Contract (CAMC) in the supply order preparation and initial paperwork process when purchasing equipment for a hospital.

k) Kept up daily audits in accordance with IPSG chapters and standards.

CHAPTER 1: INTRODUCTION

Introduction

1. A hospital's quality department is an expert unit tasked with managing and supervising the healthcare facility's overall quality improvement programs, patient safety, and standards of care. It guarantees that the services offered maximize patient outcomes and satisfaction while lowering risks and errors, and that they meet or beyond recognized standards, recommendations, and best practices. In order to consistently monitor, evaluate, and improve the standard of care delivery procedures and results, this department works with a variety of stakeholders from within the business.

2. Patient safety is a field that focuses on improving health care safety by preventing, reducing, reporting, and analysing medical errors that frequently have unfavourable outcomes.
The World Health Organization describes patient safety as a common concern, noting that healthcare errors affect one in ten patients globally. In fact, patient safety has become its own field within healthcare, bolstered by a young but growing body of scientific research.

3. Until recently, medical errors were considered to be a tragic result of bad healthcare providers or a natural outcome of modern medicine, despite the fact that Hippocrates preached the first lesson in medicine more than 2000 years ago and that many hospitals have long held conferences to discuss errors (Morbidity and Mortality conferences). The idea of doing everything possible to heal the patient, take precautions against hospital acquired diseases and unfavourable events, and guarantee patient safety is intrinsic to the idea of doing no harm to the patient.

4. Hospitals nowadays are complicated organizations. In addition to offering patients 24/7 multispecialty medical treatment, they also provide a wide range of other hospitality-based services. As a result, there are now more individuals caring for patients during their hospital stay. As a result, any patient coming to a hospital might have to go through the following procedures or locations where different services, both medical and non-medical, will be interacting:

(a) Reception.
(b) OPD of various specialties.
(c) IPD.
(d) Laboratory.
(e) Radiology.
(f) Emergency.
(g) ICU/HDU/CCU.
(h) Pharmacy.

5. Even before, the development of medical documentation in hospitals was predicated on the prior experiences of healthcare institutions. But these days, with the assistance of accrediting procedures that have arisen in wealthy nations, this irregular and uneven method of self-learning has been replaced. While healthcare accreditation began in the 1990s in the developed West, it was not until 2006 that the NABH was established in our country. The accreditation process entails a series of steps that culminate in the creation of standardized check lists. These checklists serve as the foundation for a healthcare organization's standard operating procedures that guarantee patient safety. The accreditation provides significant room for modifications that can be made to the Patient Safety standards based on the facilities that an institution may have. These modifications can be accomplished by matching of the current 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.

6. The treatment itself is determined by the subjective opinions of the physicians, but from the perspective of a hospital administrator, one can also affect patient safety by learning about how patient safety functions and contributing to its development (e.g., high-reliability design, use of safety sciences, methods for causing

change, including cultural change). One of the easiest ways to meet the patient safety goals is to maintain patient medical documentation that is based on standardization.

7. A system for continually assessing patient safety measures must be created, yet in a future accredited healthcare facility, the comparison criteria could not be accessible. It's possible that the prior data needed for the study won't offer enough information to support reasonable conclusions about patient safety. In these situations, close supervision of the newly formed procedures is necessary to ensure the development of a professional culture within the organization. Because of this, all processes are carried out in accordance with the established Standard Operating Procedures if the healthcare institution is accredited, and documentation of every step is necessary. Therefore, if a certified hospital maintains appropriate patient medical documentation, the audit process itself might serve as one of the indicators used by management to evaluate whether patient safety requirements are being maintained.

8. A patient's medical history and care are methodically documented in a medical record, often known as a health record or medical chart. Medical records provide a wealth of information on the start and growth of the hospital, statistical analysis both past and present, patterns in the cases admitted to the hospital, and other topics. Medical records need to be carefully and methodically assembled, maintained, and safeguarded for the good of the hospital, physicians, and patients. The idea that **"People forget, but records remember"** supports the need for complete and accurate medical records for therapeutic, legal, financial, and research objectives.

9. The medical record serves as a tool to enhance the quality of care as well as to assess it. The medical record serves as a communication tool and information source for healthcare professionals, but it also has growing legal significance.

10. While the patient's safety should always be the primary concern, different stakeholders may have different goals for the medical documentation.
The establishment of a medical record in a healthcare facility may have the following goals: to preserve patients in secure custody; to have enough information documented in a chronological fashion to support each patient's diagnosis, course of treatment, and outcome; and to make them easily accessible for the patient, the physician, the hospital administration, medicolegal purposes, and external reporting as needed:

(a**)** **The Patient**. The patient's medical file.

(i) Medical intervention serves to record the patient's activities and clinical history.

(ii) Prevents the omission of treatment measures or carrying out diagnostic

(iii) Supports care continuity even in the event of a future illness, whether it necessitates hospitalization or not.

(iv) Is used as proof in medicolegal proceedings.

(v) Grant the required certification to get a job.

(b) **The Physician**. For the physician,

i. Guarantees the effectiveness and suitability of the treatments and diagnostic procedures carried out.
ii. Provides reassurance over the availability of medical care.
iii. Assesses medical procedures.
Iv. Litigation protection.

(c) **Administrators of hospitals.**

i. The task of the hospital administrator is to record the kind and volume of work that is done.

ii. to assess the medical staff's competence for both clinical and administrative needs.

iii. to assess the hospital's services in light of widely recognized norms and standards.

iv. to act as a performance and administrative record.

v. to support future programmers for hospital planning and development.

(d) **For legal purposes, medico.** It serves two purposes for medical legal purposes:

(i) as documentation evidence.

(ii) for resolving insurance claims.

(iii) The patient's WILL to specify whether the patient was in a normal mental state.

(iv) Malpractice lawsuits

(v) A signed consent form or authorization for the surgery will attest to the patient's or relative's approval of the procedure's execution.

(vi) Criminal Cases: A Possible Record.

(e) **Independent Reporting**. The development of hospital performance statistics, statistical, and epidemiological data are required for the management and implementation of medical care planning, as well as for the acquisition of health indicators that hospital management can use to track and assess the effectiveness of these plans:

(i)Bed Occupancy Rate

(ii) The mean count of absent patients.

(iii) The mean number of admissions.

(iv) Entrance based on gender.

(v) The Typical Duration of Patients' Stay.

(vi) Death Rate, Gross, and Net.

(vii) Total number of operations (major and minor) conducted.

(viii) The quantity of CT scans, ultrasounds, and X-rays, etc.

(ix) Laboratory Examinations.

11. **Medical Audit.** Medical audit is a study of some part of the structure, process, and outcome of medical care, carried out by those personally engaged in the activity concerned, to measure whether set objectives have been attained, and thus assess the quality of care delivered.

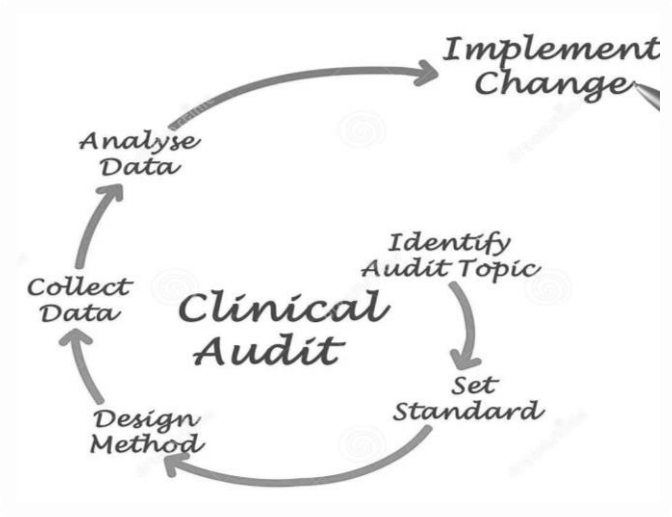


Figure 1.1: The Steps of Medical Audit

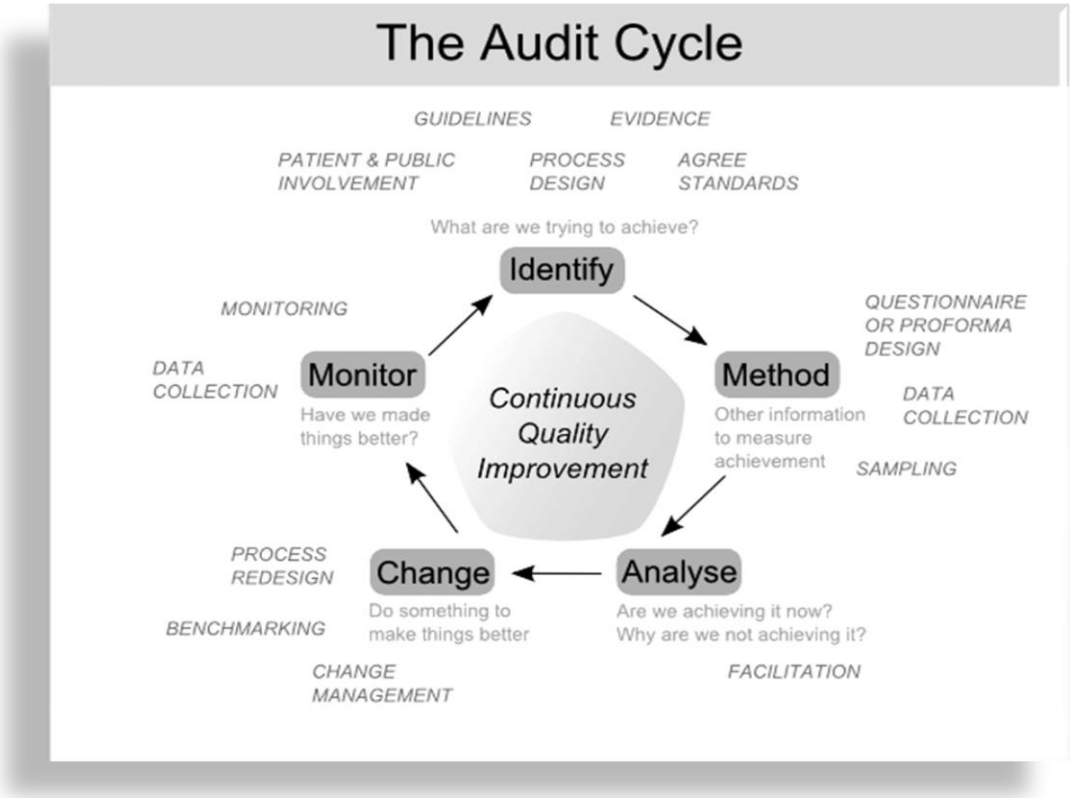


Figure 1.2: Audit Cycle

CHAPTER 2: REVIEW OF LITERATURE

PATIENT SAFETY

12. Hospitals may not be completely safe spaces for healing, despite the recognized ability of modern medicine to treat and prevent disease. Patients may suffer from medication errors, accidents, sentinel events, hospital acquired infections (HAI), etc. The most significant reaction to this information was the rise in interest in patient safety among every organization involved, which caused it to become a discipline with its own comprehensive body of knowledge and experience.

13. Patient safety as a discipline or field of investigation and activity has not yet been adequately defined in the key consensus statements of the organizations that have spurred its establishment, despite the Institute of Medicine (IOM) defining safety as the absence of unintended injury. It is a topic related to the quality of healthcare.

14. There is a lack of accurate and trustworthy information about the metrics that indicate the Patient Safety standards that apply to India. In industrialized nations, on the other hand, these statistics are preserved and open to interpretation. For example, studies conducted in the United Kingdom indicate that 10% of hospitalized patients experience an adverse event.

15. Thanks to global awareness campaigns like the World Alliance for Patient Safety organized by the World Health Organization, patient safety is becoming acknowledged in developing nations like as India. A novel method must be clearly evaluated in terms of its resources and influence on patient safety outcomes for a healthcare institution to implement it. Established readers have articulated and executed many aspects of patient safety, and their model can be used as a point of reference. Even the set of established expectations for patient safety provided by the accreditation is arbitrary. The evolution of a hospital's patient safety goals should start within the company with the purpose and vision statements provided by the head of the company. After considering all relevant aspects, these characteristics ought to serve as the cornerstone for achieving the intended requirements for patient safety.

16. The fact that patient safety is typically left out of even the most fundamental healthcare building block shows how little importance is placed on providing safe patient care. Only with appropriate training and support in staying up to date on current developments in the field can safe patient care be enhanced. A healthcare organization would be best served by concentrating on modern training and assessment methods and working to establish institutionalized on-the-job learning mechanisms in a developing nation such as ours.

17. Healthcare companies must understand why mistakes are made to meet patient safety goals. To do this, they must learn from the experiences of industrialized nations rather than only obtaining certification. The evolution of the patient safety process must be studied, and compliance to the standards established by standardization must be embraced. It will be like passing along technology while also improving equipment. The evolution of patient safety in developed countries has progressed through several stages, each building upon the lessons learned and challenges identified along the way. Here are the basic stages that can be identified in the evolution of patient safety :

Recognition of Patient Injury: In the past, patient safety concerns were frequently disregarded or taken for granted as inevitable byproducts of medical treatment. Determining the degree of patient injury brought on by medical mistakes, unfavorable events, and illnesses linked to healthcare is the first step.

Cultural change Towards Safety: As the public, legislators, and healthcare professionals became more conscious of the avoidable nature of many adverse events, a cultural change toward emphasizing patient safety occurred. The notion that patient safety is an essential element of high-quality healthcare was becoming more widely accepted.

Establishment of Patient Safety Initiatives: Programs and initiatives aimed at enhancing patient safety were put into place by professional associations, healthcare organizations, and governments. Among these efforts was the creation of best practices, procedures, and recommendations with the goal of lowering adverse events and medical errors.

Development of Patient Safety Law and Regulation: To enforce patient safety requirements and encourage provider accountability, legislative and regulatory frameworks were developed. During this phase, adverse

event reporting systems were put into place, and regulatory organizations were set up to monitor patient safety in hospital settings.

Integration of Patient Safety into Healthcare Delivery: The fundamentals of patient safety have been woven into the systems that provide healthcare. This included implementing safety checklists, standardized processes, and clinical protocols as well as other systematic approaches to risk identification and mitigation.

Emphasis on Openness and Transparency: When it comes to patient safety issues, there has been a growing emphasis on openness and transparency between healthcare practitioners, patients, and their families. This included program aimed at helping healthcare professionals communicate more effectively with one another and at including patients in their own treatment and decision-making.

Technology and Data Utilization: To improve patient safety, technological advancements in healthcare, including electronic health records (EHRs), drug management systems, and clinical decision support tools, were utilized. By enabling more proactive measures to avert injury, these technologies permitted the real-time monitoring of patient data, prescription errors, and adverse events.

Constant Learning and Improvement: It is acknowledged that patient safety is a constant process of development. To promote future improvements in patient safety, healthcare institutions actively participate in collaborative learning networks, share best practices, and analyze the underlying causes of adverse occurrences as part of their ongoing quality improvement initiatives.

18. Any system's failure is almost always primarily caused by human factors and characteristics. This is about how humans and systems interact and play together. Task management, multidisciplinary teamwork, risk perception, decision-making, and acknowledging one's own and technology limitations are among the subjects covered in medical training that have been demonstrated to enhance knowledge of error and prevent it. See one, do one, teach one is a common learning philosophy that is promoted to students. This is not a suitable way to guarantee the safety of medical care. Inadequate training of healthcare personnel can play a significant role in the development of unfavorable outcomes. Healthcare organizations have limited control on the fundamental training that their employees get, but they can several ways to modernize and enhance its workforce to proactively solve the patient safety issue. These days, multispecialty hospitals employ people from a variety of areas, and their presence offers expertise from other fields as well, which may offer prefabricated insight into the training methodologies used in those fields.

ROLE OF COMMUNICATION IN PATIENT SAFETY

19. One of the main causes of errors and the key to patient safety is effective communication. Additionally essential to handling a situation after it has happened is effective communication.
There are two main categories of communication in a healthcare setting: interactions between healthcare professionals and the patient (or family member) and the healthcare worker. Medical errors can be caused by a variety of factors.

Interactions Between Medical Professionals and Patients

20. Health care workers and patients have intricate interactions. The intricacy stems in part from shifting expectations. In today's world, consumers typically expect their healthcare provider to guide them through a complex system and base communication on joint decision-making.
Different forms of communication may be utilized during a contact between a patient and a healthcare professional, including:

(a) **Nonverbal:** It has been demonstrated that patients' interpretation of the information they are given is greatly influenced by the cues they take up from the body language of the healthcare provider.

(b) **Verbal:** Research has indicated discrepancies in the perceptions of patients and healthcare professionals on communication. The ability of patients and healthcare professionals to speak in the same language is among the most significant aspects that affect communication. Research have demonstrated that having interpreters available is not only more economical but also better for patients. The ideal way to offer this kind of interpretation is unclear. Everyone is acknowledged that appropriate analyzing is best provided by professionals. They are expensive though, and not always accessible. Patients consider family members as the second-best choice, but medical professionals appear to choose phone translation.

(c) **Documentary Data:** Written information is the last type of communication that can be employed between patients and healthcare professionals. There are hazards with this as well. Many patients find it challenging to grasp printed health-related information. Research indicates that comprehension of this kind of information, sometimes referred to as Functional Health Literacy (FHL), is unrelated to other types of literacy. Moreover, it seems that the average FHL is far lower than the FHL needed to read the stuff that is typically produced. Furthermore, new methods such as online patient support materials necessitate reading abilities to access the websites, which not everyone possesses.

Interactions Among Healthcare Professionals

21. Research has revealed that a key factor in the creation of errors is the communication between healthcare professionals.

22. A key component in preventing mistakes before they happen is empowering professionals to speak up through team-building activities and breaking down hierarchies.

Effective Communication and Incident Management

23. When an incident does happen, communication is crucial to handling these unfavorable situations. Even though it can be challenging to appease the patient and their family, it is morally required to apologize and provide an explanation.

24. In all facets of error, communication is crucial. It helps to enhance the standard of communication between medical personnel and between patients, which helps to prevent errors. Effective communication is essential when handling mistakes that have already happened.

PATIENT MEDICAL RECORD AND AUDIT

Patient Medical Record

25. Prior to examining the precise function of medical records in relation to patient safety, we must first address the medical record. what it is, how it grows, and why it matters so much. An essential source of information regarding a patient's life and health is their medical record. It contains records of the patient's past and current medical conditions as well as their treatments, written by the medical staff who are attending to them. A patient's medical record must have enough information to identify them, validate their diagnosis or cause for visiting the hospital, support their course of therapy, and precisely record the outcome of that course of care.

26. There are four main sections in the medical record:

(a) Administrative, containing patient name and other socioeconomic and demographic information (identification), sex, birthplace, date of birth, patient's permanent address, and medical record number.

(b) Clinical data about the patient, whether they are being treated as an emergency patient, an outpatient, or admitted to the hospital.

(c) Legal data, such as a signed consent form giving permission for treatment by designated physicians and information sharing.

(d) Financial data about the payment of medical service and hospital accommodation fees.

Documentation vs. Record:

27. Documents are generated by planning what must be done, while records are generated when something is completed.

(a) Definition of Record: "Evidence about a past event" Records are any data you gather while operating your business; they are facts and should not change.

(b) Definition of Documentation: "The term documentation is generally used for the gathering and recording of information, especially to establish or provide evidence of facts or testimony."

28. Proper preparation of Assessments, Care and Discharge plans requires in-depth professional judgment and reflection. Rather than considering documentation as time-consuming and laborious, professionals should consider it as a crucial component of their work.

29. **PATIENT MEDICAL FORMS**

a. Admission Request Form

b. General & Informed Consent

c. Patient Education

d. OT Surgery & Post Surgery Notes

e. Monitoring for PACU

f. Medical Administration Record

g. Nutritional Assessment

h. Discharge Summary

i. Plan Of Care

j. Viral Marker

k. Face Sheet

AIM AND OBJECTIVES

Aim

Medical audit of a multispecialty hospital's inpatient medical record reporting.

Objective of Study

- To determine if the hospital's policy is being followed by the current documentation process.
- To highlight all the errors in the same and offer some potential fixes.
- To define the function of documentation in patient safety and medical
- To determine the most likely non-medical mistakes made by physicians and nurses in patient medical records that directly affect patient safety.
- To use patient medical documentation internal audit as a tool for patient safety and physician defensibility in a newly opened hospital.
- To suggest a comprehensive internal audit system to influence how documentation is approached behaviorally to enhance patient safety and physician defensibility in a hospital.

METHODOLOGY

Study Setting: The Study will be conducted in Aakash Healthcare Super Speciality Hospital, Dwarka.

Study Population/Area: A 230 Bedded Super Speciality Hospital in the Medical Ward records of 2 months, 30 Patient Files from each floor, Micu, Nicu, Dialysis, Gastro, Broncho, Medical Record Department.

Material and Methods

Data Collection Methods: Retrospective and Cross-Sectional Descriptive Study, Electronic Health Records.

Sr. No	Name of Ward/ICU/MRD	No of folders audited
1	IPD – 4^{th},5^{th},6^{th} floor	529
2	ICU's – 2^{nd} floor	59
3	MRD Section	30
	Total	**616**

Study Tool: Appendix A, the patient medical documentation audit form, was used.

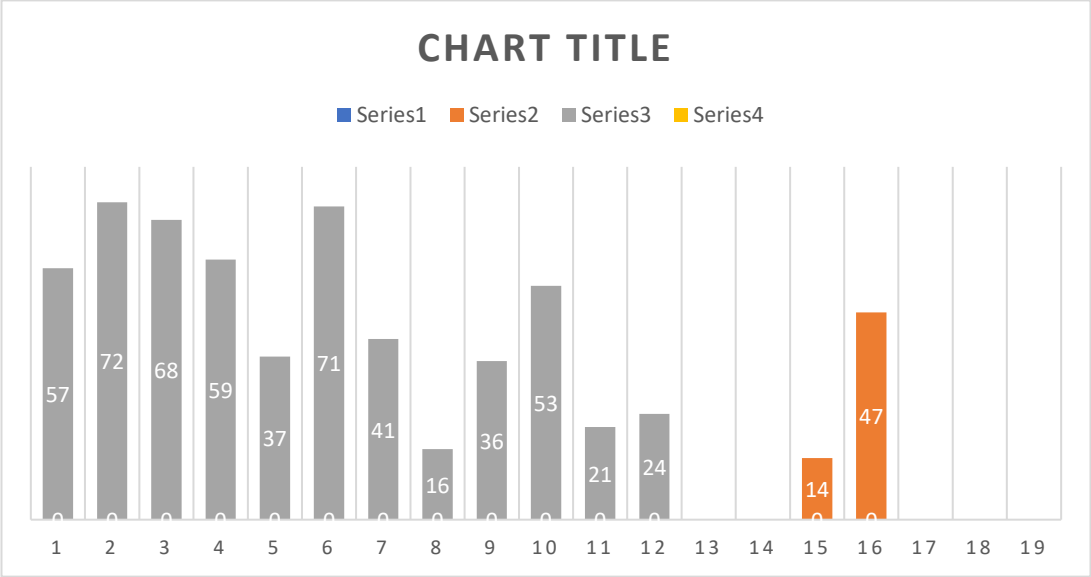
Sampling Technique: The goal was to protect patient safety by not interfering with the medical treatment process. Technique used was nonprobability purposive sampling.

Observation And Analysis

Breakdown – Department Wise:

	NO. OF FILES
Gastro	57
Obs Gynae	72
Int Med 1&2	68
Neuro	59
Nephro	37
Peads	71
Euro & Renal trans	41
Surgical & Onco	16
Gen Surg	36
Respiratory Med	53
Micu	21
Nicu	24
Nsicu	14
Orho	47

Total	**616**



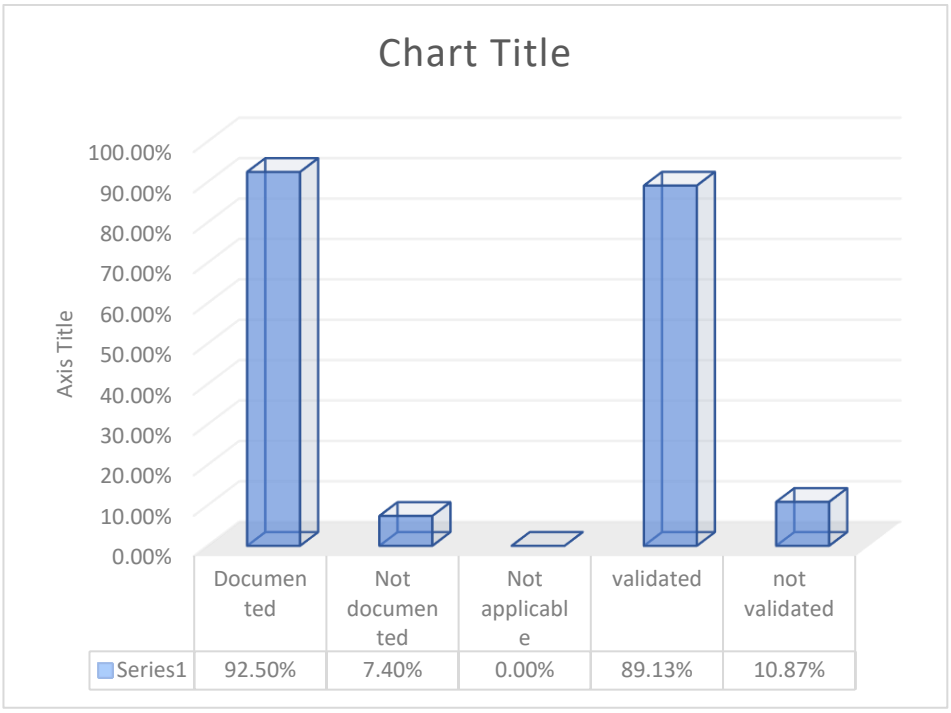
Total Medical file Audited.

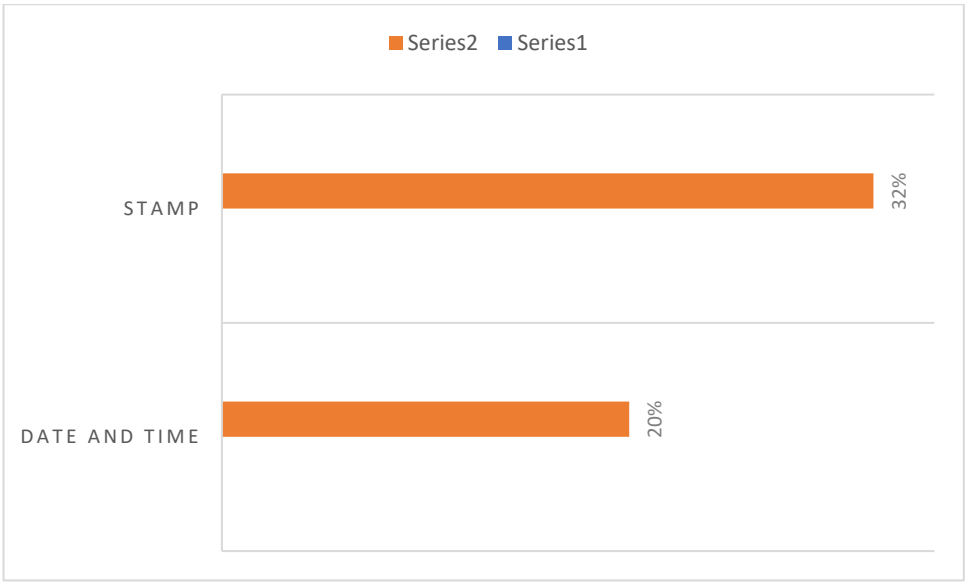
IP Initial Assessment (IA)

92.50 % of the IP Initial Assessment were documented and 89.13% of the documents have been validated. The IP Initial Assessment (Doc's IA) is responsible for the plan of treatment and needs to be done as per the documented procedure and should be completed. Even though, the Doc's IA seemed to be complete as per the format evolved as per the NABH guidelines, there were general shortcomings noted in the documentation which are given as under:

(a) The time for Doc's IA has not been endorsed in 20 % of the documents.

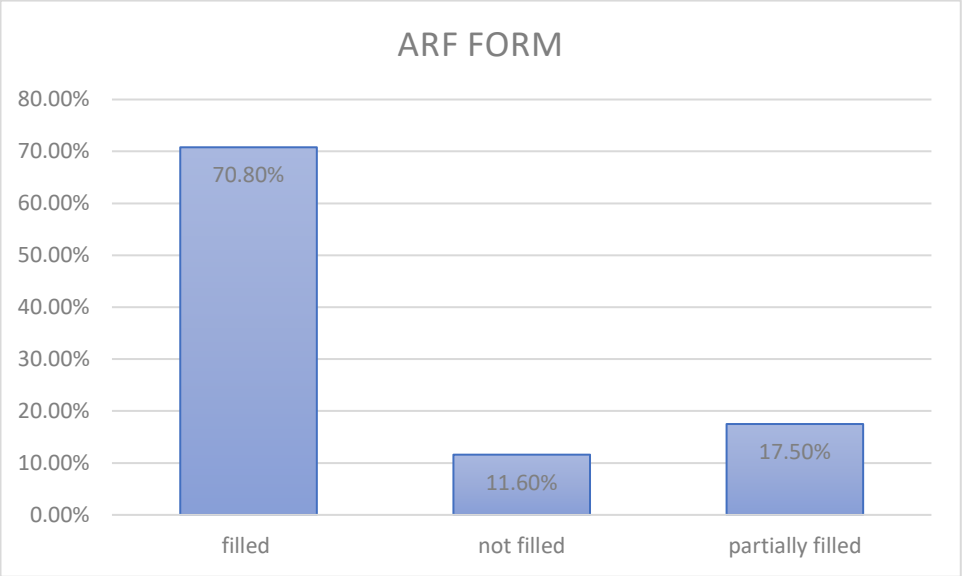
(b) The names of doctor's and consultants were not legible in 32% of the places. Even though many doctors have been issued with personalized rubber stamps, they were not used in many of the forms.





Date and Time – Stamp of consultant

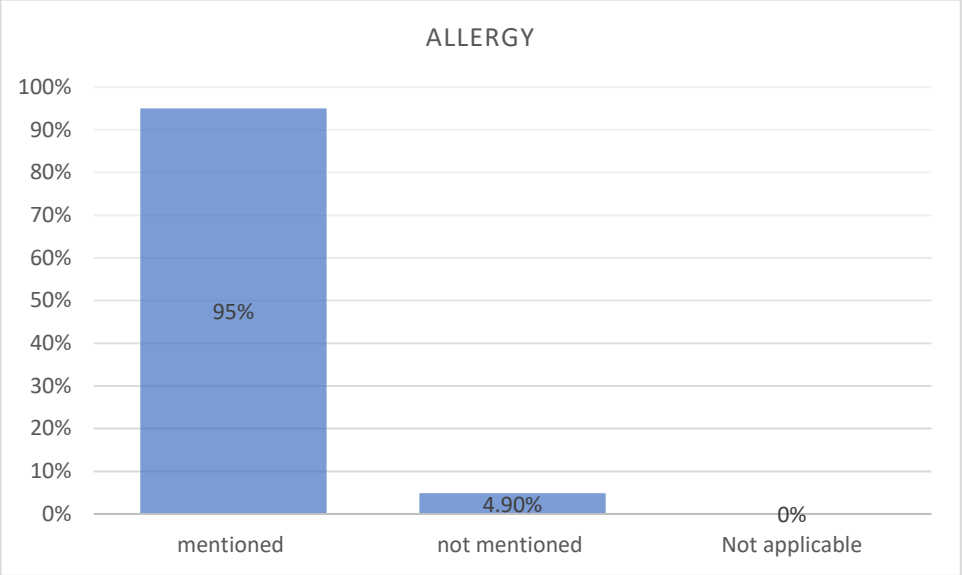
Admission Request Form: Completed ARF forms with a doctor's signature, date, and time are filled out by 70.8% of the total; forms that are not filled out are 11.6%, and forms that are partially filled out are 17.5%.



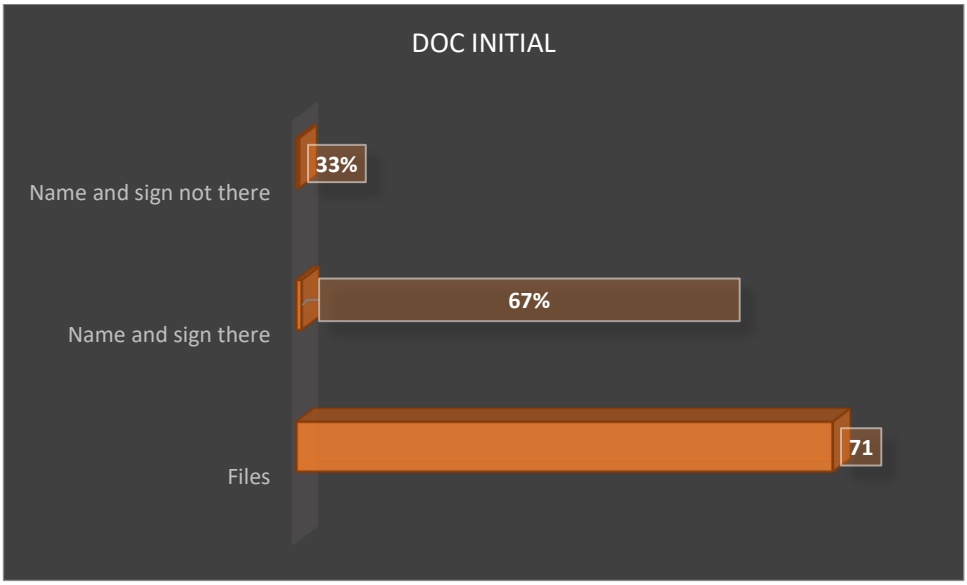
DOC'S IA

Medical administration Record: One of the most important interventions carried out by medical experts is documented in the medication administration chart. It is designed to identify every cause of an adverse medication event in accordance with NABH guidelines. The audit's findings are as follows:

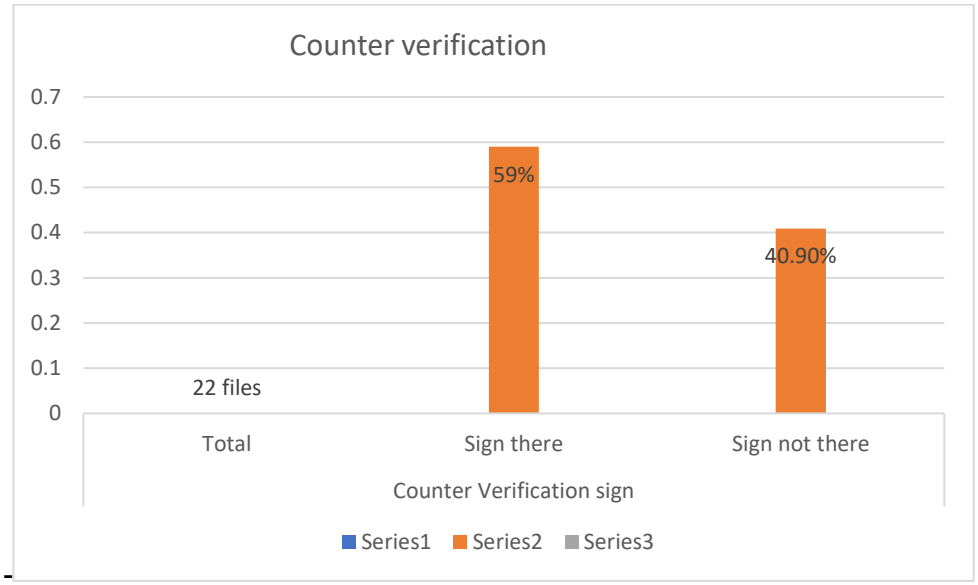
a) Allergies mentioned in the sheet has not been done in 4.90% of MAR



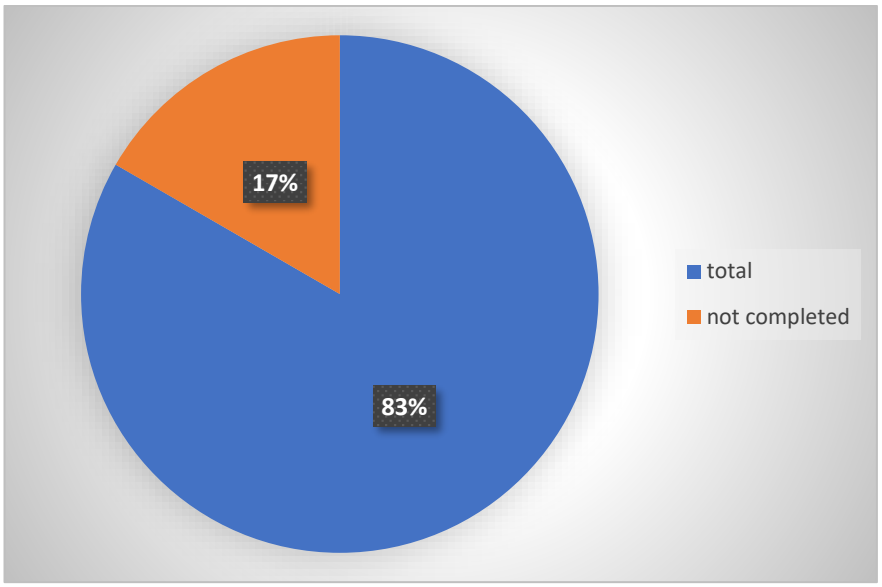
b) Name & Sign of Doctors mentioned in the sheet. After the audit the Non-Compliance was found to be 33%.



c) High risk medicines must be signed by the doc during administrating and need to be counter verified by another consultant. The non-compliance was 40/9 %



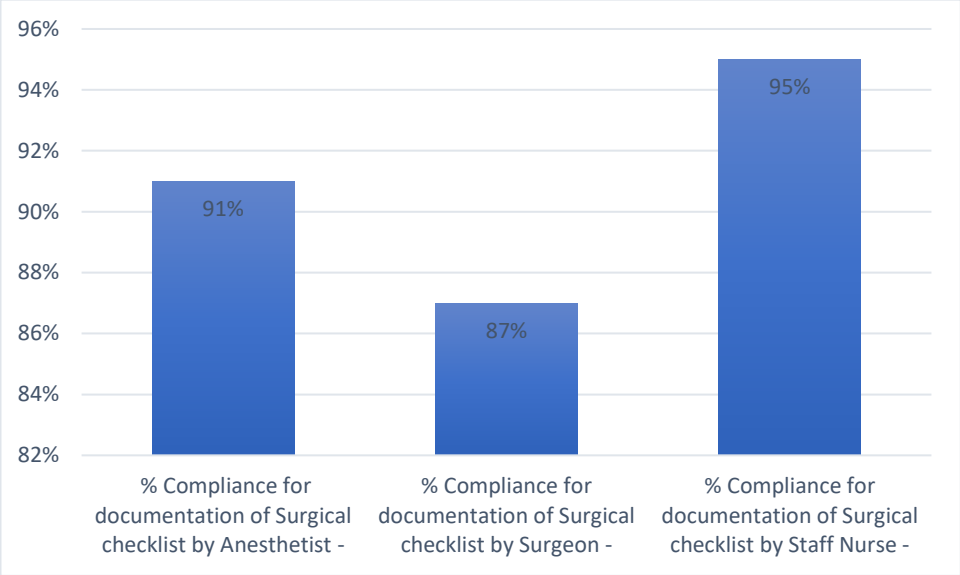
Documentation Practices of Sedation - Audit (BRONCHO) : Total 15 Surgical cases files in endoscopy was audited. There was no non compliance . Total number of 3 forms i.e. 17 % of the forms were found to be partially complete .



All the forms were with premedication and advice for care but 3 forms were without the name of the consultant who had given the sedation.

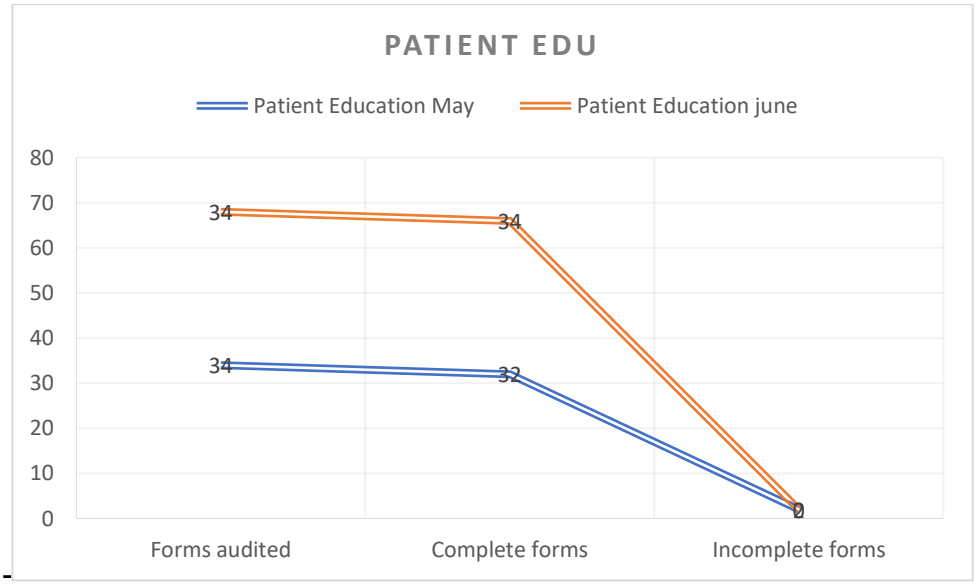
Surgical Safety : the NABH checklist consists of three main parts , which are implemented at specific time points during the surgery . The sign , name , dmc / emp id of anaesthetist , surgeon , staff nurse needs to be completed.

The Compliance for documentation of Surgical checklist by Anaesthetist was 91%
The Compliance for documentation of Surgical checklist by Surgeon was 87%
The Compliance for documentation of Surgical checklist by Staff nurse was 95%



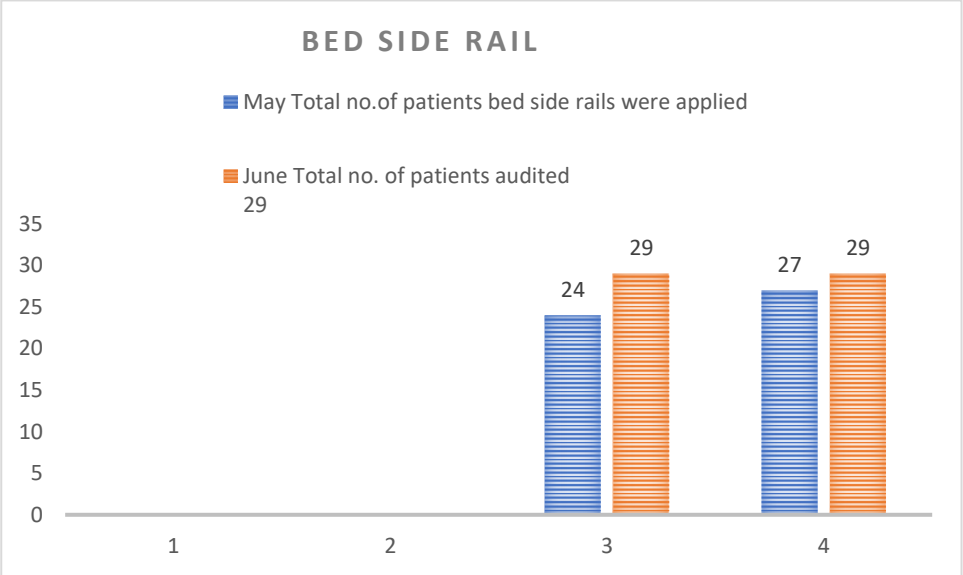
Patient Education: NABH Goal 6-Reduce the risk of patient injury resulting from falls includes patient education. It consist of how to use the Call Bell , how to close and open the side rails of bed, and emergency numbers . After explaining the nurse the patient or the attendant signs at the form .

Total forms audited were 34 in may in which 2 were not signed. And then did the re audit in June for 34 files again and all were signed and filled completely.



Bed Side Rails : Bed rails can lessen the possibility that patients will roll over, slide, slip, or tumble out of bed and suffer serious harm as a result.

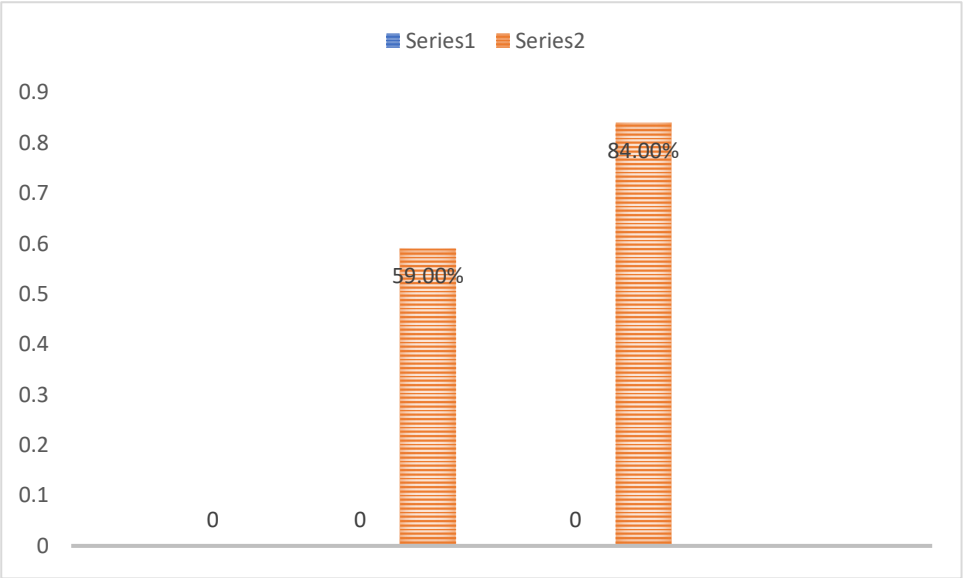
%Compliance of patient's bed side rails were applied	82.79%	93%



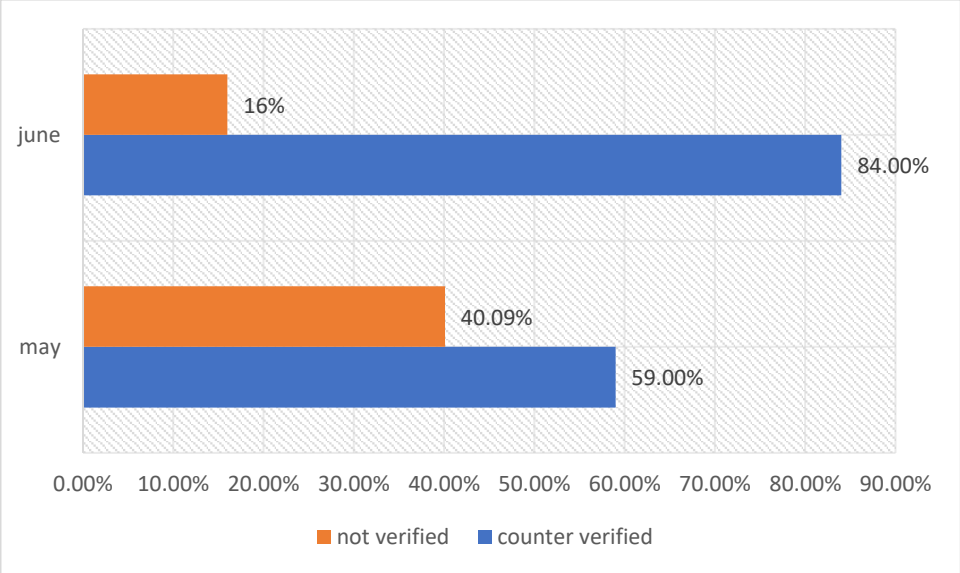
Talking points and suggestions:

One workable way to enhance the paperwork and advance patient safety could be to employ audits to evaluate the types of errors and set standards. Notwithstanding the fact that better patient medical documentation is necessary to raise patient safety in India, a relevant study has been published in Indian J Medical Science, Vol. 62, No. 11, November 2008. Bates et al. conducted a study to evaluate adverse drug events.
They showed that 28% of these events might have been prevented and that 56% of those avoidable adverse events happened during the ordering* stage. Although there isn't any evidence available for India in this regard, it can be inferred that Bates's research findings would be more than relevant.

Progress of Admission Request Form: It was found that the Completed ARF forms with a doctor's signature, date, and time was filled out by 70.8% of the total; forms that are not filled out are 11.6%, and forms that are partially filled out are 17.5%.
After the Training and daily auditing, the noncompliance got reduced and the IA improved by doctor's signature, date, and time was endorsed by 76.74% of the total; forms that are not filled out are 10.4%, and forms that are partially filled out are 12.7%.
Since many persons are involved in modern medical treatment, and much is communicated regarding the potential thought process of the physician supporting the document, this makes the assessment that follows more challenging: The admission request form's lack of originality limits the following assessor from understanding the crucial previous reasoning, which is itself supported by evidence.



Progress of counter verification sign: High risk medicines signed by the doc during administrating that needed to be counter verified by another consultant. The non-compliance was 40/9 %, after internal audit the files audited were 26 in which 22 files were counter verified and 4 were still not verified. So, he total compliance was 84% and non-compliance reduced to 16 %.



Progress of MAR sheet: Previous - a) Allergies mentioned in the sheet has not been done in 4.90% of MAR.

b) Name & Sign of Doctors mentioned in the sheet. After the audit the Non-Compliance was found to be 33%.

Later - a) Allergies mentioned in the sheet has not been done in 2.27% of MAR.

b) Name & Sign of Doctors mentioned in the sheet. After the audit the Non-Compliance was found to be 20%.

CONCLUSION:

- It is advised to take the auditing process into account to raise medical care standards. It is imperative that trainees learn the importance of spelling drugs properly, reviewing their course of therapy, and identifying the prescribing physician.

- The current Make in India activities in our nation have brought to light the mismatch between growth and thought processes, resource mismanagement, inadequate policy execution, etc. The same is true in the medical industry, where a mismatch between early-life fundamental education and rising national aspirations based on Developed World standards has led to incoherent advancement. Actually, because of the failing educational system in our nation the expectations outlined in benchmarks—which use the developed world as a point of reference—and the actual situation are diverging more and more.

- As part of the Made in India program, we must begin to look inside and develop our own standards for healthcare that are based on an indigenous, holistic approach. The rapid implementation of the certification criteria, which were designed in developed countries after thorough research, is a result of the private healthcare sector's shift in focus to attract business from such nations. This has resulted in the development of an accreditation system in our nation's healthcare industry that is primarily based on industrialized nations rather than being locally formed.

- However, the accreditation has been granted by This for the most part caused our nation's medical treatment to become more standardized. The process of becoming accredited involves adhering to standard operating procedures, which are put into practice by developing different forms and documentation. Per the requirements of the accreditation, these documents are audited both internally and externally. Instead, then being limited to the requirements of accreditation and the legal framework, the documentation should prioritize patient safety and physician defensibility. According to the study's findings, a hospital's internal audit of patient medical documentation can help to positively influence physicians' and nurses' attitudes regarding documentation, ultimately leading to improved patient safety and physician defensibility.

- Strengthening this kind of internal audit of patient medical documentation is necessary to return a hospital's attention to patient safety, which has previously switched to document completion solely for the purpose of meeting regulatory requirements.

- By aiming to change the sharp end's behavior, the current study addressed the issues of physician defensibility and patient safety through improvements in patient medical documentation. Further confirmation of this element needs to be done by comparing the more direct patient safety indicators, which could be possible in an older setup where longer-term comparative data would be available.

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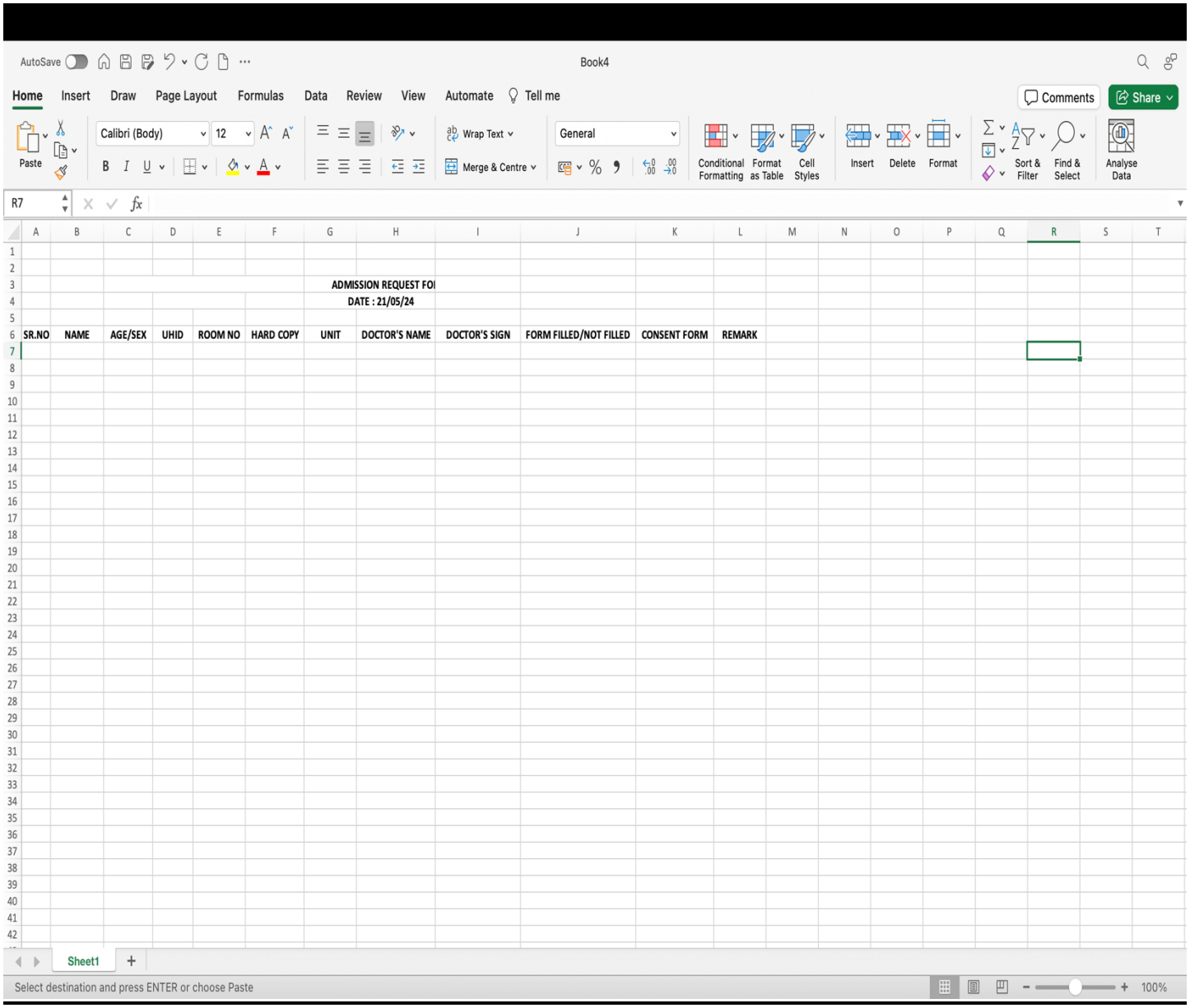
ANNEXURE:



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R7

ADMISSION REQUEST FOI

DATE : 21/05/24

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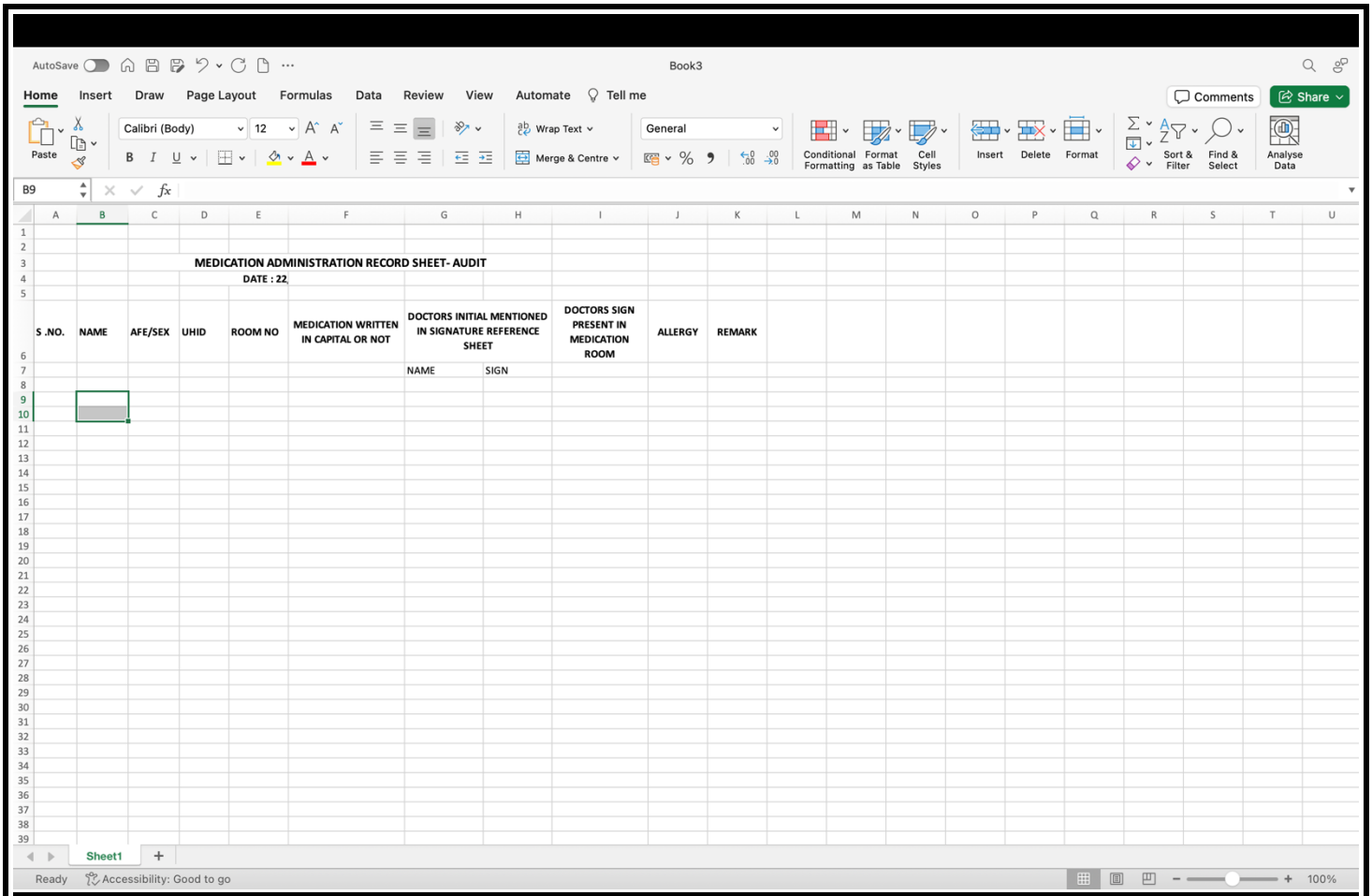

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MEDICATION ADMINISTRATION RECORD SHEET- AUDIT

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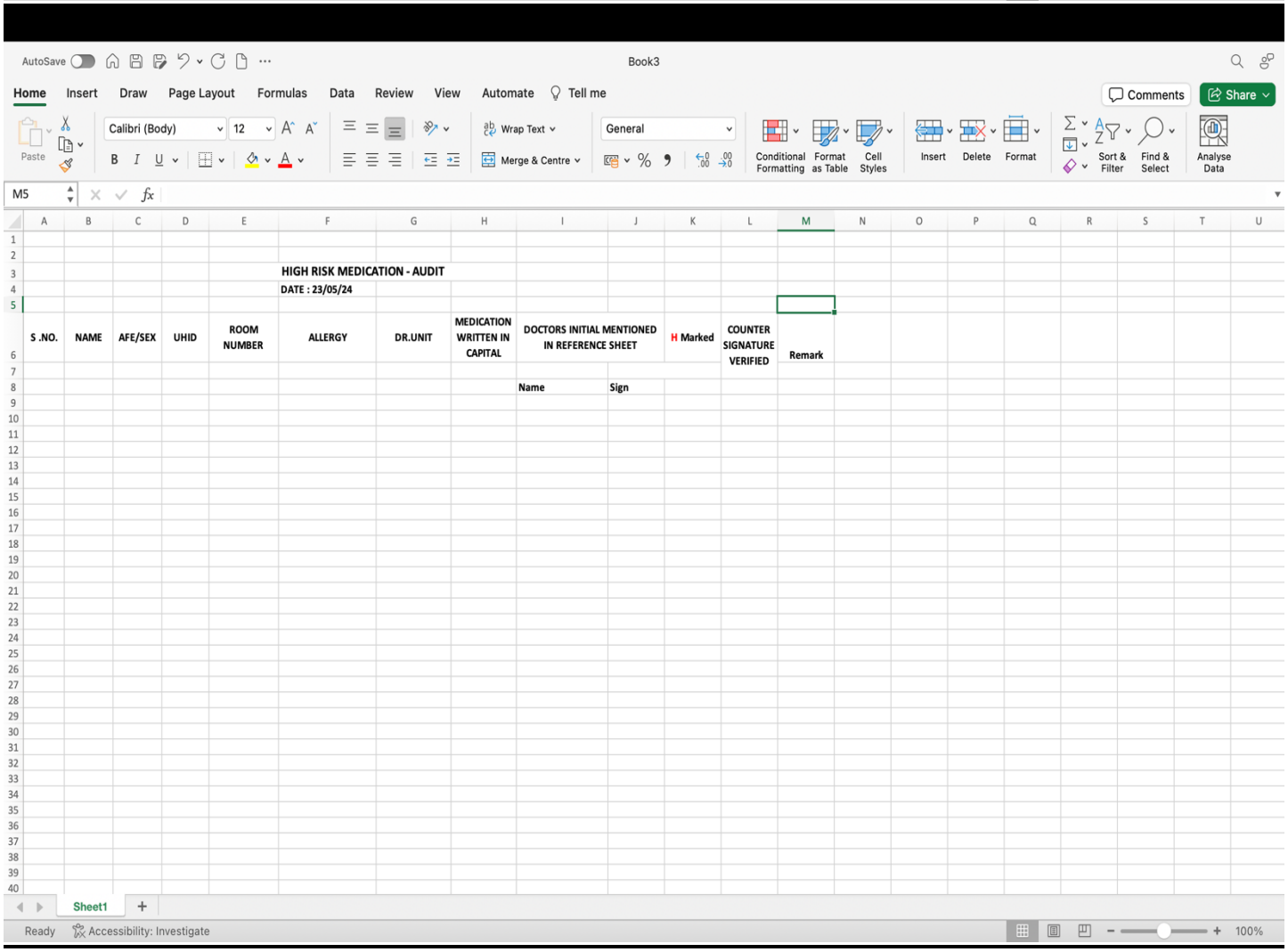

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M5

HIGH RISK MEDICATION - AUDIT

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