SUMMER INTERNSHIP REPORT

AT

MAX SMART SUPERSPECIALITY HOSPITAL

SAKET, NEW DELHI

(APRIL 22ND TO JUNE 21st,2024)

A REPORT ON

"MEDICAL DOCUMENTATION AUDIT OF ACTIVE IPD PATIENTS"

PRIYANSHA SRIVASTAVA

POST GRADUATE DIPLOMA IN HOSPITAL AND HEALTH MANAGEMENT

2023-2025

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

Completion of Summer Internship from Max Smart Superspeciality Hospital, Saket

This certificate is awarded to

Ms. Priyansha Srivastava

in recognition of having successfully completed his/her internship in the department of

Hospital Operations

and has successfully completed her project on

"Medical Documentation Audit of Active IPD patients"

From 22nd April to 21st June, 2024

Max Smart Superspeciality Hospital, Saket, New Delhi

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

We wish her all the best for future endeavors

Organisation Supervisor

Head- HR/Department head

MAX Healthcare
Dr. Manju Khemani
Senior Director & Head of Unit
Obstetrics & Gynaecology
Max Smart Super Speci..lity Hospital
(A Unit of Gujarmal Modi Hospital & Research Centre For Medical Sciences)
DMC Regn. No. 7166

Certificate No – 2024/16801

CERTIFICATE

OF ACHIEVEMENT

MAX Healthcare

Max Institute of Medical Education

Certifies that

Priyansha Srivastava

has completed Internship in the department of

Hospital Operation

at Max Smart Super Speciality Hospital, Saket, New Delhi

from 22nd April 2024 to 21st June 2024

Head of the Department

Dr Vinitaa Jha
Director - Research & Academics
Max Healthcare Institute Ltd

Certificate of Approval

The Summer Internship Project of titled **"MEDICAL DOCUMENTATION AUDIT OF ACTIVE IPD PATIENTS" at MAX Smart Superspeciality 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.

Dr. Rupsa Banerjee
Assistant Professor
IIHMR, Delhi

FEEDBACK FORM
(Organization Supervisor)

Name of the Student: PRIYANSHA SRIVASTAVA

Summer Internship Institution: MAX SMART SUPER SPECIALITY HOSPITAL, SAKET, NEW DELHI

Area of Summer Internship: HOSPITAL OPERATIONS

Attendance: 98%

Objectives met: ① She is brilliant in her work and very dedicated student. ② focussed and understands.

Deliverables: ① She proved to be good in handling process. patient & improved patient satisfaction

Strengths: ② Communication with senior doctors is good.

① focussed ② Dedicated ③ hardworking

Suggestions for improvement:

① Need to be meticulous & go in details bit

②

Date: 21/06/2024

Place: Delhi

Signature of office-incharg (internship)

FEEDBACK FORM

(IIHMR MENTOR)

Name of the Student: PRIYANSHA SRIVASTAVA

Summer Internship Institution: MAX SMART SUPER SPECIALITY HOSPITAL, SAKET, NEW DELHI.

Area of Summer Internship: HOSPITAL OPERATIONS

Attendance: 98%

Objectives met: Yes.

Deliverables: Internship project report, Organizational learnings

Strengths: Sincere, Hardworking.

Suggestions for Improvement: -

Signature of the Officer-in-Charge (Internship)

Date: 1/7/24.
Place: N. Delhi

TABLE OF CONTENT

ACKNOWLEDGEMENT

It is my esteemed pleasure to present the dissertation report on "MEDICAL DOCUMENTION AUDIT OF ACTIVE IPD PATIENTS IN SECOND FLOOR OF MAX SMART SUPERSPECIALITY HOSPITAL" in the organization.

I take this opportunity to express my profound gratitude and deep regards to Dr. Shahar Quereshi for her exemplary guidance, monitoring and constant encouragement throughout the internship period. I express my deep gratitude to my project guide Dr. Nutan Panda (Associate General Manager) for her guidance and constant supervision, as well as for providing necessary information regarding the project & also for the support in completing the project. I would also like to extend my sincere thanks to all of them in the organization who helped me out with this project.

I am very thankful to the operations team, Doctors and Nurses, without whose support at various stages, this project wouldn't have materialized. I am also thankful & grateful to all the supporting staff at the organization who directly and indirectly helped me in completing my project.

I would also like to express my gratitude towards Dr. Rupsa Banerjee (IIHMR, Delhi) for her kind co-operation and encouragement at each step, which helped me in completion of this project.

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS

- ✓ BMT :Bone marrow transplant
- ✓ BMW :Bio medical waste
- ✓ CAPA :Corrective and preventive action
- ✓ CT :Computer tomography
- ✓ CTVS :Cardio thoracic vascular surgery
- ✓ ECG :Electrocardiogram
- ✓ ECP :External counter pulsation
- ✓ EEG :Electroencephalogram
- ✓ EMG :Electromyogram
- ✓ EHR : Electronic Health Record
- ✓ EM :Emergency medicine
- ✓ F&B :Food & beverage
- ✓ FC :Fully complete
- ✓ HIS :Hospital information system
- ✓ HR :Human resources
- ✓ ICU :Intensive care unit
- ✓ ICCU :Intensive coronary care unit
- ✓ IT :Information technology
- ✓ IVF :In vitro fertilization6
- ✓ IPD :In patient department
- ✓ JCI :Joint commission international
- ✓ LAMA :Leave against medical advice
- ✓ MRD :Medical record department
- ✓ MRI :Magnetic resonance imaging
- ✓ MICU :Medical intensive care unit
- ✓ NABH :Nation accreditation board of hospital
- ✓ NCS :Nerve conduction studies
- ✓ NCV :Nerve conduction velocity test
- ✓ NC :Not complete
- ✓ NA :Not applicable
- ✓ NCB :Needle core biopsy

- ✓ OPD :Outpatient department
- ✓ PC :Partial complete
- ✓ PFT :Pulmonary function test
- ✓ RMST :Rehabilitation medicine scientist testing
- ✓ RCA :Root cause analysis

CHAPTER 1: OBSERVATIONAL LEARNING

OVERVIEW OF HOSPITAL

INTRODUCTION TO MAX SMART SUPERSPECIALITY HOSPITAL

ABOUT:

Max Smart Super Speciality Hospital, Saket (a unit of Gujarmal Modi Hospital & Research Centre for Medical Sciences). 250 bed facility with 12 high-end modular Operation Theatres, an Emergency Resuscitation and Observation unit, 72 critical care beds, 18 HDU beds, a dedicated Endoscopy Unit, an advanced Dialysis Unit.

It is a tertiary care hospital equipped with 256 Slice CT Angio, 3.0 Tesla digital broad band MRI, Cath Labs with electrophysiology navigation, and a flat panel C-Arm detector. It offers services in the medical disciplines of Cardiac Sciences, Orthopaedics, Urology, Neurology, Paediatrics, Obstetrics, and Gynaecology, making us the best hospital in Delhi. (1)

With the help of over 300 leading specialist Doctors, strong nursing staff, and state-of-the-art innovative medical tools, Max Smart Super Speciality Hospital, Saket aims to provide the highest standard of medical care to the patients, right from the admission and all the way to the patient discharge. Max Smart Super Speciality Hospital, Saket, offers the advantage of integrated medical care in a multidisciplinary setting provided by a faculty of highly qualified doctors, nurses, & healthcare professionals.

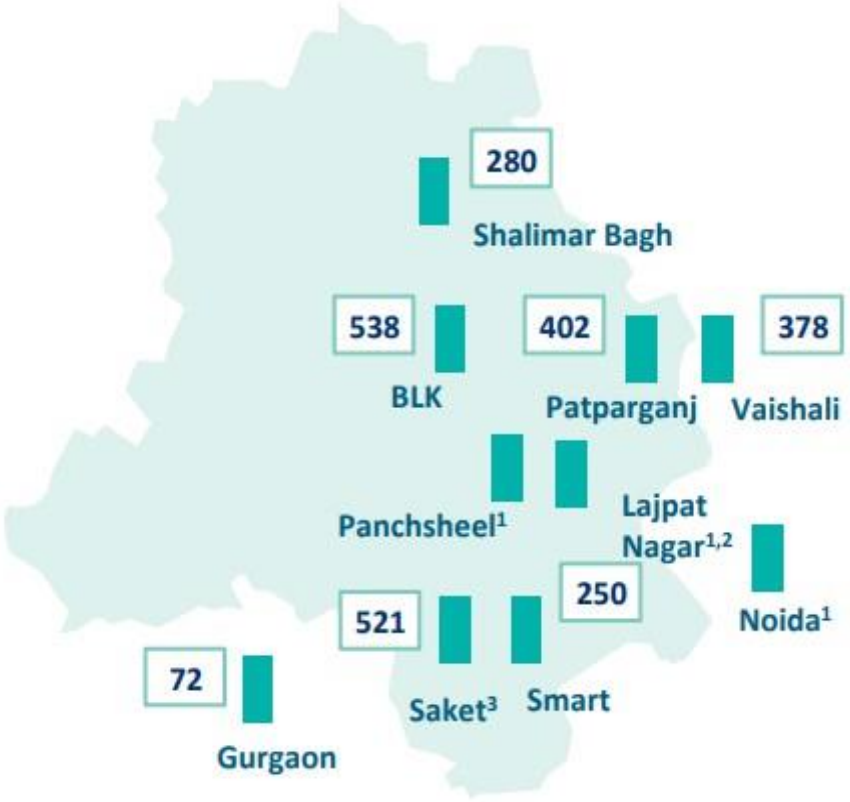
Max Smart Super Speciality Hospital, Saket is a regional hub for complex procedures such as neuro-vascular intervention, targeted cancer treatments, heart surgeries, orthopedic surgeries, renal, bariatric, paediatrics, obstetrics and gynecological treatments.(1)

OUR STORY

Max Healthcare Institute Limited ("Max Healthcare") is one of India's largest healthcare organizations. We operate 19 healthcare facilities (4000+ beds), 30+ specialities and 5000+ clinicians across the NCR Delhi, Haryana, Punjab, Uttarakhand and Maharashtra. Almost 85% of our bed capacity is in Metro/Tier 1 cities. Apart from hospitals, Max Healthcare also operates a homecare business and pathology business under brand names Max@Home and Max Labs respectively. Max@Home offers health and wellness services at home while Max Lab provides Pathology Services outside our hospital network. Max Healthcare is promoted and led by Abhay Soi as its Chairman and Managing director.

The present amalgamated company was formed subsequent to the acquisition of 49.7% stake in erstwhile Max Healthcare Institute Limited by Radiant Life Care Pvt. Ltd. ("Radiant") and the amalgamation of Max Healthcare with Radiant thereafter. The amalgamated entity assumed the name Max Healthcare Institute limited. Prior to the amalgamation, Radiant was led and promoted by Abhay Soi.

NCR



Outside NCR

SPECIALITIES IN HOSPITAL

The hospital is specialized with 12 high-end modular operations theaters, an emergency resuscitation and observation units.

- Cardiology
- Cancer care
- Kidney transplant
- Neurology
- Liver transplant
- Eye care
- Joint replacement
- Lung transplant
- Nephrology
- Dental care
- Obs. and Gyn.
- Orthopedics
- Robotic surgery

FACILITIES IN HOSPITAL

✓ COMFORT DURING STAY:

TV in room

Private rooms

Free wifi

Phone in room

Mobility accessible rooms

Family accomodation

Laundry

Welcome

Call bell

✓ MONEY MATTERS:

Health insurance coordination

Medical travel insurance

Foreign currency exchange

ATM

Credit/ Debit card

Net banking

- ✓ FOOD:

Diet on request

Restaurant

International cuisine

- ✓ TREATMENT RELATED:

Medical record transfer

Online doctor consultation

Rehabilitation

Pharmacy

Home care

Document legislation

Post operative followup

- ✓ LANGUAGE:

Interpreter

Translation services

- ✓ TRANSPORTATION:

Airport pickup

Local tourism option

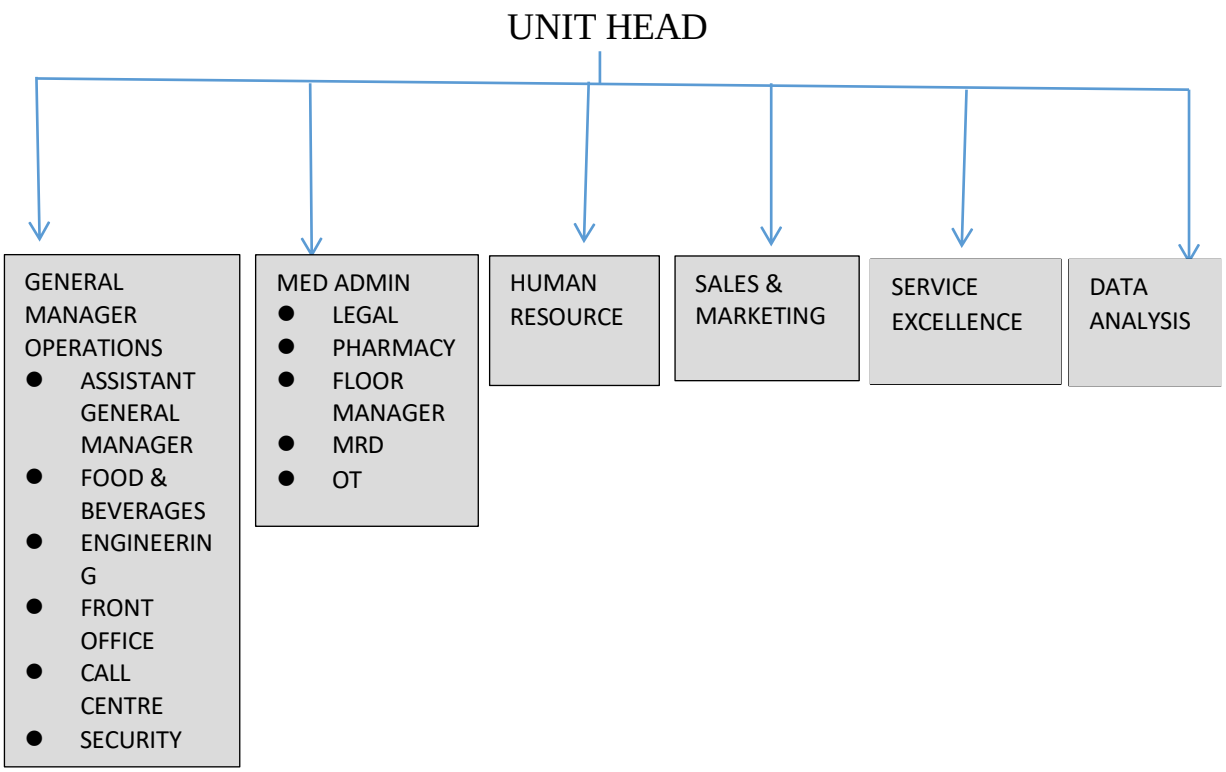
Local transportation booking

Visa/ travel office

Air ambulance

Car hire

HOSPITAL OPERATIONS HIERARCHY



MAX RESEARCH CENTRE

The Office of Research (OOR) at Max Healthcare (MHC) promotes supports and guides our diverse research enterprise. It also acts as a "front door" for new research partnerships. Strong research capabilities and an academic environment have been a priority for Max Healthcare.

Since its inception in 2005, the OOR has had a simple and constant mission: **To increase the quality, quantity and efficiency of translating fundamental science advances into improved clinical care for our patients.** The OOR has dedicated personnel to support researchers who want to conduct research or clinical trials in terms of operational, administrative, scientific, academic, technology support.

MHC has established a very strong image both nationally and internationally in Research, which includes clinical trials, clinical research studies, and funded grant studies increasing year on year.

VISION

At Max Healthcare, our vision is to be the most well regarded healthcare provider in India committed to the highest standards of clinical excellence and patient care, supported by latest technology and cutting edge research.

VALUES

COMPASSION	EXCELLENCE
We have a deeper level of patient understanding and are always empathetic to their needs. This encourages a culture of providing a higher standard of patient-centred care. We respect each other and our patients, and ensure that their needs are met with dignity. We rise to the occasion each time for we recognize the positive social impact we can create.	We ask more of ourselves and are always passionate about achieving the highest standards of medical expertise and patient care. We understand that being the best is a continuous journey of becoming better versions of ourselves every day.

EFFICIENCY

We create a responsive healing environment, by being nimble to the needs of our patients and delivering what they really need with precision and timing. We are focused yet fast, personal yet practical, advanced yet seamless in delivering the exact care our patients need.

CONSISTENCY

We always deliver on our commitment and ensure the highest level of patient care is met at every stage, every time. We believe that only through consistency can we achieve our patients' trust and fulfil our goals.

PURPOSE

To Serve.
With commitment and compassion in our heart, we deliver the highest standard of patient-centred care to those we serve.

To Excel.
From a dream team of doctors and specialists to support staff that goes the extra mile to deliver quality care, excellence is in our DNA.

OUR MILESTONES

2020	**Listing on NSE and BSE** Max Healthcare listing on NSE and BSE
2017	**JCI Accreditation** Max Super Speciality Hospital, Saket is accredidated by the Joint Commission International(JCI)
2016	**Max Institute of Cancer Care, Lajpat Nagar** Max Institute of Cancer Care, a dedicated Cancer Care daycare centre opens in Lajpat Nagar in June 2016
2015	**Max Smart Super Speciality Hospital, Saket** Saket City Hospital officially becomes Max Smart Super Speciality Hospital, Saket
2015	**Max Super Speciality Hospital, Vaishali** Pushpanjali Crosslay Hospital officially becomes Max Super Speciality Hospital, Vaishali
2014	**Max Multi Speciality Hospital, Greater Noida** Max Multi Speciality Hospital, Greater Noida - Secondary Care Hospital in Greater Noida
2012	**Max Super Speciality Hospital, Dehradun** Max Super Speciality Hospital, Dehradun, Max Healthcare opened its first Super Speciality hospital in Uttarakhand in May 2012

2011	**Max Super Speciality Hospital, Bathinda** Max Super Speciality Hospital, Bathinda- Max Healthcare extended its footprint in North India (in PPP with Govt. of Punjab) in September 2011
2011	**Max Super Speciality Hospital, Mohali** Max Super Speciality Hospital, Mohali- Max Healthcare extended its footprint in North India (in PPP with Govt. of Punjab) in September 2011.
2011	**Max Super Speciality Hospital, Shalimar** Max Super Speciality Hospital, Shalimar Bagh- Max Healthcare Consolidated its position in Delhi & NCR through the launch of its 300 bedded Facility in Shalimar Bagh in November 2011.
2009	**NABH Accreditation** Max Healthcare receives NABH Accreditation for Blood bank
2009	**D L Shah National Award** Max Healthcare receives D L Shah National Award on 'Economics of Quality' by Quality Council of India
2008	**Express Healthcare Awards** Max Healthcare receives Express Healthcare Awards for Excellence in Healthcare
2007	**Max Healthcare Certification** Max Healthcare receives NABH & NABL certification for its laboratories.
2007	**Max Hospital, Gurgaon** Max Hospital, Gurgaon - High End Secondary Care Centre in Gurgaon

2006	**Max Super Speciality Hospital, Saket** Max Super Speciality Hospital, Saket - First Multi, Super Speciality Tertiary Care Location
2005	**Max Hospital, Patparganj** Max Hospital, Patparganj - 1st Multispecialty Tertiary Care centre in East Delhi with 147 Beds, 3 OTs and 1 Cath Lab
2004	**Max Heart & Vascular Institute** Max Heart & Vascular Institute, Saket - First Super Tertiary Care Facility with Advanced Cardiac Life Support Ambulances and Air Evacuation Service.
2002	**Max Hospital, Noida** Max Hospital, Noida - Focus on Mother and Child care with Non-invasive Cardiology, Orthopaedics, ENT, Ophthalmology, Nephrology etc.
2002	**Max Hospital, Pitampura** Max Hospital, Pitampura – First hospital to be ISO certified & first high end secondary care centre in North Delhi.
2000	**Max Medcentre, Panchsheel Park** Max Medcentre, Panchsheel Park – First Medcenter with OP facilities & day care surgeries
1985	**Max Foundation** Founded in 1985, Max India Limited is a Public Limited company listed in the NSE and BSE with over 37,000 shareholders.

ACCREDIATIONS & CERTIFICATIONS OF MAX HEALTHCARE

- **National Accreditation Board for Hospital & Healthcare Providers (NABH) Accreditation**

Max Healthcare maintains several Blood Banks and offers international standard blood bank services following NABH standards and guidelines issued by the National AIDS Control Organization (NACO). Presently, three of the Max Healthcare Blood Banks are accredited by NABH.

- **National Accreditation Board for Testing and Calibration Laboratories (NABL) Accreditation**

Max Healthcare has a variety of laboratories spread across its large Hospital Network, which are accredited by NABL in their respective fields of medical testing.

- **The Joint Commission International (JCI) Accreditation**

Max Super Speciality Hospital, Saket, is accredited by The Joint Commission, a US-based independent organization that has accredited 21,000+ US healthcare institutions and programs. The accreditation from Joint Commission International (JCI) is considered as the gold standard in the world of global healthcare, and JCI accreditation ensures that a hospital has state-of-the-art clinical protocols and arrangements for finest patient care.

AS PER OBSERVATION

Hospital consists of 4 floors:

- Basement- Administrative office, engineering and maintenance, CSSD, IP Pharmacy, linen and laundry, housekeeping services, medical record department, uniform rooms, staff cafeteria.

Fig 1: Basement directory of the hospital

- Ground floor- A-block OPD, B-block OPD, C-Block OPD, radiology, non-invasive cardiac lab, mother and child OPD, IP admission and billing, pediatric OPD, EWS OPD, pediatric ICU, physiotherapy, visitor's cafeteria

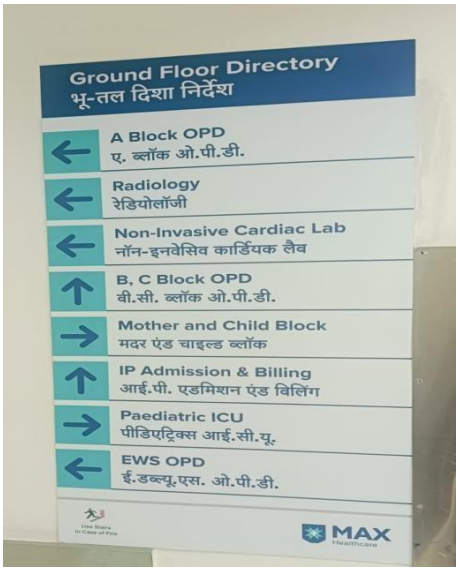


Fig2: Ground floor directory of the hospital

- Mother & Child block directory- Emergency, OPD- mother and child, labour delivery suites, labour room, neonatal ICU, nursery, Max pharmacy

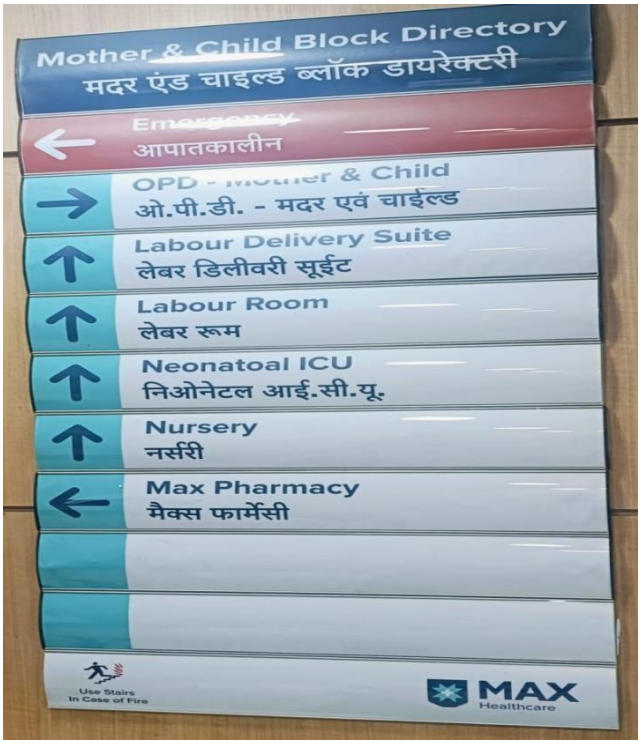


Fig3: Mother and child block directory

- First floor- Cath lab, intensive care unit level-1, economy rooms (1111-1145), operation theatre complex, intensive care units, surgical ICU, dialysis unit

Fig4: First floor directory of the hospital

- Second floor- Room no. (1201-1234), general ward 2, office, ortho intensive care level 1, ortho HDU 2, bed no. (1235-1260), operation theatre complex 2

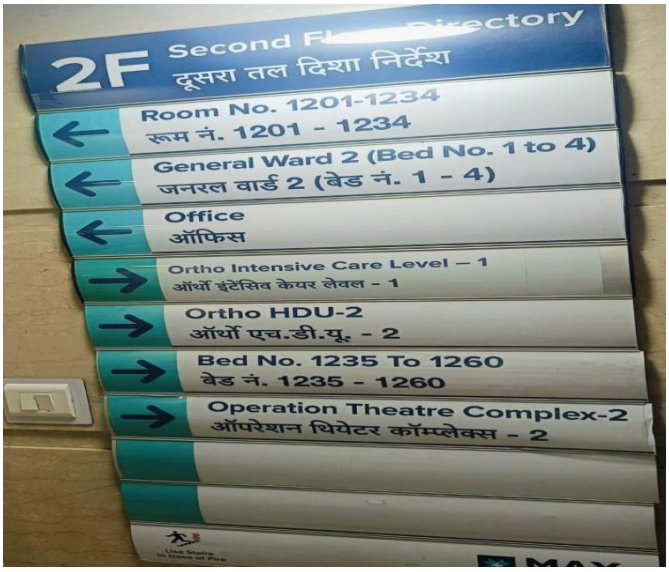


Fig5: Second floor directory of the hospital

- Third floor- Offices, general ward 3, room no. (1301-1335), play room

Fig6: Third floor directory of the hospital

- Fourth floor- Deluxe room (1401-1402), single room (1403-1406), presidential suite (1407), single room (1408-1413), deluxe room (1414-1415), single room (1416-1421), deluxe room (1422-1423), general ward 4 (bed no.1-4), onco daycare

Fig7: Fourth floor directory of the hospital

MODE OF DATA COLLECTION

The mode of data collection is primary data collection which is done through reviewing the records manually and checking through software.

- **Manual Review**: Manually examine physical or electronic patient file which are self observed by Also, reviewed documentation such as admission notes, progress notes, medication records, consent forms, face sheets etc.
- **Electronic Health Records (EHR) Analysis**: Use EHR systems to extract relevant data automatically through a software called CPRS by entering the ID no. This can include reviewing transfer notes, doctor's initial assessment, handover notes, operative notes etc.
- It is done by record reviewing.

DEPARTMENT-WISE OBSERVATIONS

Department: IP Billing and admission

Observation: Performed conversions of OPD to IPD by calling the patients and convincing the patients in Max Smart Superspeciality hospital.

Also, performed BTD (billing till date) which means compiling and reviewing all charges accrued by a patient from the date of admission until the current date. This process includes capturing charges for various services, treatments, and other expenses.

Observed the IPD process of admission and discharge of patient.

IPD Admission: Max Healthcare's admission process involves multiple steps to ensure smooth patient intake and allocation. Initially, an admission request form is received and checked for doctor's signatures before determining the type of admission—routine or urgent. The cost estimate is then provided to the patient or attendant, and the room allocation is discussed. Checks are also made to determine whether the room required is a ward or ICU.

For surgical cases, a written cost estimate is given. A pre- adt OT number and face sheet are generated, and general consent is obtained from the patient or attendant. Coordination for escorting the patient to the ward follows. The patient or attendant is then handed an advance receipt, information, and a briefing sheet. Finally, the advance amount is collected as per policy.

IPD Discharge: The discharge process at Max Healthcare involves several steps to ensure a smooth and efficient transition for patients. It begins with the HIS (Hospital Information System) updation, followed by the collection of any interim advances. Once these steps are completed, discharge intimation is sent and acknowledged. This acknowledgment triggers bill preparation, which is followed by bill settlement. Concurrently, there are processes for TPA (Third Party Administrator) involvement, including BTD (bill till date) follow-up, TPA coordination, TPA approval, and TPA bill payment. After the payment receipt and the generation of the discharge slip, the final step is scroll settlement, concluding the discharge process.

TPA (third party administrator) process: At Max Healthcare, the insurance administration procedure commences with the reception of the Third Party Administrator (TPA) client and the submission of a pre-authorization form. After first approval, the patient is informed and any questions are followed up with. Following discharge notification, the final bill is created and sent to the TPA for final approval along with the discharge statement. Once the final approval

has been obtained, the patient or attendant is informed of the approval status and any outstanding questions are addressed to guarantee prompt resolution. For efficient processing and ultimate approval, it is imperative to have precise documentation, timely follow-ups, and effective communication.

Department: IPD (second floor)

Observation: Went to take rounds and collected patient opinions on each service. Active patient file audits are done on daily basis. Made the planned discharge one day prior by monitoring the CPRS program. Enhancing patient satisfaction, care quality, and overall hospital efficiency are contingent upon these actions.

Department: Obs. And Gyn. OPD

Observation: Worked as a co-ordinator of doctor. Act as a mediator between hospital and patient. If any surgery is planned then processed the TPA. Understood TPA processing and resolving the query.

Department: Emergency

Observation: An emergency department (ED), also known as an accident and emergency department (A&E), emergency room (ER), or casualty department, is a medical treatment facility that specializes in emergency medicine, or the acute care of patients who arrive without an appointment, either on their own or via ambulance.

Observing how patients are treated under observation according to their level of urgency, following triage colour codes.

- Critical factors affecting conversion of OPD to IPD are:

Availability of Beds: The capacity of the hospital to accommodate additional inpatients.

Scheduling: The ability to schedule admissions promptly and conveniently.

Insurance Coverage: Patients' insurance policies and coverage for inpatient services.

- Major problems occurred on the floor are:

Issues regarding room cleanliness, nurses rounds, sometime kitchen services etc.

- As a coordinator for doctors, several factors can influence the effectiveness in ensuring smooth operations, efficient communication, and overall quality of patient care.

Skills in mediating and resolving conflicts between staff members or between doctors and patient

KEY LEARNINGS

- This internship period taught me the importance of regular Auditing and supportive supervision of medical documentation.
- It taught me about the importance of discharge summary and how planned discharge is being processed from one day prior.
- Learned how to take rounds on floor with the team, how to communicate, listen and resolve their problem on the urgent basis.
- Also, learned in IP billing that how to convert patients from OPD to IPD by convincing.
- Observed the admission process in IPD.
- Learned how to convince the patients who are going LAMA.
- As a coordinator of doctor, I learned how to be a mediator between patient and doctor. Learned how to process the TPA for the patients.

CHAPTER 2: PROJECT REPORT

INTRODUCTION

MEDICAL RECORD

It's a popular saying in the healthcare industry that documentation of medical records are very important, and it helps illustrate why documentation is important in healthcare. In few other industries is thorough, efficient documentation as essential as in the healthcare field, as inadequate record keeping could result in claims denials, lower productivity, lawsuits, and even negative patient health outcomes. With so much at stake, many healthcare providers heavily invest in clinical documentation improvement (CDI) systems to streamline their record-keeping processes. Electronic health records can facilitate communication between providers, patients, and payers, but if those records aren't properly maintained, the same consequences can still result. That's why it's important that facilities not only invest in the proper tools to improve their clinical documentation, but that they implement best practices as well — and the first step to that is understanding why documentation is so important. Medical audit in the current scenario of increasing medical demands and the increasing trend of medical multi-speciality has been a crucial tool to analyse and regulate the service provided to the service receiver or the patient.[(2)] Medical Records can be defined as the set of documents that provide the clinical, para-clinical, and financial data about the patient. The Medical Records Department is completely responsible for collecting, and protecting the patient information, and providing it to the people or an organization who are responsible for providing quality treatment to patient.

A Medical Record, Health Record or medical chart is a systematic documentation of patient's medical history and care OR the medical record is a clinical, scientific, administrative and legal document relating to patient care in which is recorded sufficient data written in sequence of events to justify the diagnosis and warrant the treatment and end results. The terms are used for both the physical folder that exists for each individual patient and for the body of information found therein. Medical record is intensely personal document and there are many ethical and legal issues surrounding them such as third-party access and appropriate storage and disposal. The medical record includes a variety of types of "notes" (like progress note, handover notes, operative notes, transfer notes) entered over time by health care professionals, recording observations and administration of drugs and therapies, orders for the

administration of drugs and therapies, test results, x-rays, reports, etc. The maintenance of complete and accurate medical records is a requirement of health care providers. The medical record serves as the central repository for planning patient care and documenting communication among patient and health care provider and professionals contributing to the patient's care. An increasing purpose of the medical record is to ensure documentation of compliance with institutional, professional or governmental regulation. In addition the individual medical record may serve as a document to educate medical students/resident physicians, to provide data for internal

hospital auditing and quality assurance, and to provide data for medical research and development.

MEDICAL AUDIT

"Audit" is a Latin word, and the verb audio ('hear') indicates both active listening and the action of investigation and interrogation of the judiciary. Transferred to the English vocabulary, "audit" takes on a meaning of "an official inspection of an organization's accounts, typically by an independent body"[3]. A clinical audit is a quality improvement cycle that involves comparing the effectiveness of healthcare to agree-upon and demonstrate high-quality standards, then, taking steps to bring practice in line with these standards to enhance care quality and health outcomes.[4]

The audit is a regular multidisciplinary activity by which all participants of health care, including doctors, nurses, and other health professionals, carry out a systematic review of their own practices for the amelioration of the system and improving the quality ultimately. In previously reported studies,[3,5] it was suggested that in hospitals and health care systems, costs can be significantly reduced by using health informatics software for the maintenance of hospital data collected over long periods of time.

- Medical audit also called peer review or Clinical audit is defined as evaluation of medical care through review and analysis of medical record.
- Medical audit is an ongoing activity involving study of medical records of the patient aimed at assessing the quality of care given to patients as well as the quality of record generated.

Proper documentation of patient files in hospitals is a cornerstone of high-quality healthcare. Comprehensive and accurate patient records are essential for ensuring continuity of care, enhancing communication among healthcare providers, and supporting clinical decision-

making. They serve as a detailed account of a patient's medical history, treatments, and outcomes, thereby playing a crucial role in patient safety and care quality.

In addition to clinical benefits, thorough documentation is critical for legal and regulatory compliance. Hospitals must adhere to strict guidelines set by health authorities and accreditation bodies, which mandate accurate and timely record-keeping. Failure to comply with these standards can result in legal ramifications and loss of accreditation, which can severely impact a hospital's reputation and operational capabilities.

Furthermore, patient file documentation supports hospital administration and management. It provides valuable data for quality assurance, performance evaluation, and strategic planning. By analyzing patient records, hospitals can identify trends, measure outcomes, and implement evidence-based improvements in care delivery.

In an era where electronic health records (EHRs) are becoming the norm, hospitals must also focus on integrating technology with their documentation processes. EHR systems enhance the accessibility, accuracy, and efficiency of patient file management, but they also come with challenges such as ensuring data security and managing the transition from paper to digital records.

Ultimately, the meticulous documentation of patient files is a multidisciplinary effort that involves healthcare providers, administrative staff, and IT professionals. By prioritizing accurate and comprehensive record-keeping, hospitals can improve patient care, ensure compliance with regulatory standards, and drive continuous improvement in healthcare delivery.

RATIONALE OF THE STUDY

I took this topic of medical documentation in Max Smart Super speciality Hospital because in Max Smart most of the records are paperless which need to be maintained and audited. Medical documentation audit is important as it outlines the patient's past medical past history and current health status. As, in Max Smart, records are maintained web based (I.e, CPRS) software. So, I with floor manager did the file audit of the active patients who were there in wards. There were also some loops and gaps which we tried to close at the same time by co- ordinating with doctors team and if there were issues related to nurses then we tried to close the gaps. Medical documentation maintains the medical record of the patients as well as hospital. It checks the records and minimizes the compliance of the active files.

REVIEW OF LITERATURE

- The adoption of EHRs has been shown to improve the accuracy, accessibility, and efficiency of patient documentation (Menachemi & Collum, 2011). EHR systems can streamline the documentation process, reduce errors, and facilitate better data sharing among healthcare providers (Bates et al., 2003). Studies also indicate that EHRs support clinical decision-making through integrated decision support systems (DesRoches et al., 2010).
- Documentation of patient files is not only a clinical necessity but also a legal requirement. Various studies underscore the importance of maintaining thorough records to meet the standards set by regulatory bodies such as the Joint Commission and the Centers for Medicare & Medicaid Services (CMS) in the United States (Jha et al., 2009). Failure to comply with documentation standards can result in significant legal liabilities and penalties for healthcare institutions (Brooks, 2017).
- Research consistently highlights the critical role of accurate and comprehensive documentation in ensuring quality patient care. Studies show that detailed patient records improve clinical outcomes by providing healthcare providers with complete medical histories, enabling informed decision-making (Thomas & Peterson, 2012). Proper documentation also facilitates continuity of care, especially in complex cases involving multiple healthcare professionals (Hertzum & Ellingsen, 2019).
- Literature emphasizes the need for continuous improvement in documentation practices. Ongoing education and training for healthcare providers are essential to maintain high documentation standards (Emani et al., 2010). Implementing regular audits and feedback mechanisms can also help identify areas for improvement and ensure compliance with documentation standards (Davenport & Kalakota, 2019).

DOCUMENTS THAT ARE PRESENT IN ACTIVE PATIENT FILE

1. Face sheet
2. Admission request form
3. Generic consent form
4. Informed consent of the procedure
5. Anaesthesia consent form (if required)
6. Blood transfusion consent form (if required)
7. Nursing initial assessment
8. Pre- operative checklist
9. Doctors initial assessment (in CPRS)
10. Operative notes (in CPRS)
11. Dietician notes (in CPRS)
12. Pre and Post operative notes (in CPRS)
13. Transfer notes

i. **Face sheet:** It includes patient's demographic data i.e; identification number, name, address, age, bed no., floor no., father/ mother name, email, doctor's name, date of admission, signature of guardian and signature of doctor. Face sheets are frequently used in clinics and hospitals to give medical staff instant access to patient data.

ii. **Admission request form:** It is a request form filled prior to admission by the consultant .

iii. **Generic consent form:** Filled prior to the admission in in-patient department.

iv. **Informed consent of the procedure:** The following are the required elements for documentation of the informed consent discussion: (1) the nature of the procedure, (2) the risks and benefits and the procedure, (3) reasonable alternatives, (4) risks and benefits of alternatives, and (5) assessment of the patient's understanding of elements.

v. **Anaesthesia consent form:** In order to get a patient's informed permission before using anesthesia, a form known as an anesthetic consent form is essential in medical settings. It guarantees that patients are aware of the advantages, disadvantages, and substitutes for anesthesia in addition to offering legal security to medical professionals. It includes name of procedure, risk of procedure, benefits, alternatives, likelihood of success, anaesthesia classification, risk stratification, signature of patient, witness, and doctor.

vi. **Blood transfusion consent**: This consent's goal is to give written information about the risks, advantages, and alternatives of blood transfusions or blood components (such as platelets, plasma, red blood cells, or other components obtained from the patient (autologous) or another person (allogeneic)).

vii. **Nursing initial assessment:** It includes all the information regarding the patient. It should be filled by team leader of the nurse. Nurses gather and arrange all the data to guarantee that the patient get the individualized, superior care that they are entitled for. It includes pain assessment, ulcer risk assessment, name and signature of patient, TL, and doctors are necessary. The purpose of a pain assessment is to determine whether or not you are in pain. The degree of pain will also be considered throughout the assessment.

viii. **Pre-operative checklist:** The Preoperative Checklist is completed by clinicians working within their scope of clinical practice and is designed to aid patient preparation prior to their transfer to operation theatre and support effective clinical handover when there is a transfer of professional responsibility and accountability.[6] Postoperative plan with implant sticker in surgery records should be attached by nursing staff in file.

ix. **Doctor's initial assessment:** A doctor's initial assessment of a patient in a patient file typically includes subjective data and objective records of vital signs. The assessment may also include a physical exam, medical history, and a treatment plan. The first step in assessing a patient is to confirm airway, breathing, and circulation.

x. **Operative notes:** The operative note is an essential part of the medical record and provides a detailed account of the surgical procedure performed, including all pertinent information.

xi. **Dietitian notes:** It includes the diet of the patient when the patient admit in the hospital. They are not allowed to take the diet outside the hospital.

xii. **Transfer notes:** These are the notes that when the patients transfer from one department to another. When the patient transfer from emergency to ward, ward to ICU etc then transfer notes are maintained.

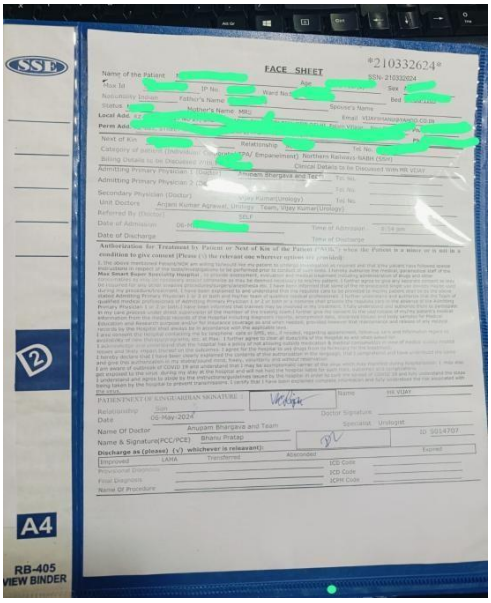


Fig8: Face sheet of the patient's file

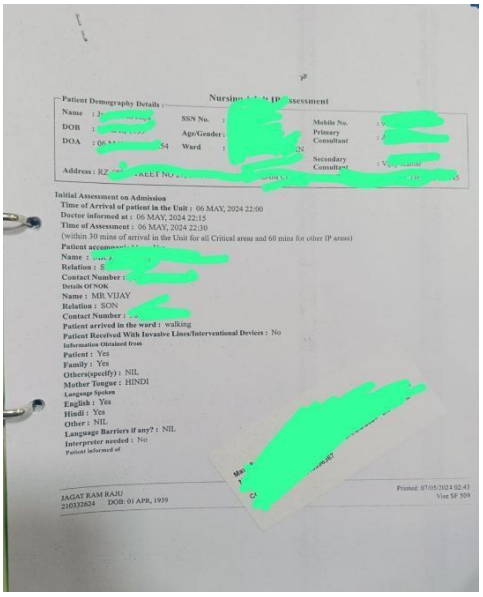


Fig9: Initial assessment by nurses

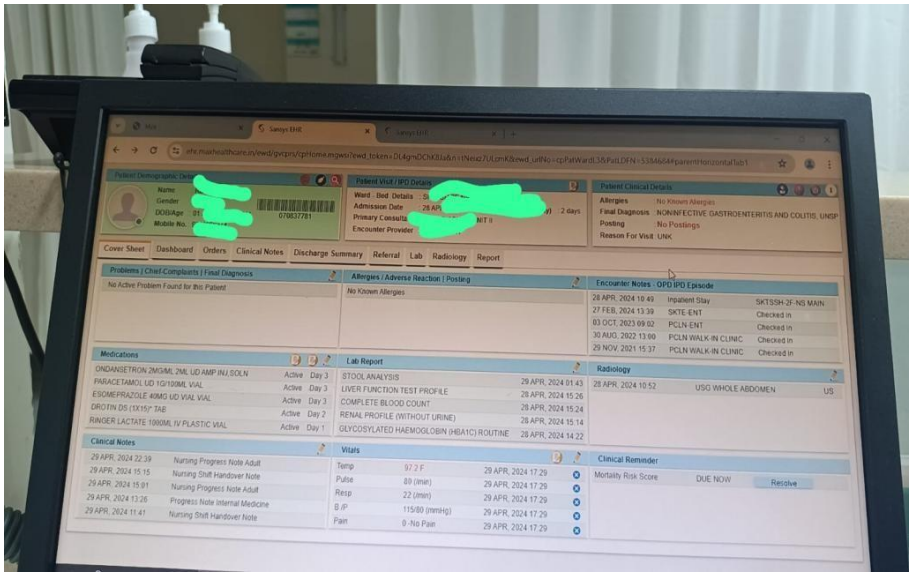
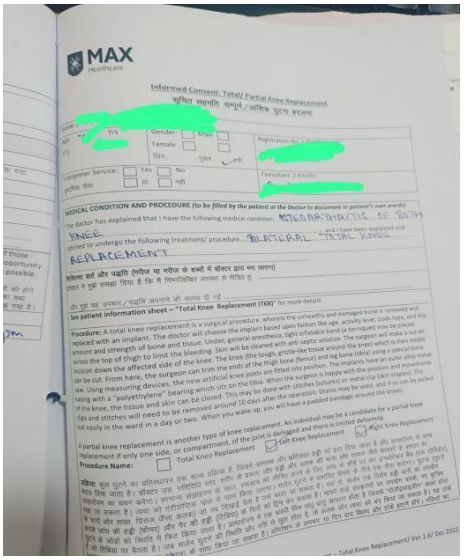


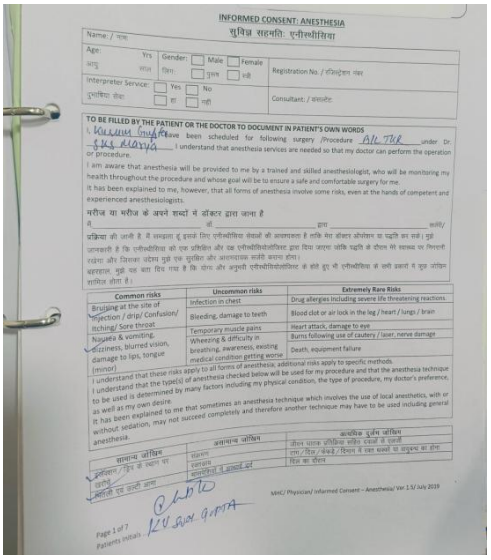
Fig10: EHR of the hospital



Informed Consent: Total/ Partial Knee Replacement

MEDICAL CONDITION AND PROCEDURE (to be filled by the patient or the Doctor to document in patient's own words)

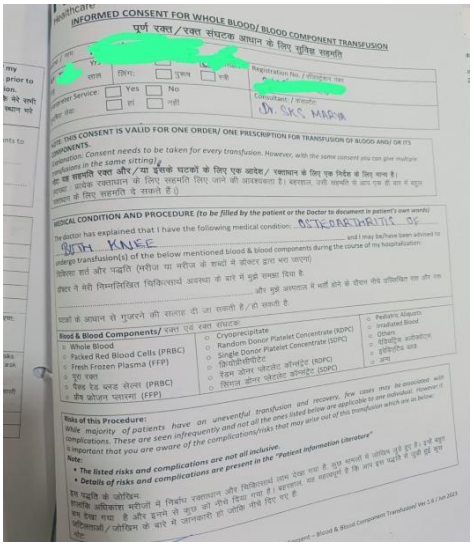
Fig11: Informed consent form of the procedure



INFORMED CONSENT: ANESTHESIA

TO BE FILLED BY THE PATIENT OR THE DOCTOR TO DOCUMENT IN PATIENT'S OWN WORDS

Fig1: Anaesthesia consent form

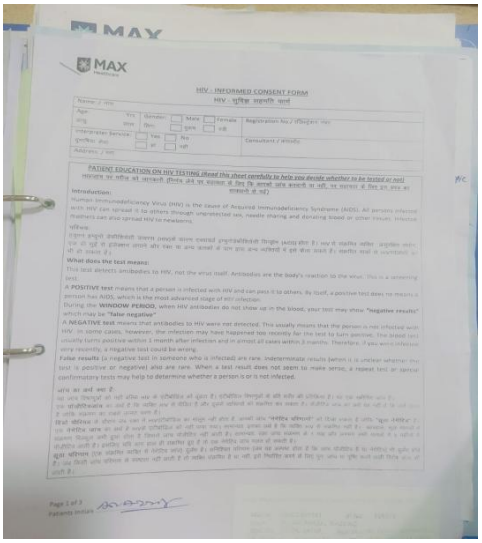


INFORMED CONSENT FOR WHOLE BLOOD/ BLOOD COMPONENT TRANSFUSION

पूर्ण रक्त / रक्त संघटक आधान के लिए सूचित सहमति

MEDICAL CONDITION AND PROCEDURE (to be filled by the patient or the Doctor to document in patient's own words)

Fig13: Blood transfusion consent form



HIV - INFORMED CONSENT FORM

HIV - सूचित सहमति पत्र

PATIENT EDUCATION ON HIV TESTING (Read this sheet carefully to help you decide whether to be tested or not)

Fig14: HIV consent form

Fig15: Rounds in the morning with the team

OBJECTIVE

Primary objective	To evaluate the accuracy and completeness of the patient active files on the second floor (old wing) of Max smart superspeciality hospital.
Secondary objective	To assess the current documentation practices: By thorough evaluation of existing medical documentation practices to identify strength, weakness and area of improvement
	To identify initial assessment of the records in the patient file: To evaluate that past history with all the medication is mentioned or not (done by both doctors and nurses) when patient entered in emergency or ward initially assessed by nurses and then doctor

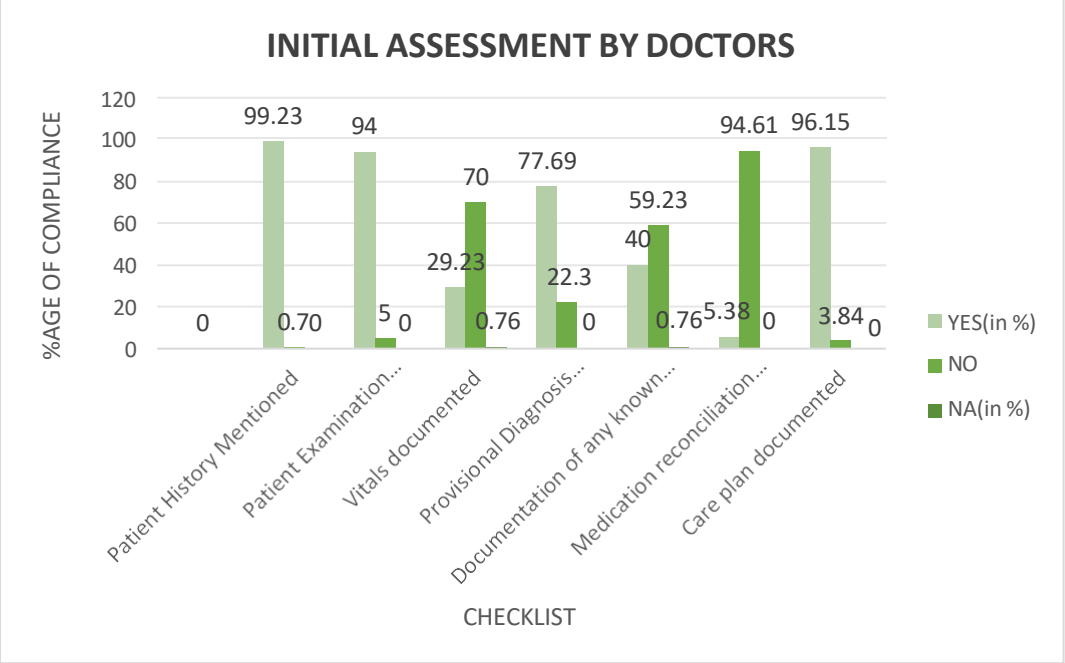
METHODOLOGY

- **Study setting:** The study is conducted in Max Smart Superspecilality Hospital, Saket, New Delhi
- **Study population:** All active IPD patients of second floor (old wing) of Max Smart Superspecilality Hospital, Saket, New Delhi
  IPD - 130 files
- **Data collection method:** By record review
- **Study design:** Descriptive study
- **Tool:** Checklist (like admission request form, initial assessment by doctors, initial assessment by nurses, generic informed consent, informed consent of the procedure, anaesthesia consent, blood transfusion consent, pre-operative checklist, transfer notes)
- **Sampling method:** Simple random sampling method
- **Data source:** Secondary data Analysis
- **Study duration:** 29th April to 20th May, 2024
- **Data Analysis:** Microsoft Excel was use to analyse the data

RESULTS AND FINDINGS

INITIAL ASSESSMENT BY DOCTORS: (TABLE 1) ACTIVE FILES (130)

INITIAL ASSESSMENT BY DOCTORS	YES(in %)	NO (in %)	NA(in %)	PC(partially completed)(in %)
Patient History Mentioned	99.23	0.7	0	0
Patient Examination Documented	94	5	0	0
Vitals documented	29.23	70	0.76	0
Provisional Diagnosis documentation	77.69	22.30	0	0
Documentation of any known allergies	40	59.23	0.76	0
Medication reconciliation documentation	5.38	94.61	0	0
Care plan documented	96.15	3.84	0	0

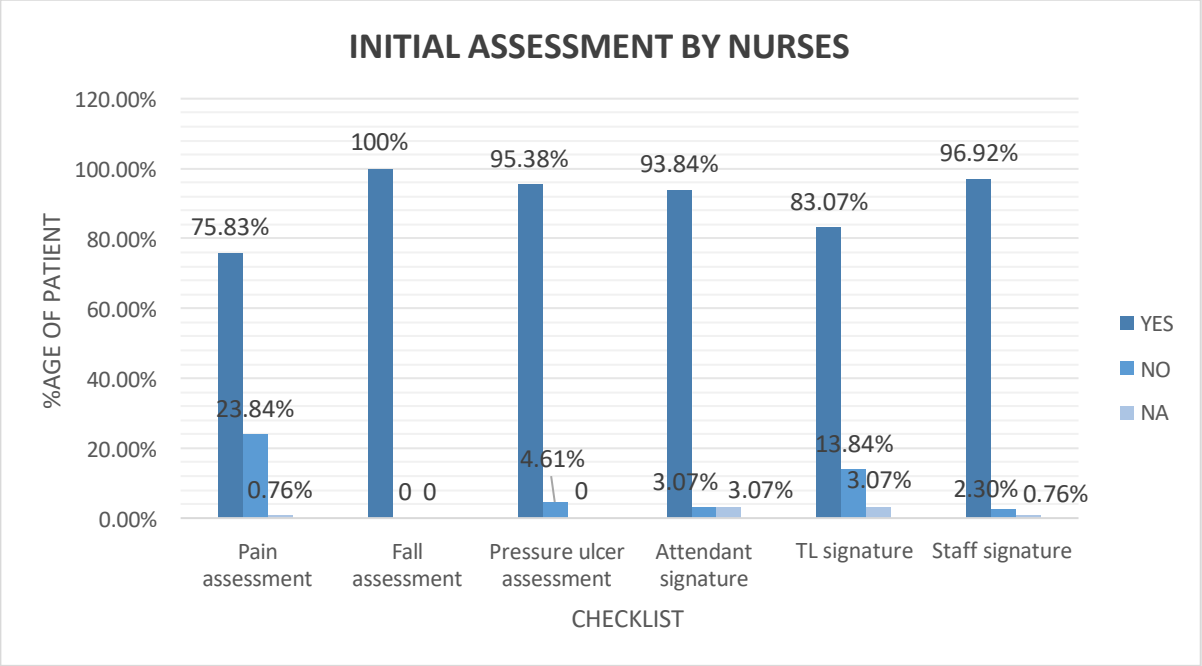


INTERPRETATION:

- Out of 130 files, patient history mentioned were fully compliance (YES) in 129 (99.23%) files.
- Similarly, patient examination mentioned, vitals documented, provisional diagnosis documentation, documentation of known allergies, medication reconciliation documentation and care plan documented were 123(94%), 38(29.23%), 10(77.69%), 52(40%), 7(5.38%), 125(96.15%).
- Medication reconciliation documentation were not mentioned in the files.
- Also, sometimes vitals were not mentioned in the doctors initial assessment. Vitals are mentioned in nurses initial assessment.

INITIAL ASSESSMENT BY NURSES: (TABLE 2) ACTIVE FILES (130)

INITIAL ASSESSMENT BY NURSES	YES	NO	NA	PC
Pain assessment	75.83	23.84	0.76	0
Fall assessment	100	0	0	0
Pressure ulcer assessment	95.38	4.61	0	0
Attendant signature	93.84	3.07	3.07	0
TL signature	83.07	13.84	3.07	0
Staff signature	96.92	2.30	0.76	0

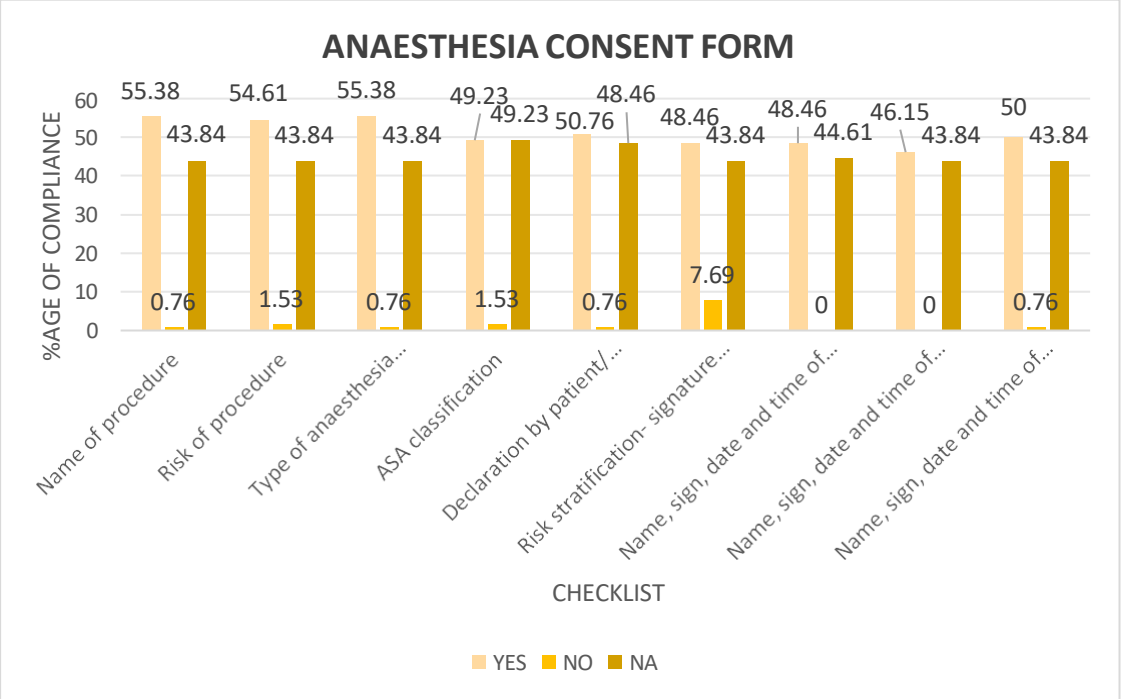


INTERPRETATION:

- Out of 130 files, pain assessment were fully compliance in 98(75.38%) files, out of which in 31(23.84%) files pain assessment were not mentioned.
- Similarly, fall assessment, pressure ulcer assessment, attendant signature, team leader signature, staff signature were 130(100%), 124(95.38%), 122(93.84%), 108(83.07%), 126(96.92%).

ANAESTHESIA CONSENT FORM: (TABLE 3) ACTIVE FILES (130)

ANAESTHESIA CONSENT FORM	YES	NO	NA	PC
Name of procedure	55.38	0.76	43.84	0
Risk of procedure	54.61	1.53	43.84	0
Type of anaesthesia documented	55.38	0.76	43.84	0
ASA classification	49.23	1.53	49.23	0
Declaration by patient/ guardian	50.76	0.76	48.46	0
Risk stratification- signature of patient	48.46	7.69	43.84	0
Name, sign, date and time of decision m aker	48.46	0	44.61	6.92
Name, sign, date and time of witness	46.15	0	43.84	10
Name, sign, date and time of doctor	50	0.76	43.84	5.38

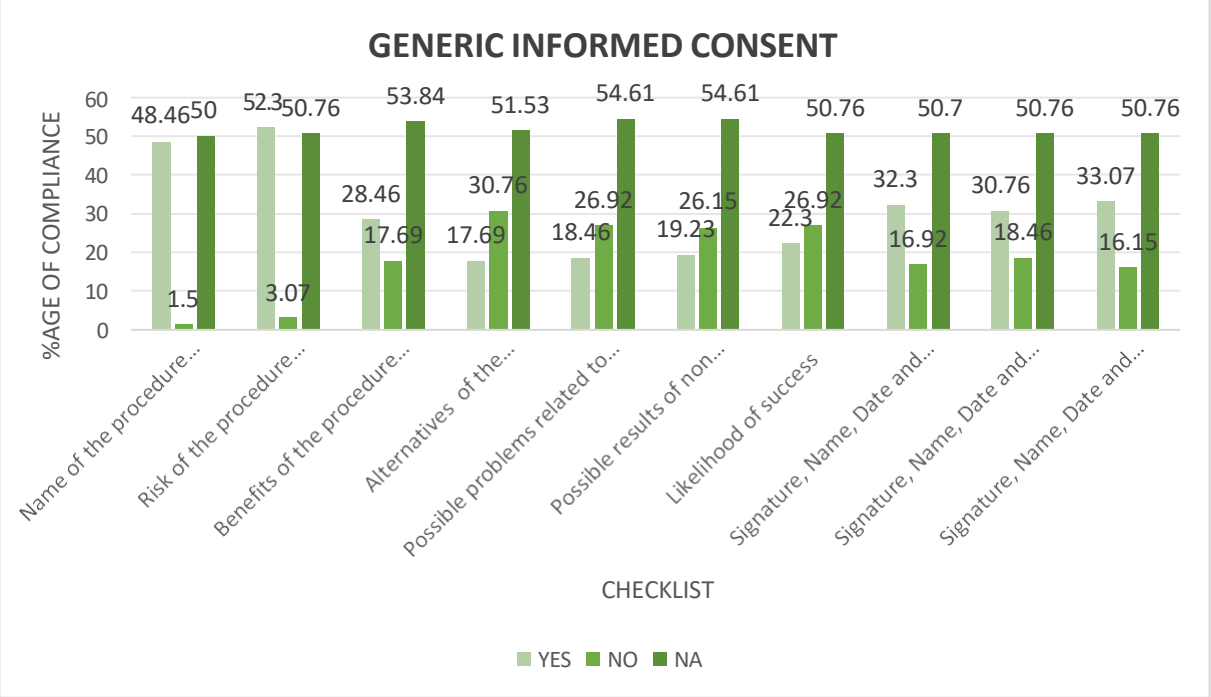


INTERPRETATION:

- Out of 130 files, name of procedure were fully compliance in 72 (55.38%) files. In some cases, name of the procedure was not mentioned which we tried to close at the same time by discussing with the doctor's team.
- Similarly, risk of the procedure, type of anaesthesia, type of ASA classification, declaration by the patient or guardian, risk stratification, name, sign, date and time of decision maker, witness and doctor, and sign of PAC anaesthetist were in 71(54.61%), 72(55.38%), 64(49.23%), 66(50.76%), 63(48.46%), 63(48.46%), 60(46.15%), 65(50%) and 69(53.07%) files.
- In some cases anaesthesia record were not fully completed, it was partially filled I.e, patient information is not filled or information of witness was not filled.
- Sometimes, signature of PAC anaesthetist was not mentioned.
- In some cases, if surgery is not performed (in internal medicine case) then anaesthesia records are not applicable in that case.
- Anaesthesia consent form must be maintained properly by the anaesthtist and the team.

GENERIC INFORMED CONSENT: (TABLE 4) ACTIVE FILES (130)

GENERIC INFORMED CONSENT	YES	NO	NA	PC
Name of the procedure mentioned	48.46	1.5	50	0
Risk of the procedure mentioned	52.30	3.07	50.76	0
Benefits of the procedure mentioned	28.46	17.69	53.84	0
Alternatives of the procedure mentioned	17.69	30.76	51.53	0
Possible problems related to recovery	18.46	26.92	54.61	0
Possible results of non treatment	19.23	26.15	54.61	0
Likelihood of success	22.30	26.92	50.76	0
Signature, Name, Date and Time of Decision Maker	32.30	16.92	50.7	10
Signature, Name, Date and Time of Witness	30.76	18.46	50.76	6.10
Signature, Name, Date and Time of Doctor	33.07	16.15	50.76	10



INTERPRETATION:

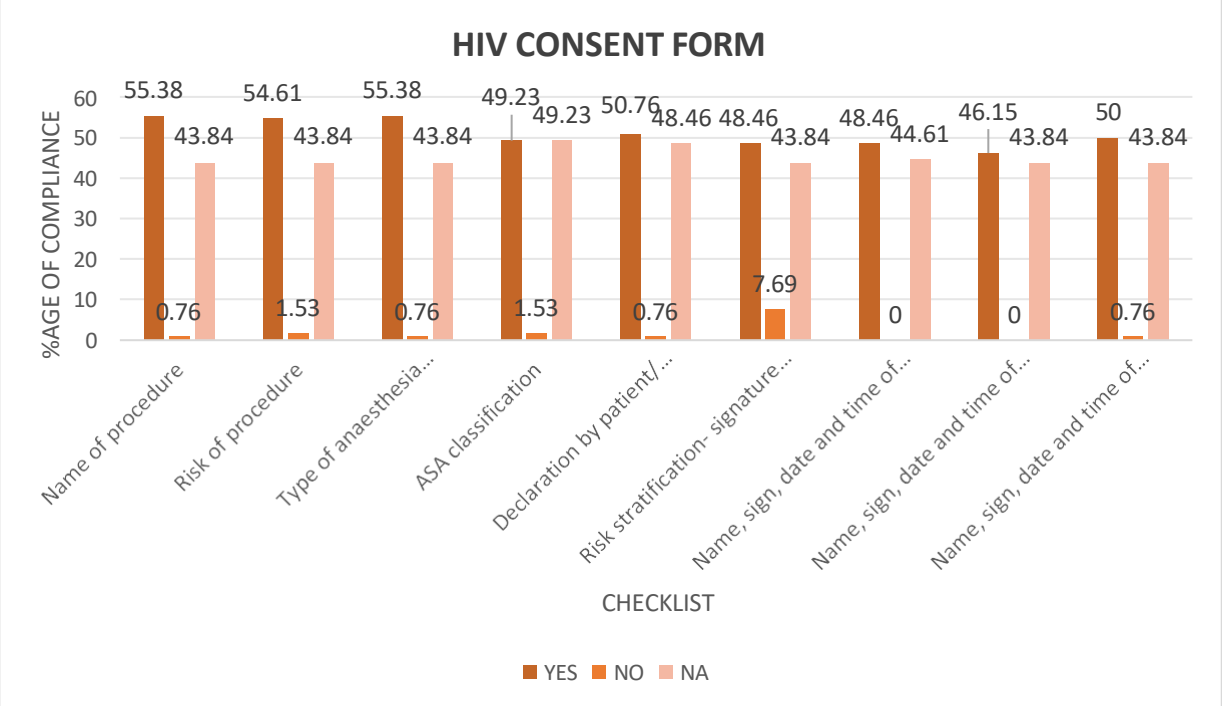
- Out of 130 files, name of procedure is fully compliance in 63 (48.46%) files. In some files, generic informed consents in 65 (50%) files were not applicable.
- Similarly, risk of procedure mentioned, benefits, alternatives, possible problems related to procedure, likelihood of success, name, signature, date and time of decision maker,

witness and doctor were in 60(46.15%), 37(28.46%), 23(17.69%), 24(18.46%), 25(19.23%), 29(22.30%), 42(32.30%), 40(30.76%), 43(33.07%).

- Sometimes, generic consent form were not present as they are not needed in some cases.
- Generic informed consent must be needed to improve.

HIV CONSENT: (TABLE 5) ACTIVE FILES (130)

HIV CONSENT	YES	NO	NA	PC
Signature, Name, Date and Time of Decision Maker	10	0.76	89.23	0
Signature, Name, Date and Time of Witness	6.15	1.53	92.3	0
Signature, Name, Date and Time of Doctor	7.69	1.53	90.76	0.76
Post test Counselling - Doctor Signature, Name Date and Time	8.46	0.76	90.76	0
Post test Counselling - Patient Signature, Name Date and Time	6.14	3.07	90.76	0



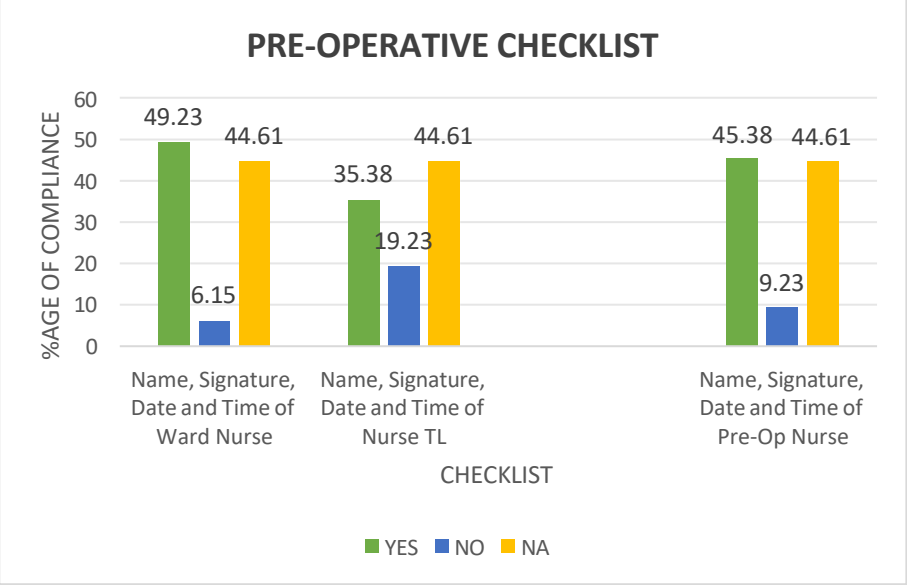
INTERPRETATION:

- In most of the files HIV consents are not present as HIV records are maintained in the CPRS.

- To check that the compliance is there or not, it must be checked in CPRS in the radiology department and search for the HIV.
- The HIV reports are present on the software.
- In most of the files, HIV consents are not applicable.

PRE-OPERATIVE CHECKLIST: (TABLE 5) ACTIVE FILES (130)

PRE-OPERATIVE CHECKLIST	YES	NO	NA	PC
Name, Signature, Date and Time of Ward Nurse	49.23	6.15	44.61	0
Name, Signature, Date and Time of Nurse TL	35.38	19.23	44.61	0
Name, Signature, Date and Time of Pre-Op Nurse	45.38	9.23	44.61	0

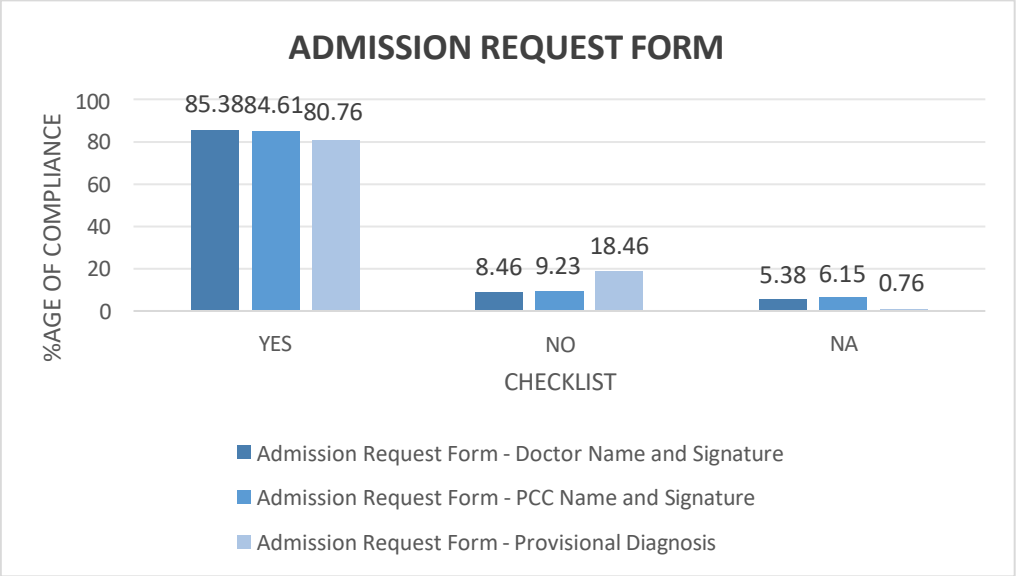


INTERPRETATION:

- Pre- operative checklist is the checklist that is prepared before any surgery is performed.
- Out of 130 files, the name, signature , date and time of ward nurse is fully compliance in 49.23% of files. Similarly, name, signature, date and time of nurse TL was compliance of 35.38% and name, signature, date and time of pre-op nurse was 45.38%.
- The signature was mandatory in the pre-op checklist.

ADMISSION REQUEST FORM: (TABLE 6) ACTIVE FILES (130)

ADMISSION REQUEST FORM	YES	NO	NA
Doctor name and signature	85.38	8.46	5.38
PCC name and signature	84.61	9.23	6.15
Provisional diagnosis	80.76	18.46	0.76



INTERPRETATION:

- It is generated before the patient gets admitted in the hospital.
- Out of 130 files, doctor's name and signature were fully compliance in 85.34% of files. Similarly, PCC name and signature was in 84.61% and provisional diagnosis was in 80.76% files.

DISCUSSION

Following are the parameter that found to be least compliance during analysis of data-

1) Initial assessment by doctors: Patient history mentioned and care plan documented
2) Initial assessment by nurses: Fall assessment and staff signature
3) Anaesthesia consent forms
4) Admission request forms
5) Transfer notes (in CPRS)
6) Progress notes (in CPRS)
7) Handover notes (in CPRS)

RECOMMENDATIONS

- Conduct regular training sessions for staff on proper documentation practices, legal requirements, and the importance of accurate record-keeping.
- Inform the doctors through medical superintendent about the issues.
- In each floor a nurse/ floor manager could be made accountable for checking if the documentation is complete or not.
- Provide patients with access to their medical records and involve them in the audit process by encouraging them to review and report discrepancies.
- Develop and utilize standardized templates and forms for documenting medical audits. This ensures consistency and completeness in capturing necessary information.
- Use the findings from each audit to drive continuous improvement in patient file documentation and overall patient care practices.
- Keep detailed records of all audit reports, including the methodology, findings, recommendations, and follow-up actions. Maintain an audit trail to track the changes and actions taken based on the audit findings.

CONCLUSION

Documenting active patient file audits in hospitals is essential for compliance, quality improvement, and enhanced patient care. A well-defined audit process begins with clear objectives and scope, followed by a detailed audit plan that includes criteria, sample selection, and audit tools. Systematic data collection and thorough review of patient files ensure comprehensive analysis, allowing hospitals to identify areas for improvement. The creation of actionable recommendations and a follow-up plan is vital for addressing identified gaps.

Maintaining compliance with legal and confidentiality requirements is critical throughout the audit process. Detailed record-keeping and audit trails support accountability and facilitate continuous improvement. Regular audits and periodic reviews of audit tools and criteria ensure ongoing compliance and adaptation to changing standards.

Training staff and establishing a communication plan ensure that all stakeholders are informed and engaged in the audit process. By implementing these recommendations, hospitals can create a robust and effective documentation process for patient file audits, leading to better patient outcomes, improved documentation practices, and a culture of quality and accountability. This structured approach not only enhances patient care but also supports regulatory compliance and organizational excellence.

LIMITATION

1. The study is limited to Max Smart Superspeciality Hospital, Saket, New Delhi, and therefore, the results of the study are applicable only to this hospital.
2. Conducting thorough audits can be time-consuming and require significant manpower, potentially straining hospital resources.
3. Variability in how different staff members document patient information can lead to inconsistencies, making audits more challenging.
4. Achieving staff engagement and compliance with new audit processes and documentation standards can be difficult, especially if there is resistance to change.Established practices and attitudes within the hospital culture may hinder the adoption of new audit procedures.
5. Dependence on electronic health record (EHR) systems can be a limitation if the systems are not user-friendly, comprehensive, or compatible with audit requirements.
6. Ensuring that the sample of patient files audited is truly representative of all cases can be challenging, potentially leading to biased results.

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ANNEXURE

DATE
UHID
CONSULTANT NAME
time of admission in the ward (T0)
time of initial assessment By doctor (T1)
time taken for initial assesment (in mins)
Face Sheet - Guardian Signature
Face Sheet - PCC Signature
Admission Request Form - Doctor Name and Signature
Admission Request Form - PCC Name and Signature
Admission Request Form - Provisional Diagnosis
Initial Assessment by Doctors - Patient History mentioned
Initial Assessment by Doctors- Patient Examination Documented
Initial Assessment by Doctors- Vitals documented
Initial Assessment by Doctors- Provisional Diagnosis documentation
Initial Assessment by Doctors- Documentation of any known allergies
Initial Assessment by Doctors- Medication reconciliation documentation
Initial Assessment by Doctors- Care Plan Documentation
Initial Assessment by Nurses - Pain Assessment
Initial Assessment by Nurses - Fall Assessment
Initial Assessment by Nurses - Pressure Ulcer Assessment
Initial Assessment by Nurses - Attendant Signature

Initial Assessment by Nurses - TL Signature
Initial Assessment by Nurses - Staff Signature
Dietetics - Nutritional Assessment
DVT prophylaxis assesment (within timeframe)
Generic Informed Consent - Name of the procedure mentioned
Generic Informed Consent -Risk of the procedure mentioned
Generic Informed Consent -Benefits of the procedure mentioned
Generic Informed Consent -Alternatives of the procedure mentioned
Generic Informed Consent -Possible problems related to recovery
Generic Informed Consent -Possible results of non treatment
Generic Informed Consent - Likelihood of success
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)
Generic Informed Consent - Signature, Name, Date and Time of Witness
Generic Informed Consent - Signature, Name, Date and Time of Doctor
Informed Consent of Procedure- Name of the procedure mentioned
Informed Consent of Procedure -Risk of the procedure mentioned
Informed Consent of Procedure -Benefits of the procedure mentioned
Informed Consent of Procedure -Alternatives of the procedure mentioned
Informed Consent of Procedure-Possible problems related to recovery
Informed Consent of Procedure -Possible results of non treatment
Informed Consent of Procedure - Likelihood of success

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)
Informed Consent of Procedure - Signature, Name, Date and Time of Witness
Informed Consent of Procedure - Signature, Name, Date and Time of Doctor
Anaesthesia Consent - Name of the procedure mentioned
Anaesthesia Consent -Risk of the procedure mentioned
Anaesthesia Consent - Type of Anaesthesia Documented
Anaesthesia Consent - ASA Classification documented
Declaration by the Patient/ Gaurdian/Close Relative
Anaesthesia Consent - Risk Stratification - Signature of the patient
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)
Anaesthesia Consent - Signature, Name, Date and Time of Witness
Anaesthesia Consent - Signature, Name, Date and Time of Doctor
PAC - Signature of Anaesthetist
Blood Transfusion Consent - Mention of medical Condition
Blood Transfusion Consent -Type of Blood Component ticked
Blood Transfusion Consent - Risk of BT ticked
Blood Transfusion Consent - Patient specific Risk
Blood Transfusion Consent -Benefits of the procedure mentioned

Blood Transfusion Consent-Alternatives of the procedure mentioned
Blood Transfusion Consent- Possible problems related to recovery
Blood Transfusion Consent -Possible results of non treatment
Blood Transfusion Consent - Likelihood of success
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)
Blood Transfusion Consent - Signature, Name, Date and Time of Witness
Blood Transfusion Consent - Signature, Name, Date and Time of Doctor
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)
HIV Consent - Signature, Name, Date and Time of Witness
HIV Consent - Signature, Name, Date and Time of Doctor
HIV Consent - Post test Counselling - Doctor Signature, Name Date and Time
HIV Consent - Post test Counselling - Patient Signature, Name Date and Time
Pre - Operative Checklist - Name, Signature, Date and Time of Ward Nurse
Pre - Operative Checklist - Name, Signature, Date and Time of Nurse TL
Pre - Operative Checklist - Name, Signature, Date and Time of Pre-Op Nurse
CPRS - Daily RMO progress notes (minimum twice daily)
CPRS - Daily Consultant team progress notes (minimum twice daily)

CPRS - Nurses' Transfer notes during shifting of patients from one department to another
CPRS - Pre operative/ pre procedure orders
CPRS - Site Marking documentation by the Operating surgeon (or by team member)
CPRS - Operation/ Procedure Notes
CPRS Post-Operative/Post procedure Orders (including Aldrete criteria)
CPRS - Post operative pain scoring by the nurses in the post op area/ ward

Ms Priyansha ST

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