Internship Training

At

B.L.Kapur Hospital

BY

Avinash Prasad

PGDHM
2012-2014

International Institute of Health Management Research

Internship Training

At

B.L.Kapur Hospital

Auditing of In-Patient medical record files as per NABH guidelines in BLK Super Specialty Hospital, Pusa Road

By

Avinash Prasad

Under the guidance of

Dr. A.K Agarwal

Post Graduate Diploma in Hospital and Health Management
2012-2014

International Institute of Health Management Research
New Delhi

BLK
Super Speciality Hospital

Radiant Life Care
Private Limited

Ref: - BLK/HR/2014/APR/ 352

Dated: 30.04.2014

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Mr. **Avinash Prasad** has completed his Internship w.e.f . 15th Feb. 2014 to 30th Apr., 2014 in the department of **Quality.**

During his tenure, his conduct was found to be excellent.

We wish him all the best for his future.

For Dr. B.L. Kapur Memorial Hospital

Rupinder

Rupinder Kaur
Head-Learning & Development

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Certificate of Approval

The following dissertation titled **AUDITING OF IN-PATIENT FILES AS PER NABH GUIDELINES** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a pre-requisite for the award of **Post-Graduate Diploma in Hospital and Health Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Prof AK Agarwal	
Prof S. Satpathy	
Dr. Suprasanna Pal	

CERTIFICATE

TO WHOMSOEVER MAY CONCERN

This is to certify that AVINASH PRASAD student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at Dr. BL KAPUR HOSPITAL from 15-02-2014 to 30-04-2014.

The Candidate has successfully carried out the study designated to his during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

Dean, Academics and Student Affairs
IIHMR, New Delhi

Professor
IIHMR, New Delhi

6/5/14

Certificate from Dissertation Advisory Committee

This is to certify that **AVINASH PRASAD,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled **"AUDITING OF IN-PATIENT MEDICAL RECORD FILES AS PER NABH GUIDELINES** at **"Dr. BL KAPUR SUPERSPECIALITY HOSPITAL, NEW DELHI"** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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Institute Mentor Name,
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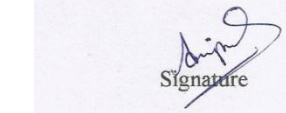
Organization BL Kapur Hospital

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**Auditing of In-Patient medical record files as per NABH Guideline**" and submitted by **Mr. Avinash Prasad** Enrollment No. **PG/12/016** under the supervision of Dr. A.K Agarwal For award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 15th February 2014 to 30th April 2014 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.



Signature

FEEDBACK FORM

Name of the Student: Mr. Avinash Prasad

Dissertation Organisation:
Dr. B. L. Kapur Memorial Hospital

Area of Dissertation:
Audit & Implementation of effective documentation practise by the healthcare providers

Attendance:
98%.

Objectives achieved:
- Concurrent & Retrospective study of pt. medical records
- Developing MIS of HR dept. for tracking credentials of medical practitioners.

Deliverables:
- Deligent
- Effective communication
- Hard working

Strengths:
- Focused
- Time bound
- learner

Suggestions for Improvement:
- More efforts toward better career
- All the best.

Dr. Ajay
Signature of the Officer-in-Charge/ Organisation Mentor (Dissertation)

Date:
Place:

TABLE OF CONTENT

ACKNOWLEDGEMENT

It is my esteemed pleasure to present the dissertation report on "**Auditing of In-Patient medical record files as per NABH guidelines**" in the organization. I would like to extend my sincere thanks to all of them in the organization who helped me out with this project.

I express my deep gratitude to my project guide **Dr. Ajay Singh (Asst. Manager Quality Department)** for his guidance and constant supervision, as well as for providing necessary information regarding the project & also for the support in completing the project.

I am very thankful to the Medical record Department members, 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. A.K Agarwal (Mentor, IIHMR)** for her kind co-operation and encouragement at each step, which helped me in completion of this project.

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ABBREVIATIONS	FULL FORM
BAER	Burn Area Emergency Rehabilitation
BERA	Brain stem evoked response audiometery
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
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 fertilization

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
SSEP	Somatosensory evoked potential
TMT	Treadmill test

INTERNSHIP REPORT

ORGANIZATION PROFILE

BLK Super Specialty Hospital is one of the largest tertiary care private hospitals spread over five acres of land with a capacity of 700 bed and has consistently ranked amongst the 'Top 10 Multi Super Specialty Hospitals' in Delhi NCR. The hospital is located in the heart of Delhi on Pusa Road, Rajendra place and it is very conveniently located within a 30 minutes drive from the international airport .it is in close proximity of railway and bus station also. BLK Super Specialty Hospital has a unique combination of the best in class technology, put to use by the best names in the professional circles to ensure world-class health care to all patients.

The Hospital has a team of more than 1500 healthcare providers including over 150 globally renowned super specialists, more than 300 medical experts ,dedicated nursing teams and specifically trained paramedical staff with most modern infrastructure which focus on patient centric processes across clinical and non-clinical functions ensuring that patient avails best services.

VISION

To create a patient-centric tertiary healthcare organization focused on non-intrusive quality care utilizing leading edge technology with a human touch.

MISSION

- Achieve professional excellence in delivering quality care
- Push frontiers of care through research and education
- Adhere to national and global standards in healthcare
- Ensure care with integrity and ethics
- Provide quality healthcare to all sections of society

LOGO

A passion for healing…

We are passionate about delivering the highest standards of healthcare, be it having the finest Doctors, cutting edge technology, state-of-the-art infrastructure or nursing with a smile. When we are passionate about healing the lives that have been entrusted to us, nothing is too big or too small to ignore.

LEGACY

Dr. B L Kapur, an eminent Obstetrician and Gynaecologist, set up a Charitable Hospital in 1930 at Lahore. In 1947, he moved to post-partition India and set up a Maternity Hospital at Ludhiana. In 1956 on the invitation of the then Prime Minister, Dr. B L Kapoor initiated the project for setting up a 200 bed hospital in Delhi. The hospital was inaugurated by the Prime Minister, Pt. Jawahar Lal Nehru on 2nd January, 1959.

During the late 1990s, the Trustees of the hospital felt the need to upgrade it to a tertiary care hospital and tied up with Radiant Life Care Private Limited to re-develop and manage the facility. Today, a modern state-of-the-art tertiary care hospital has come up in place of the old hospital. It is one of the biggest stand alone private Hospitals in the National Capital Region today.

HOSPITAL MANAGEMENT

BLK Super Specialty Hospital is being managed by **Radiant Life Care Private Limited**, prior to taking over management of Hospital, Radiant was responsible for financing and re-developing the erstwhile facility.

In order to manage the operations of the Hospital, Radiant has deputed the entire leadership including the CEO, CFO, Head Medical Services and heads of Human Resources, Marketing and Administration.

Radiant aims at facilitating the ongoing pursuit of excellence at the hospital by assisting in bringing in not only the best clinical and non-clinical talent but also the ultra-modern equipment and technology enabling delivery of the highest standards of healthcare.

INFRASTRUCTURE

BLK Super Specialty Hospital Spread on five acres of land, with a capacity of 700 beds, BLK Super Specialty Hospital is one of the largest tertiary care private hospitals in the country, BLK has consistently ranked amongst the Top 10 Multi Super Specialty Hospitals in Delhi NCR. The outpatient services are spread on two floors with 60 consultation rooms. All ambulatory services have been designed with intent to create dedicated aides for all specialties, with their interventional services in close vicinity. Therefore, whether it is the proximity of diagnostic services and blood bank to the emergency or one of the best Endoscopy suites to ensure timely and efficient services, the infrastructure speaks volumes about BLK's commitment to 'PASSION FOR HEALING'.

The Hospital has 17 state-of-the-art well equipped modular operation theatres with three stage air filtration and gas scavenging system to ensure patient safety. All the Operation Theatres are fitted with best in class pendants, operating lights, anesthesia work stations and advanced information management system.

The Hospital has one of the biggest critical care programs in the region with 125 beds in different intensive care units viz Medical, Surgical, Cardiac, Pediatrics, Neonatology, Neurosciences and Organ Transplant. Liver and Renal Transplant Centers have been equipped with dedicated ICUs with individual hepafilters, specialized instruments and equipments, Veno-venous bypass system and dedicated anesthesia equipment.

The Hospital has specialized birthing suites with telemetric foetal monitors to follow the progression of labour, and also the facility for the family to stay with the patient during the labour. A dedicated operation theatre adjacent to the labour room helps in shortening the response time in case there is a need to conduct the delivery through surgical means.

The Hospital's advanced Building Management System provides for multi-tiered access control, electronic security systems with integrated CCTVs spanning across the facility and advanced fire management system amongst other utilities. The Hospital is the first in NCR to install and use automatic pneumatic chute system to enhance the efficiency and efficacy of health care delivery.

The whole campus is Wi-Fi enabled, with the vision of the Hospital becoming the first truly paper-less healthcare facility in the country. BLK has top of the line Hospital Information System (HIS) which is seemingly connected across outpatient, inpatient and diagnostic areas. The system has facility for contemporary electronic medical records (EMR) with remote-accessibility enabling ongoing consultation to patients from distance as well.

AS PER OBSERVATION:

Hospital consists of 8 floors with 8 exits on each floor and 7 lifts for patients, staff, visitors, F&B etc.

Basement – Radiation oncology department, Physiotherapy Department, MRD, BMW Department, Laundry, Parking

Ground Floor – Emergency, Sample collection Room , OPD pharmacy, Radiology, X-ray, MRI, CT Scan, Ultrasound, Nuclear Medicine, Blood Bank, Admission & Billing , Cafeteria

OPD 1: ENT & Cochlear Implant, Obstetrics & Gynecology, Paediatrics, Medicine , General Surgery , Ayurveda, Orthopaedics, Dermatology.

OPD 2: Ophthalmology

First floor –

OPD 3: Cardiology, Cardiac Surgery, TMT PFT ECG, Echocardiography, Colour Doppler, Executive Health Check Up , Dental, Urology, rheumatology, Endocrinology, Diabetes, & thyroid, Respiratory Medicine, Nephrology & Renal Transplant, Paediatric Cardiology, Sports injury clinic, International Patient lounge.

OPD 4: Plastic Surgery, Reconstructive & Craniofacial Surgery

OPD5: Surgical Gastroenterology, Gastroenterology & Hepatology

OPD 6: Nephrology & Dialysis

OPD 7: Oncology, Mammography & Interventional Radiology, Haemato Oncology & BMT

OPD 8: HPB & Liver Transplant, Neurosurgery, Neurology, EEG, EMG, NCS, NCV, RMST, VER, BAER, BERA, SSEP.

Second floor – ICU, MICU, Paediatric ICU, Organ Transplant ICU, Anaesthesia care unit(recovery room), OT Complex & CSSD, ICCU (Intensive coronary care unit), CTVS, Cath lab, Cardiac Thoracic & Vascular Surgical ICU, Neurosurgical ICU, Decontamination room, Attendant waiting lounge

Utility floor – O2, electrical supply, water supply, vacuum supply etc.

Third floor – Patient rooms, sleep lab, ECP (external counter Pulsation, Nursing Station A, B, C, D Block, Doctor Duty Room, Nursing Changing room, Clean Utility & dirty Utility Room.

Fourth floor – Birthing Suites, Paediatric ICU, Day Care, Neonatal ICU, Nursery, Labour room, MBU, Patient rooms, Nursing Station A, B, C, D Block, Doctor Duty Room, Nursing Changing room, Clean Utility & dirty Utility Room.

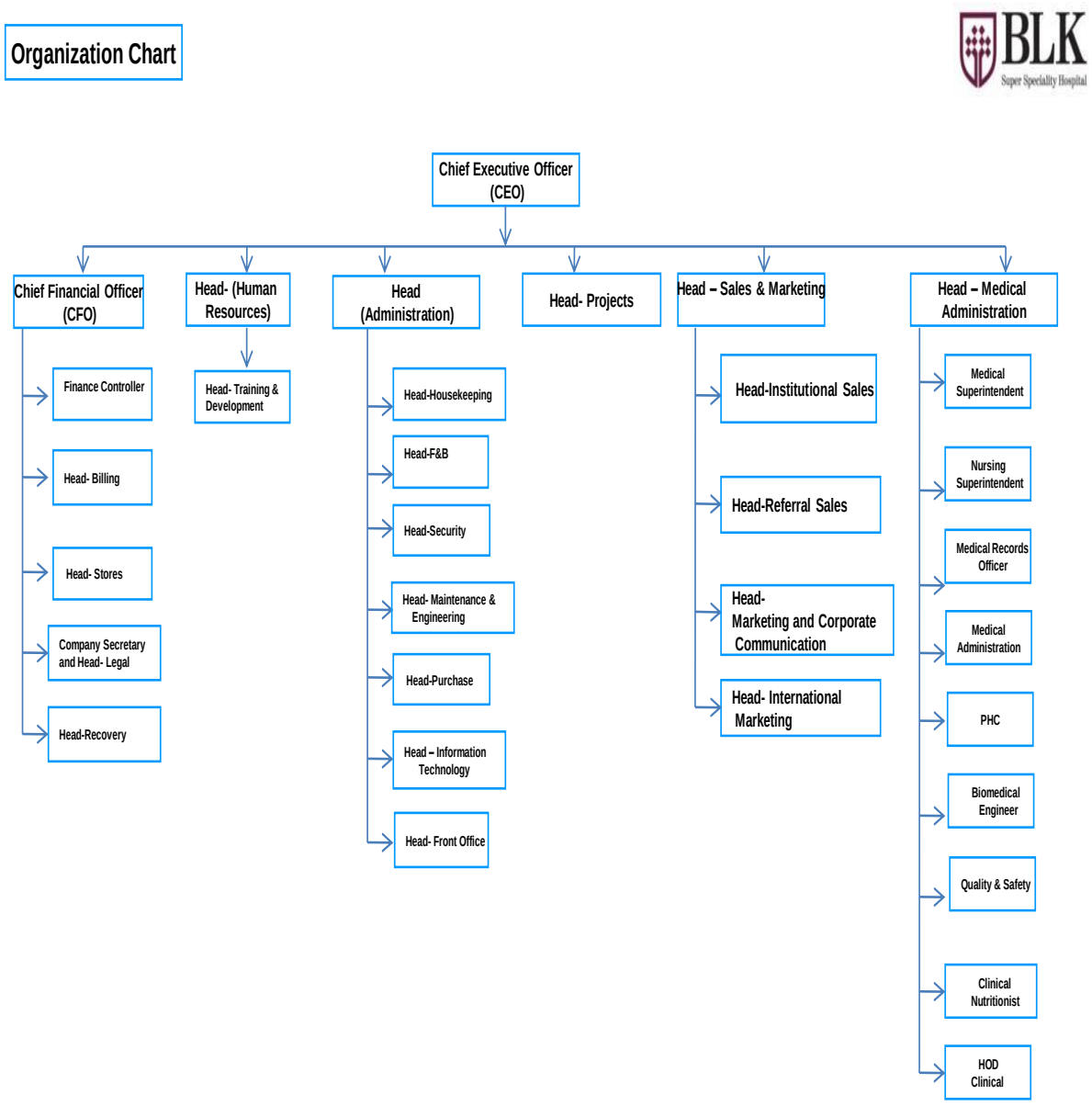
Fifth floor – Patient Room, Nursing Station A, B, C, D Block, Day care unit , Doctor Duty Room, Nursing Changing room, Clean Utility & dirty Utility Room

Sixth floor - Patient rooms, Nursing Station A, C Block, Doctor Duty Room, Nursing Changing room, Clean Utility & dirty Utility Room

Seventh floor – BMT, IVF Clinic, Aesthetic & cosmetic surgery, Consultant Room, Medical Library, Pharmacy store, Seminar 1 & 2, Amphitheatre, Accounts, IT, Medical Administration, HR Department, Marketing, Conference Room, Purchase, Finance.

ORGANOGRAM

LANDSCAPE



SCOPE OF SERVICES

Centers of Excellence

1. BLK Cancer Center
2. BLK Center for Bone Marrow Transplant
3. BLK Heart Center
4. BLK Center for Neurosciences
5. BLK Center for Digestive & Liver Diseases
6. BLK Center for Renal Sciences & Kidney Transplant
7. BLK Center for Orthopedics, Joint Reconstruction & Spine Surgery
8. BLK Center for Plastic, Reconstructive, Aesthetics, Burns & Craniofacial Injuries
9. BLK Children's Heart Institute
10. BLK Center for Critical Care

Specialties

1. Anesthesiology
2. Ayurveda
3. Bariatric & Advanced Laparoscopic Surgery
4. Dental & Maxillofacial Surgery
5. Dermatology
6. Emergency & Acute Care Medicine
7. Endocrine & Breast Surgery
8. Endocrinology & Endocrine Surgery
9. ENT Surgery & Cochlear Implant
10. External Counter Pulsation
11. General & Minimal Access Surgery
12. Obstetrics & Gynecology
13. Internal Medicine
14. Interventional Radiology
15. Infertility & IVF Treatment
16. Neurology
17. Nuclear Medicine
18. Nutrition & Health
19. Ophthalmology
20. Pathology
21. Pediatric
22. Pediatric surgery
23. Physiotherapy & rehabilitation
24. Plastic & Cosmetic Surgery
25. Psychiatry
26. Respiratory Medicine, Allergy & Sleep Disorder
27. Rheumatology
28. Surgical Gastroenterology
29. Vascular & endovascular Surgery

TASK PERFORMED

- Worked in Quality Department as an intern.
- Analysis of In-patient feedback form.
- To conduct concurrent and retrospective internal audit of patient files on routine basis as per of NABH guidelines.
- Developing MIS of HRD for tracking Credentials of medical practitioners
- To analyze the data collected from the audits at the end of the month.
- To assist Quality team Members in their routine work..
- To assist the peers in making reports.

KEY LEARNINGS

Being as an intern in Quality Department,

- This internship period taught me the importance of regular Auditing and supportive supervision and, how we should do it as per the standards of NABH
- How to Analyse an In-patient feedback form?
- What retrospective and concurrent audit means?
- Learned to apply standards of NABH in practical terms
- Learnt how important is the proper documentation of the work done and progress made in implementation of the schemes. This helps us find the gap areas and make targeted interventions.

DISSERTATION REPORT

INTRODUCTION

NABH

National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a constituent board of Quality Council of India, set up to establish and operate accreditation programme for healthcare organisations. The board is structured to cater to much desired needs of the consumers and to set benchmarks for progress of health industry. The board while being supported by all stakeholders including industry, consumers, government, have full functional autonomy in its operation.

NABH Standards for Hospitals

NABH Standards for hospitals, 3rd Edition, November 2013 has been released. This standard has been accredited by International Society for Quality in Healthcare (ISQua). The approval of ISQua authenticates that NABH standards are in consonance with the global benchmarks set by ISQua. The hospitals accredited by NABH will have international recognition. This will provide boost to medical tourism.

The standards provide framework for quality assurance and quality improvement for hospitals. The standards focus on patient safety and quality of care. The standards call for continuous monitoring of sentinel events and comprehensive corrective action plan leading to building of quality culture at all levels and across all the functions.

The 10 chapters in the standard reflect two major aspects of healthcare delivery i.e. patient centred functions (chapter 1-5) and healthcare organisation centred functions (chapter 6-10).

Outline of NABH Standards:

Patient Centred Standards

- 1. Access, Assessment and Continuity of Care (AAC).
- 2. Care of Patients (COP).
- 3. Management of Medication (MOM).
- 4. Patient Rights and Education (PRE).
- 5. Hospital Infection Control (HIC).

Organisation Centred Standards

- 6. Continuous Quality Improvement (CQI).
- 7. Responsibilities of Management (ROM).
- 8. Facility Management and Safety (FMS).
- 9. Human Resource Management (HRM).
- 10. Information Management System (IMS).

MEDICAL AUDIT

- 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 recordss of the patient aimed at assessing the quality of care given to patients as well as the quality of record generated.

MEDICAL RECORD

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" 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.

RATIONALE OF STUDY

Medical records are a reflection of medical care provided to the patient in the course of stay in the hospital. Knowing the current status of patient care that is provided is the pre-requisite for betterment of the same. Accrediting bodies responsible for rating the healthcare organization use contents of medical records to evaluate services to the patients, Hence Medical Records are audited to check whether they comply with the standards set by the accreditation bodies or not. Apart from this, Medical record audits aid in improving the validity of clinical audits. For audit results to be authentic, data has to be there. But if the data itself is absent or incomplete, outcome of the audit cannot be authenticated. Medical record auditing is one of the tools of auditing to assure quality, validity and accuracy of medical services through reviewing medical records on the basis of designed parameters as per the NABH standards. Hence auditing the medical records for availability of data can point out deficiencies and loopholes thereby aiding in solving the issues and increasing the validity of clinical audits as well as in maintaining records.

REVIEW OF LITERATURE

"Information is an important resource for effective and efficient delivery of health care. Provision of health care and its continued improvement is dependent to a large extent on information generated, stored and utilized appropriately by the organizations."

Medical records form an essential part of a patient's present and future healthcare .As a written collection of information about a patient's health and treatment, they are used essentially for the present and continuing care of the patient[1].

Khalis Mahmood, Shahid Shakkel, Hyas Saeedi, Zia Ud Din

A study done on "Audit of medical record documentation of patients admitted to a medical unit in a teaching hospital NWFP Pakistan" showed that they did retrospective study of medical record documentation in their medical unit and each parameter were graded as very good, good, average, poor, or not documented. And concluded that poor documentation in medical records might reduce quality of care[2]

Lataief M, Mtiraoui A,Mandhouj O,Ben Salem,Soltani,Bchir

A study done on evaluation of quality of medical records in the Monastir regional hospital –Tunisia showed that the quality of medical records should be improved .Two third of the cases lacked in information or sheets important for the coordination and the continuity of medical care. The quality improvement of medical records could be reached by the professional education, which should emphasise the importance of medical and administrative area in the health care management .this could be included in a continuous quality improvement programme[3].

Sinha,Saha.D,Prathibha

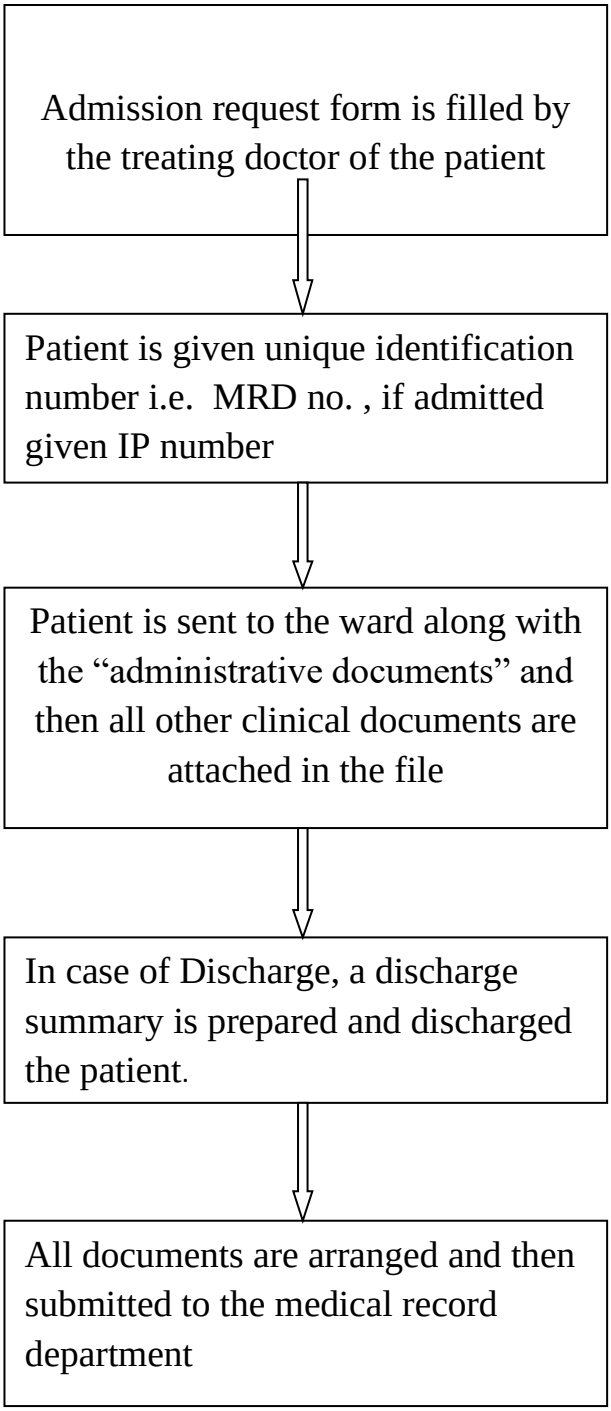
A Study done on assessment of medical documentation as per Joint commission International showed that there was compliance in the admission form ,special consent form, history and physical examination form, radiation form ,brachytherapy form ,anaesthesia consent form, post- operative form, laboratory form, doctor's record and nurse's record having almost met the standards criteria set by JCI .The deficiency was noted in the records ,like not having signature in general consent form and pre- operative form This needs to be carefully monitored and doctors made aware of their responsibility to completely fill each entries in these forms the basis of documentation of care given and aids in the continuity of care but also is an important document in case of any legal litigations[4] .

Ning Wang, David Hailey & Ping Yu

A study was done on "Quality of nursing documentation and approaches to its evaluation: a mixed-method systematic review" which reports a review that identified and synthesized nursing documentation audit studies, with a focus on exploring audit approaches , identifying audit instruments and describing the quality status of nursing documenttion[5.]

FLOW OF MEDICAL RECORDS IN BLK HOSPITAL

Figure.1



Medical record file should have following documents:

1. Face sheet
2. Consent forms
3. Admission request form
4. Initial Assessment
5. Doctor's Progress Notes
6. Operation Notes
7. Anaesthesia record
8. Medication Chart
9. Nursing Admission Assessment
10. Nurse notes/daily nursing flow sheet
11. Investigation report Discharge/Discharge on Request/LAMA or Death Summary
12. Discharge Summary

a) **Face Sheet**: It consists of all identification and demographic data like Name, Age, Sex, MRD no., IPD no. , Date of birth, Department admitted, Date of Admission etc.

b) **Consent forms**: Before any invasive and Surgical Procedure – consent for anaesthesia, consent for procedure, consent of transfusion etc should be filled.

c) **General consent form:** Filled prior to the admission in in-patient department.

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

e) **Initial Assessment**: It includes Chief complaints, history of present illness, Past and Family History, Allergy, Physical Examination, Provisional Diagnosis, Plan of care. It should be completed within 24hrs.

f) **Doctor's Progress Notes**: It consist of daily notes of Doctors with each shift mention on it with date.

g) **Operation Notes & surgery records** : Immediately after the surgery treating consultant shall write which consist of Preoperative diagnosis, description of

Findings, procedure done and surgical check list, Postoperative plan with implant sticker in surgery records should be attached by nursing staff in file.

h) **Anaesthesia record:** anaesthesiologist must record and authenticate pre and post anaesthetic recovery notes in patient record.

i) **Drug Chart:** consist of all medication which were prescribed during the stay in appropriate format by the Doctors.

j) **Nursing Admission Assessment**/Nurse notes/daily nursing flow sheet: It should be filled by the assigned nurses which consist of the Admission assessment of patient with daily flow sheet and nurses notes.

k) **Investigation report**: Duplicate copy of patient reports like Lab, Radiology, ultrasound etc.

l) **Discharge/Discharge on Request/LAMA or Death Summary:** It mainly consist of Chief Complaints, history of present illness, Past history, Physical Findings, Investigation done, Course in the hospital, Operative Diagnosis and date, Condition at time of discharge, treatment and follow up advice

STEPS OF AUDIT

Stage 1: Identify the problem or issue

In the current study, Retrospective and Concurrent audit of medical record documentation was conducted to check whether the parameters are in compliance or not as per NABH standards.

Stage 2: Define criteria & standards

NABH states that medical records have to be audited periodically for certain parameters. These Parameters were included in the audit of medical record documentation.

Stage 3: Data collection

Data was collected through the checklist designed for the retrospective and concurrent audit.

Stage 4: Compare performance with criteria and standards

The data was collected and analyzed as per the set criteria and standards of the hospital.

Stage 5: Implementing change

Recommendation were suggested for the scope of improvement.

OBJECTIVE

General Objective

To analyze the accuracy and completeness of In-patient medical record file both IPD(Active files) and MRD(Inacive files) as per NABH guideline at Dr.B.L Kapur hospital during 15th february to 31th march

Specific Objectives

1. To check the completeness of medical records documentation in In-patient files as per NABH standards of following parameters:

- Initial Assessment /IPD case note
- Emergency assessment
- Doctor's progress notes
- Drug chart
- Consent forms
- Anaesthesia record
- Surgery records
- Nursing parameters
- Discharge summary
- General consent forms
- Admission request forms
- Valuable handover form
- Estimation of expenses

2. To identify the problem areas in In-patient medical record files.
3. To provide recommendations for problem areas if required, thereby improving compliance of In-patient medical record files.

METHODOLOGY

- **Study design and area -** Study was conducted in BLK Super Speciality Hospital, Pusa Road. It was a descriptive cross sectional study in nature.
- **Sampling Method** – Simple random sampling method
- **Sample size -** 550 Inpatient medical record files, 352 IPD files and 198 MRD files.
- **Time** – 15th February 2014 to 31st March 2014
- **Tool -** Checklist
- **Data source** – Primary Data
- **Technique** – Retrospective and Concurrent audit was conducted of MRD files and IPD files with the help of a checklist. The data was collected and marked as FC (Fully complete) or PC (Partial complete) or NC (Not complete) or NA (Not applicable) in the checklist according to the completeness of parameters. Later the Data was analyzed for the percentage of compliance of MRD files as per the NABH standards and recommendations were given for the problem areas.
- **Data Analyses**- Microsoft Excel was used to analyse the data

RESULT AND FINDINGS

Initial assessment: (Table – 1) Active files(352)

Initial Assessment/IPD case note	FC	PC	NC	NA
Chief complaints/Past history	234	4	114	0
Provisional diagnosis	194	1	157	0
Plan of care (with preventive, promotive curative and rehabilitative)	174	26	152	0
Date,time,sign & name of Doctor present	131	57	164	0
Consultant counter signed	113	25	214	0
Nutritional assessment	64	0	288	0
Nutritional, growth, psychosocial and immunization assessment (for paediatric pt.)	3	9	11	329

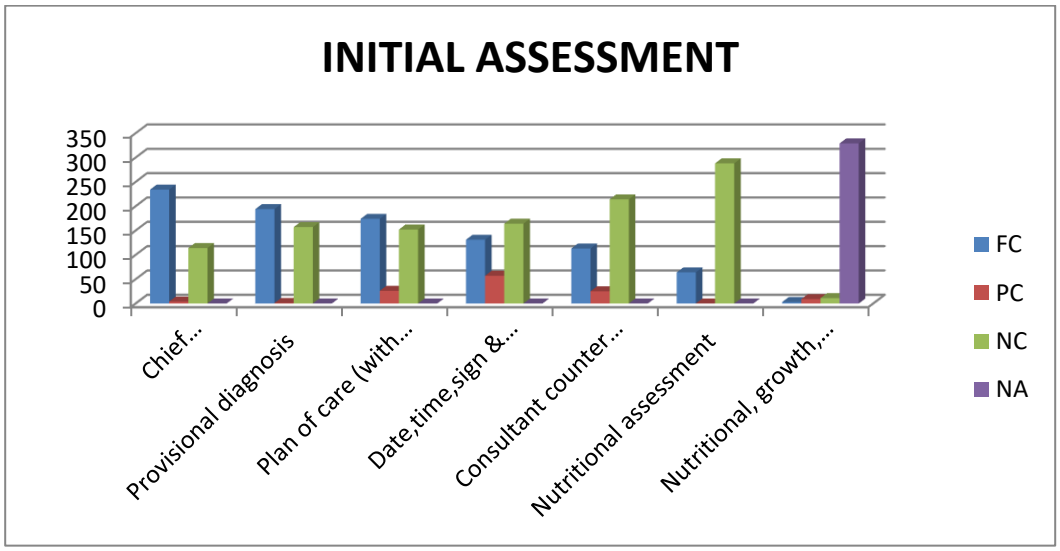


Figure.2

Interpretation:

- Out of 352 file, chief complaint were fully complaince (FC) in 234 files (66.47%).
- Similarly,provisional diagnosis,plan of care, Date,time,sign & name of Doctor present Consultant, counter signed, Nutritional assessment, Nutritional, growth, psychosocial and immunization assessment (for paediatric pt.) were FC in 194 (55.11%), 174 (49.43%), 131 (37.21%), 113 (32.1%), 64 (18.18%),3 (13.04%) files

Emergency: (Table – 2) Active files(352)

Emergency (if applicable)	FC	PC	NC	NA
Initial assessment-Audit	123	0	0	229
History/Chief complaints Proper	119	4	0	229
Provisional diagnosis	114	0	9	229
Plan of care	81	8	34	229
Reason for referral/Speciality mentioned	108	0	14	229
Date,time,sign & name of Doctor present	99	18	5	229
MLC/AR entry Proper	4	0	0	348

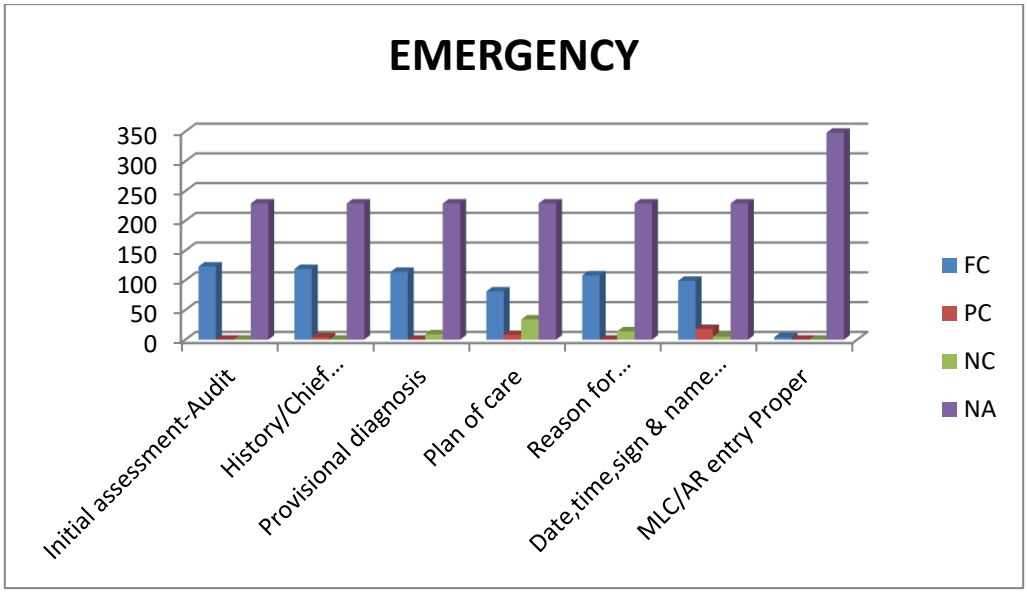


Figure .3

Interpretation :

- Out of 352 file, Initial assessment were fully complaince (FC) in 123 files (100%).
- Similarly, History/Chief complaints ,Proper Provisional diagnosis Plan of care ,Reason for referral/Speciality mentioned ,Date,time,sign & name of Doctor present ,MLC/AR entry Proper were FC in 119 (96.74%), 114 (92.68%), 81 (65.85%), 108 (87.8%), 99 (80.48%),4 (100%) files

Doctor's Progress notes (Table – 3) Active files(352)

Progress notes-Doctors:	FC	PC	NC	NA
Re-assessed at appropriate intervals	348	2	2	0
Date,time,sign & name of Doctor present	53	297	2	0

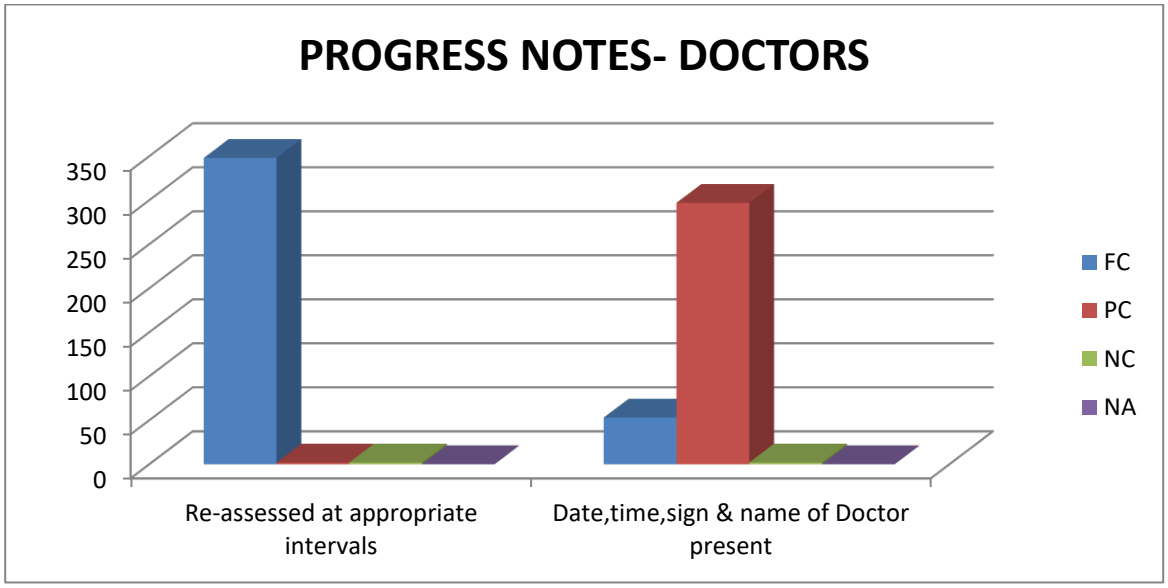


Figure.4

Interpretation:

- Out of 352 file, Re-assessed at appropriate intervals were fully complaince (FC) in 348 files (98.86%) and Date,time,sign & name of Doctor present were fully complaince (FC)in 53 files (15.05%).

Drug Chart (Table - -4) Active files(352)

Drug Chart	FC	PC	NC	NA
Medicine name in capital	111	239	2	0
Abbrevation used	316	35	1	0
Route,Dose and Frequency	282	68	2	0
Signature with name,Date and Time	109	240	2	1

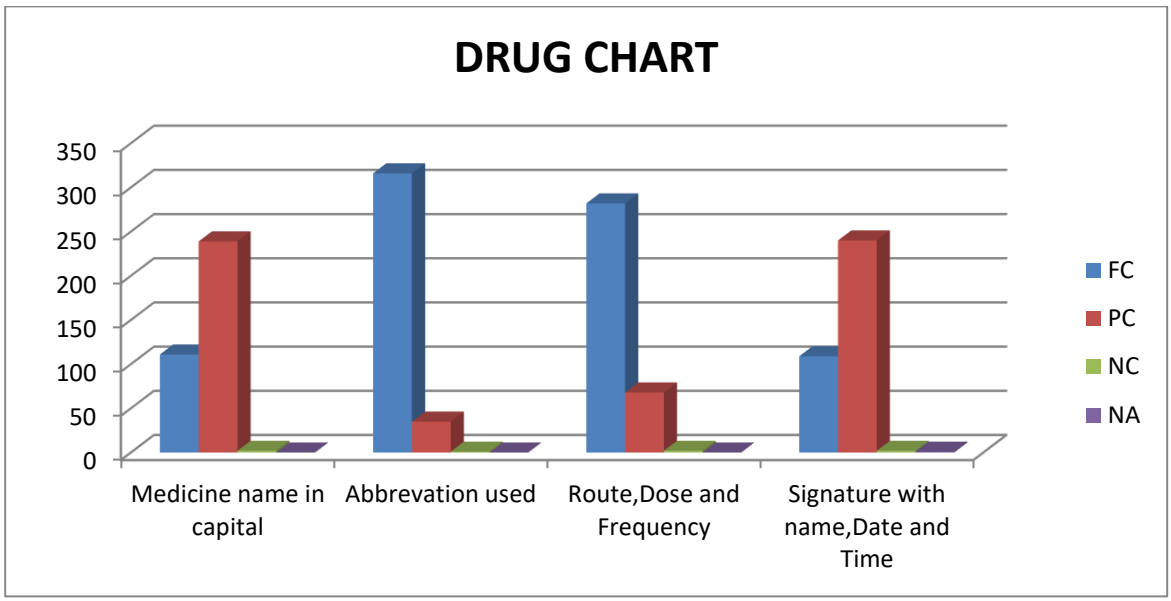


Figure .5

Interpretation:

- Out of 352 file, Medicine name in capital were fully complaince (FC) in 111 files (31.53%).
- Similarly, Abbrevation used Route,Dose and Frequency Signature with name,Date and Time were FC in 316 (89.77%), 282 (80.11%), 109 (30.96%) files

Consents (Table – 5) Active files(352)

Consents:	FC	PC	NC	NA
Risk & Benefits explained & Documented	238	1	2	111
Name,signature,Time & BLK ID	224	13	4	111
Patient/ Surrogate signature	234	5	2	111

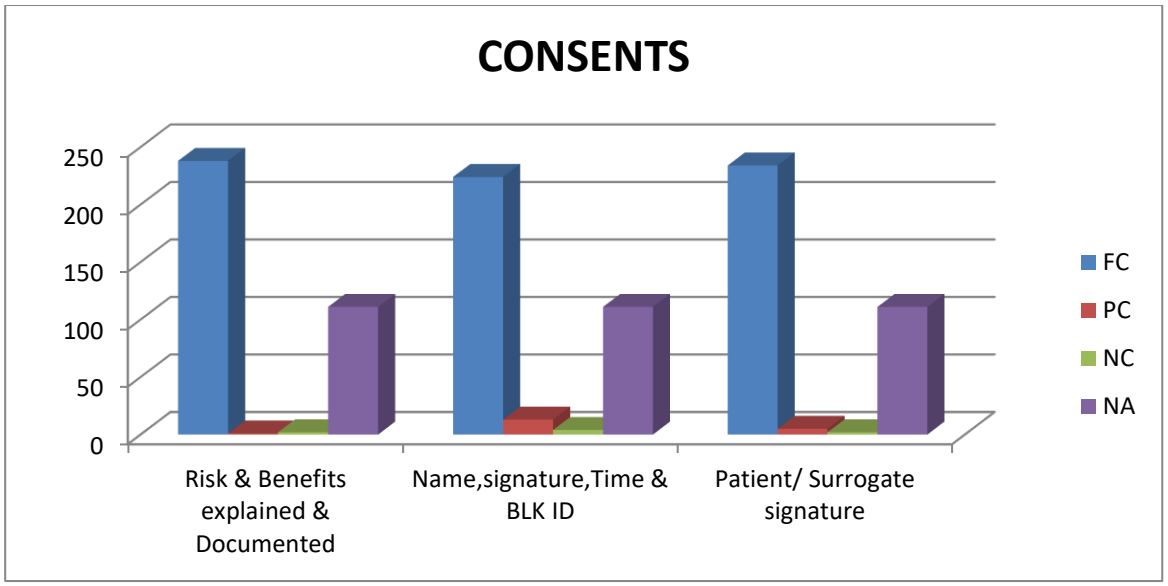


Figure .6

Interpretation:

- Out of 352 file, Risk & Benefits explained & Documented were fully complaince (FC) in 238 files (98.78%) , Name,signature,Time & BLK ID were fully complaince (FC)in 224 files (92.94%) and Patient/ Surrogate signature were fully complaince (FC) in 234 files (97.09%).

Anaesthesia Record Sheet (Table – 6) Active files(352)

Anaesthesia record sheet:	FC	PC	NC	NA
Pre-anaesthetic assessment done & planned documented	125	0	1	226
Pre-operative assessment done	126	0	0	226
Post operative monitoring done & documented	122	1	3	226

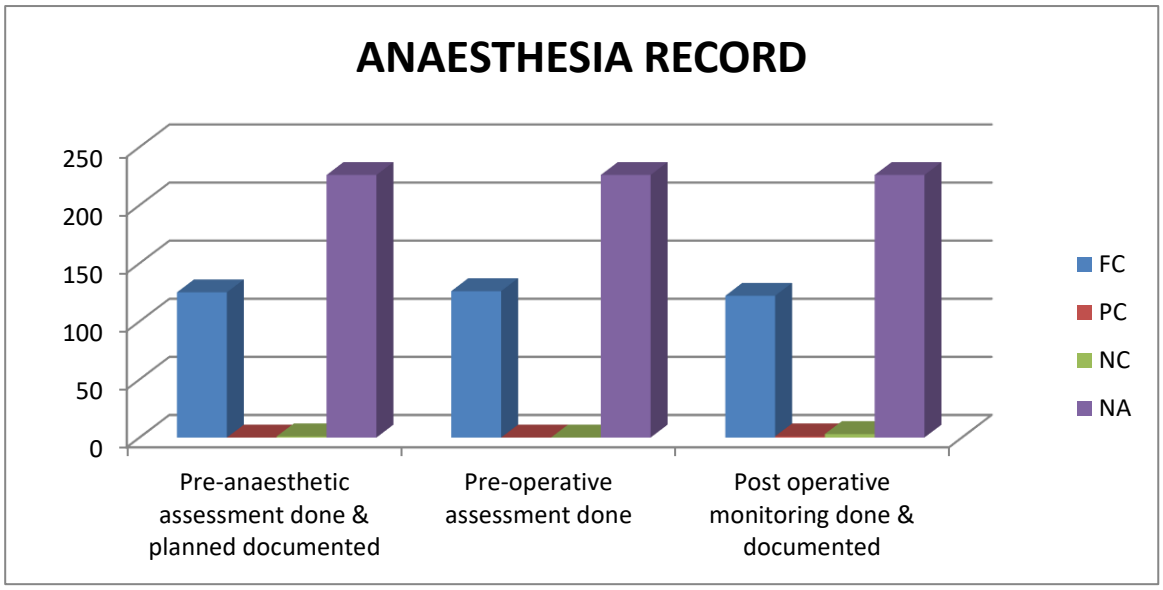


Figure .7

Interpretation:

- Out of 352 file, Pre-anaesthetic assessment done & planned documented were fully complaince (FC) in 125 files (99.2%) , Pre-operative assessment done were fully complaince (FC)in 126 files (100%) and Post operative monitoring done & documented were fully complaince (FC) in 122 files (96.82%).

Surgery Records (Table – 7) Active files(352)

Surgery records	FC	PC	NC	NA
Operative notes	116	2	8	226
Surgical safety checklist completely filled	112	10	4	226
Post operative care plan documented	122	1	3	226
Implant sticker pasted	10	0	1	341

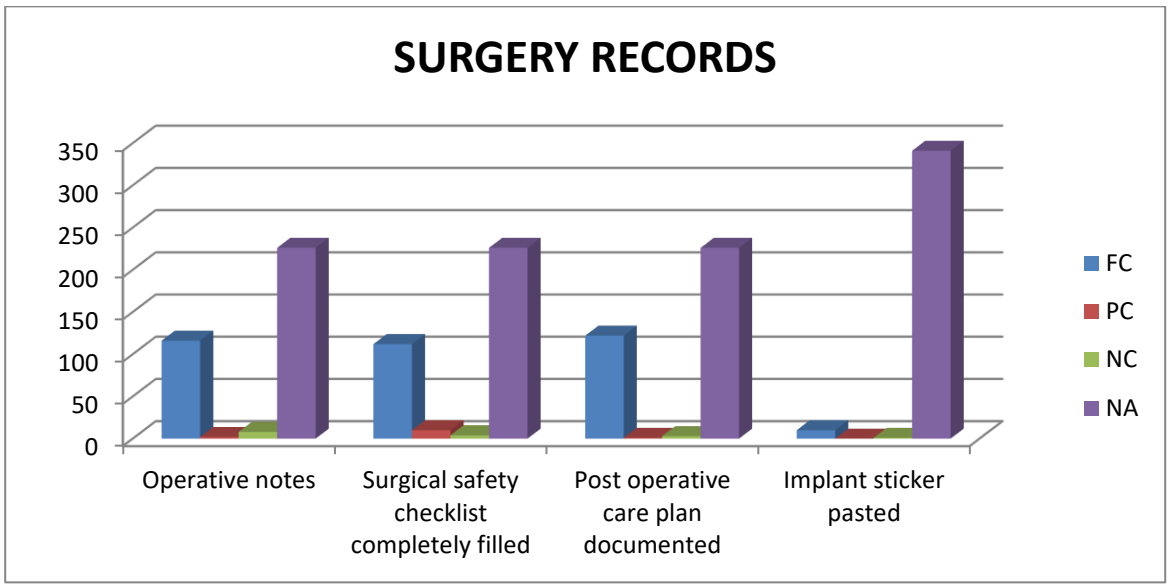


Figure .8

Interpretation:

- Out of 352 file, Operative notes were fully complaince (FC) in 116 files (92.06%) , Surgical safety checklist completely filled were fully complaince (FC)in 112 files (88.88%) , Post operative care plan documented were fully complaince (FC) in 122 files (96.82%) and Implant sticker pasted were fully complaince (FC) in 10 files (90.0%).

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Nursing (Table – 8) Active files(352)

Nursing:	FC	PC	NC	NA
Nursing initial assessment proper-All parameters (with plan of care)	319	33	0	0
Progress notes-Nurses	265	5	82	0
Re-assessment at appropriate intervals	332	20	0	0
Daily nursing Vital flow sheet	352	0	0	0
Fall risk assessment	349	2	1	0
Pain assessment (intensity, character, frequency, location, duration and referral and/or radiation)	259	90	3	0

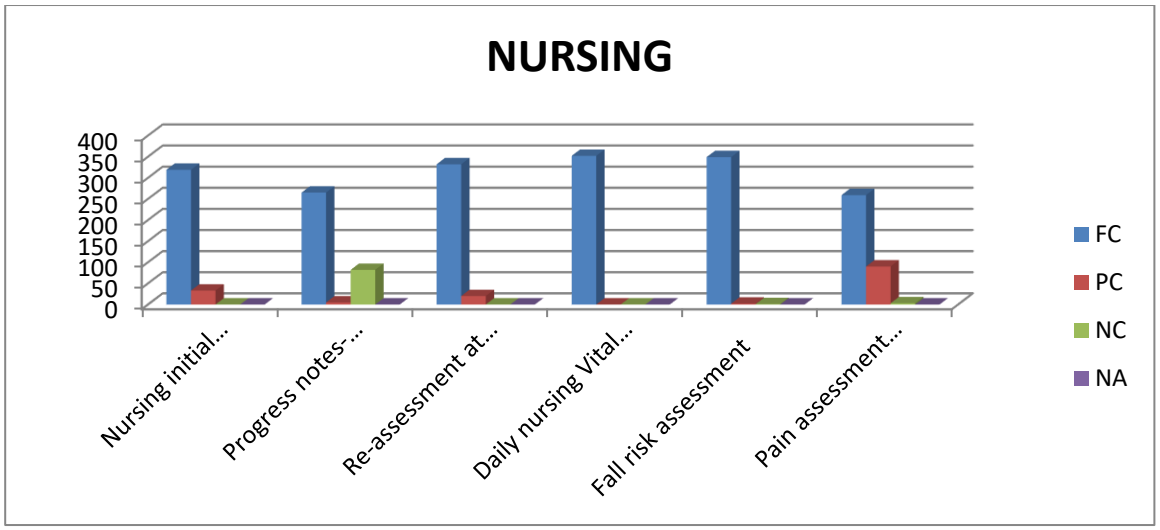

Figure .9

Interpretation:

- Out of 352 file, Nursing initial assessment proper-All parameters (with plan of care) were fully complaince (FC) in 319 files (90.62%).
- Similarly, Progress notes-Nurses, Re-assessment at appropriate intervals, Daily nursing Vital flow sheet ,Fall risk assessment, Pain assessment (intensity, character, frequency, location, duration and referral and/or radiation) were FC in 265 (75.28%), 332 (94.31%), 352 (100%), 349 (99.14%), 259(73.57%) files

Others (Table – 9) Active files(352)

Others	FC	PC	NC	NA
General consent form	327	25	0	0
Valuable handover form	320	31	1	0
Admission request	259	88	5	0
Financial councelling/ Estimate of expenses	162	4	186	0

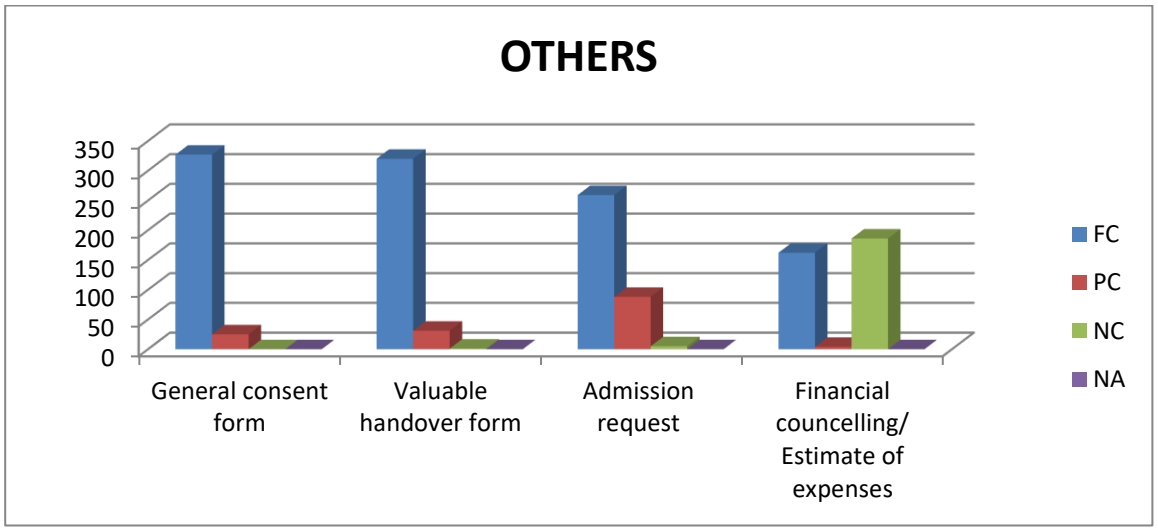

Figure .10

Interpretation:

- Out of 352 file, General consent form were fully complaince (FC) in 327 files (92.89%) , Valuable handover form were fully complaince (FC) in 320 files (90.9%) , Admission request were fully complaince (FC) in 259 files (73.57%) and, Financial councelling/ Estimate of expenses were fully complaince (FC) in 162 files (46.02%).

Initial assessment: (Table – 10) Inactive files(198)

Initial Assessment /IPD case note	FC	PC	NC	NA
Chief complaints/Past history	189	2	7	0
Provisional diagnosis	160	0	38	0
Plan of care (with preventive, promotive curative and rehabilitative)	158	14	26	0
Date,time,sign & name of Doctor present	95	33	70	0
Consultant counter signed	77	13	108	0
Nutritional assessment	15	0	183	0
Nutritional, growth, psychosocial and immunization assessment (for paediatric pt.)	5	6	10	177

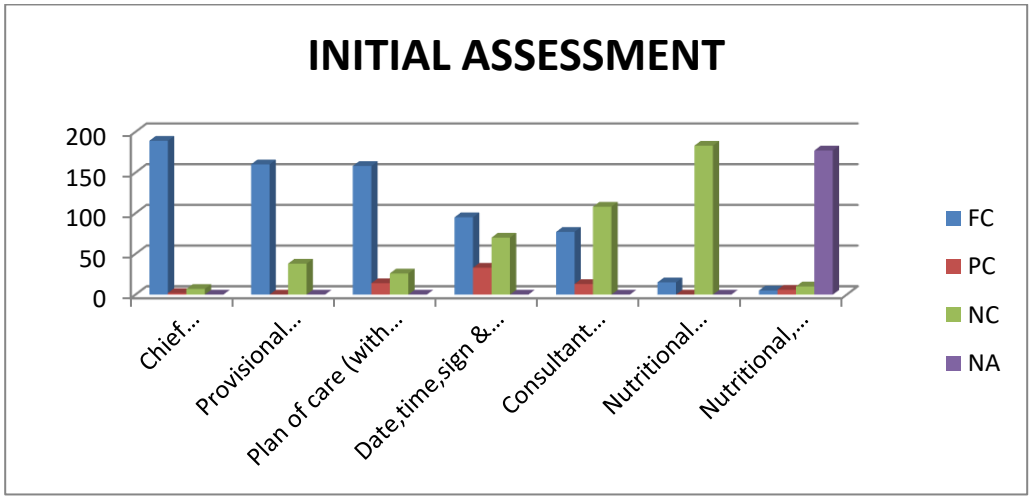

Figure .11

Interpretation:

- Out of 198 file, chief complaint were fully complaince (FC) in 189 files (95.5%).
- Similarly,provisional diagnosis,plan of care, Date,time,sign & name of Doctor present Consultant, counter signed, Nutritional assessment, Nutritional, growth, psychosocial and immunization assessment (for paediatric pt.) were FC in 160 (80.8%), 158 (79.8%), 95 (48.0%), 77 (38.9%), 15 (7.6%),5 (23.8%) files

Emergency: (Table – 11) Inactive files(198)

Emergency (if applicable)	FC	PC	NC	NA
Initial assessment	54	0	1	143
History/Chief complaints Proper	54	0	1	143
Provisional diagnosis	49	0	6	143
Plan of care	45	6	4	143
Reason for referral/Speciality mentioned	50	0	5	143
Date,time,sign & name of Doctor present	43	11	1	143
MLC/AR entry Proper	6	0	1	191

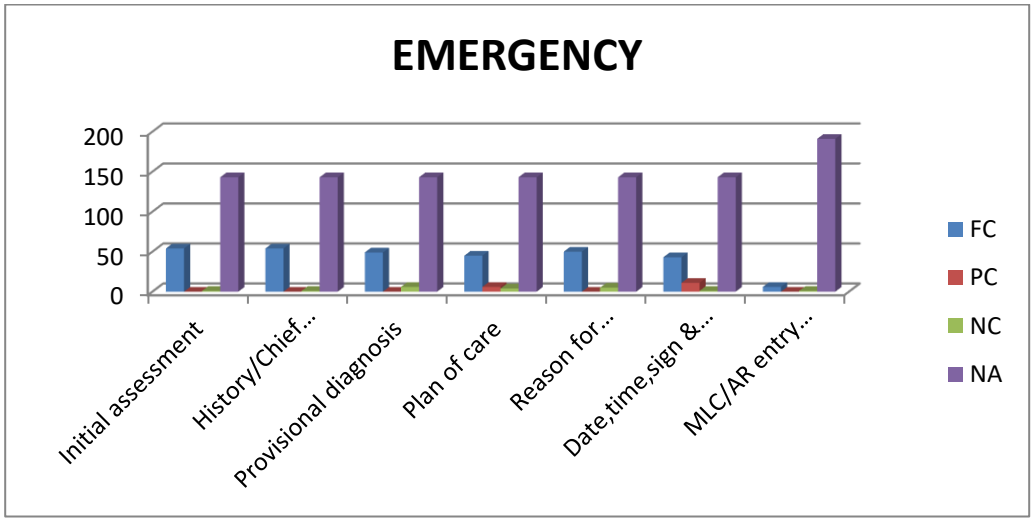

Figure .12

Interpretation:

- Out of 198 file, Initial assessment were fully complaince (FC) in 54 files (98.2%).
- Similarly, History/Chief complaints ,Proper Provisional diagnosis Plan of care ,Reason for referral/Speciality mentioned ,Date,time,sign & name of Doctor present ,MLC/AR entry Proper were FC in 54 (98.2%), 49 (89.1%), 45 (81.8%), 50 (90.9%), 43 (78.2%),6 (85.7%) files

Doctor's Progress notes (Table – 12) Inactive files(198)

Progress notes-Doctors:	FC	PC	NC	NA
Re-assessed at appropriate intervals	189	1	8	0
Date,time,sign & name of Doctor present	35	155	8	0

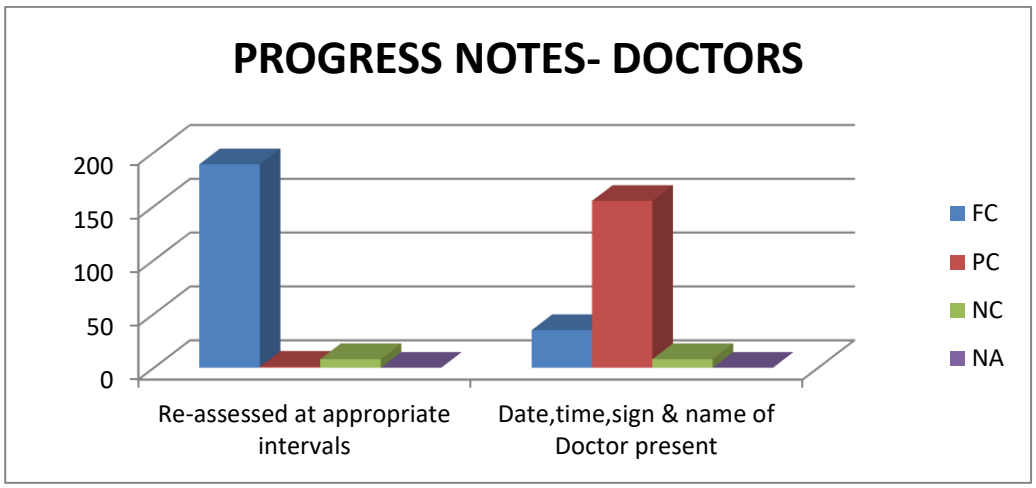

Figure .13

Interpretation:

- Out of 198 file, Re-assessed at appropriate intervals were fully complaince (FC) in 189 files (95.5%) and Date,time,sign & name of Doctor present were fully complaince (FC)in 35 files (17.7%).

Drug Chart (Table - 13) Inactive files(198)

Drug Chart	FC	PC	NC	NA
Medicine name in capital	41	147	7	3
Route, Dose and Frequency written	100	88	7	3
Abbreviations used	178	10	7	3
Signature with name, Date and Time	89	99	7	3

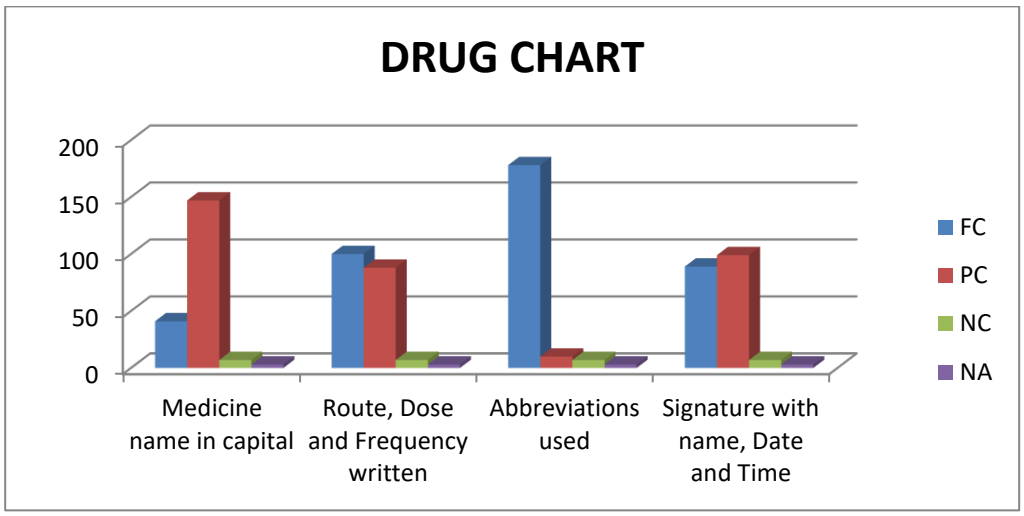

Figure .14

Interpretation:

- Out of 198 file, Medicine name in capital were fully complaince (FC) in 41 files (21.0%).
- Similarly, Abbrevation used Route,Dose and Frequency Signature with name,Date and Time were FC in 100 (51.3%), 178 (91.3%), 89 (45.6%) files

Consents (Table – 14) Inactive files(198)

Consents:	FC	PC	NC	NA
Risk & Benefits explained & Documented	127	0	3	68
Name,signature,Time & BLK ID	87	39	4	68
Patient/ Surrogate signature	120	7	3	68

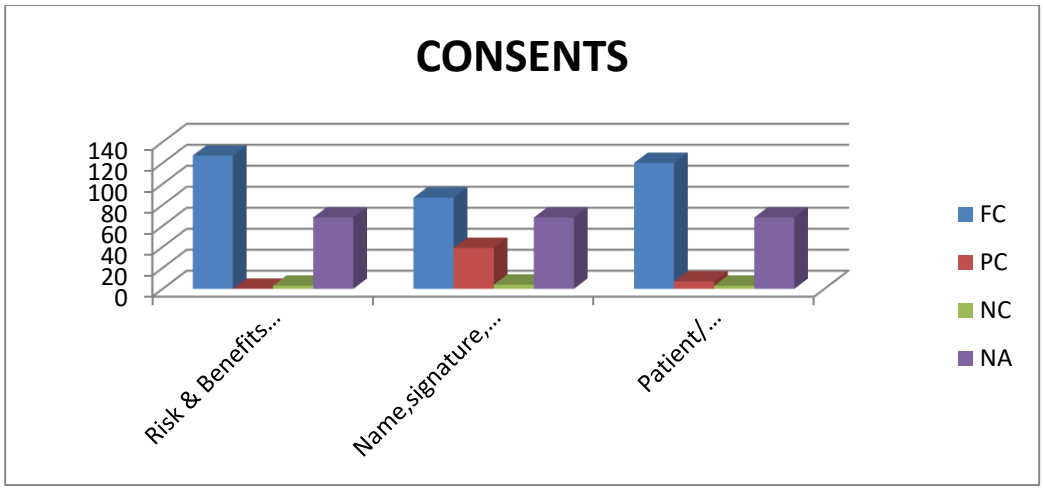

Figure .15

Interpretation:

Out of 198 file, Risk & Benefits explained & Documented were fully complaince (FC) in 127 files (97.7%) , Name,signature,Time & BLK ID were fully complaince (FC)in 87 files (66.9%) and Patient/ Surrogate signature were fully complaince (FC) in 120 files (92.3%).

Anaesthesia Record Sheet (Table – 15) Inactive files(198)

Anesthesia record sheet:	FC	PC	NC	NA
Pre-anaesthetic assessment done & plan documented	85	0	0	113
Pre-operative assessment done	83	0	1	114
Post operative monitoring done & documented	79	1	4	114

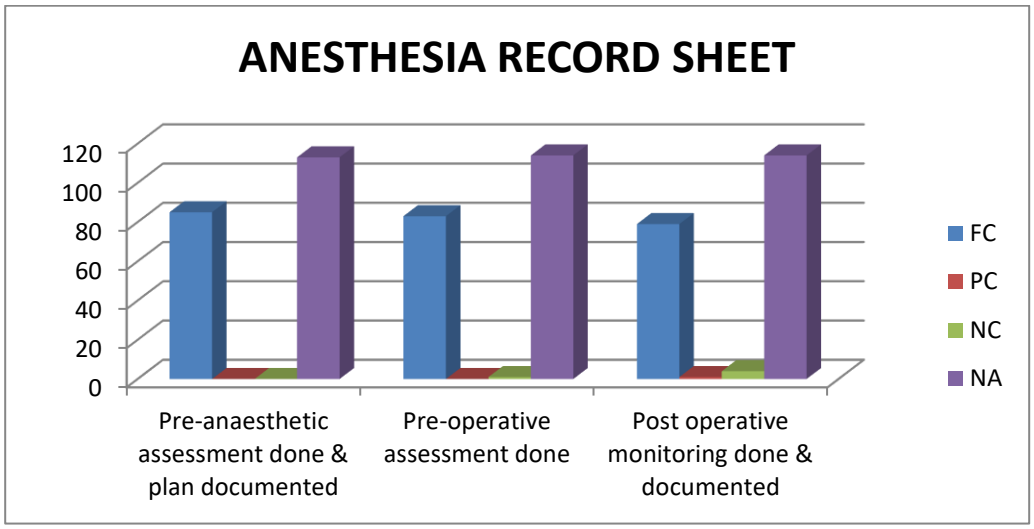

Figure .16

Interpretation:

- Out of 198 file, Pre-anaesthetic assessment done & planned documented were fully complaince (FC) in 85 files (100%) , Pre-operative assessment done were fully complaince (FC)in 83 files (98.8%) and Post operative monitoring done & documented were fully complaince (FC) in 79 files (94.0%).

Surgery Records (Table – 16) Inactive files(198)

Surgery records	FC	PC	NC	NA
Operative notes	78	2	4	114
Surgical safety checklist completely filled	63	16	5	114
Post operative care plan documented	80	0	4	114
Implant sticker pasted	6	0	0	192

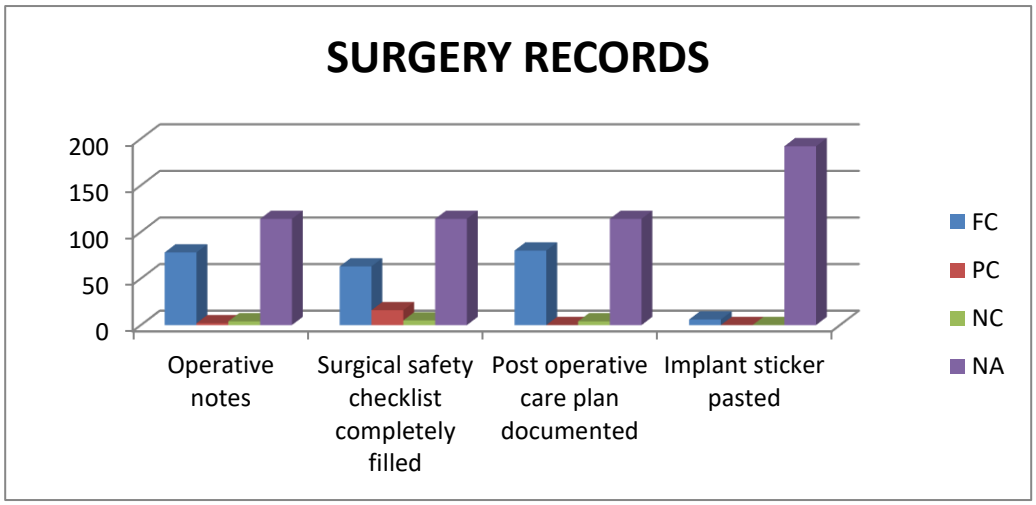

Figure .17

Interpretation:

- Out of 198 file, Operative notes were fully complaince (FC) in 78 files (92.9%) , Surgical safety checklist completely filled were fully complaince (FC)in 63 files (75.0%) , Post operative care plan documented were fully complaince (FC) in 80 files (95.2%) and Implant sticker pasted were fully complaince (FC) in 6 files (100%).

Nursing (Table – 17) Inactive files(198)

Nursing:	FC	PC	NC	NA
Nursing initial assessment proper-All parameters (with plan of care)	159	30	9	0
Progress notes-Nurses	161	7	30	0
Re-assessment at appropriate intervals	180	13	5	0
Daily nursing Vital flow sheet	189	1	8	0
Fall risk assessment	188	0	10	0
Pain assessment (intensity, character, frequency, location, duration and referral and/or radiation)	190	0	8	0

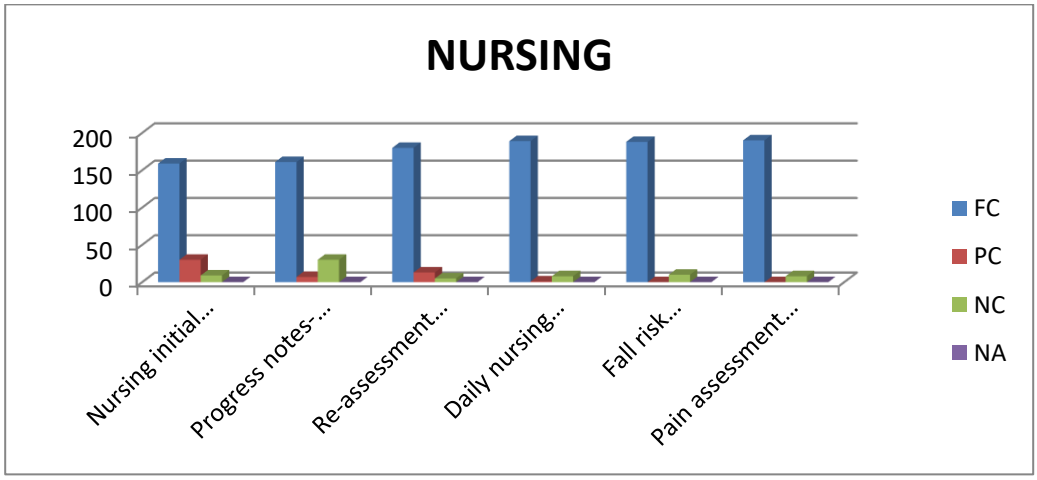

Figure .18

Interpretation:

- Out of 198 file, Nursing initial assessment proper-All parameters (with plan of care) were fully complaince (FC) in 159 files (80.3%).
- Similarly, Progress notes-Nurses, Re-assessment at appropriate intervals, Daily nursing Vital flow sheet ,Fall risk assessment, Pain assessment (intensity, character, frequency, location, duration and referral and/or radiation) were FC in 161 (81.3%), 180 (90.9%), 189 (95.5%), 188 (94.9%), 190(96.0%) files.

Discharge (Table -18) Inactive files(198)

Discharge	FC	PC	NC	NA
Discharge Summary	187	11	0	0
Diagnosis, findings and reason of admission	196	2	0	0
Investigations, procedure notes and medication documented	195	2	0	1
Follow up advice, medication	186	2	0	10

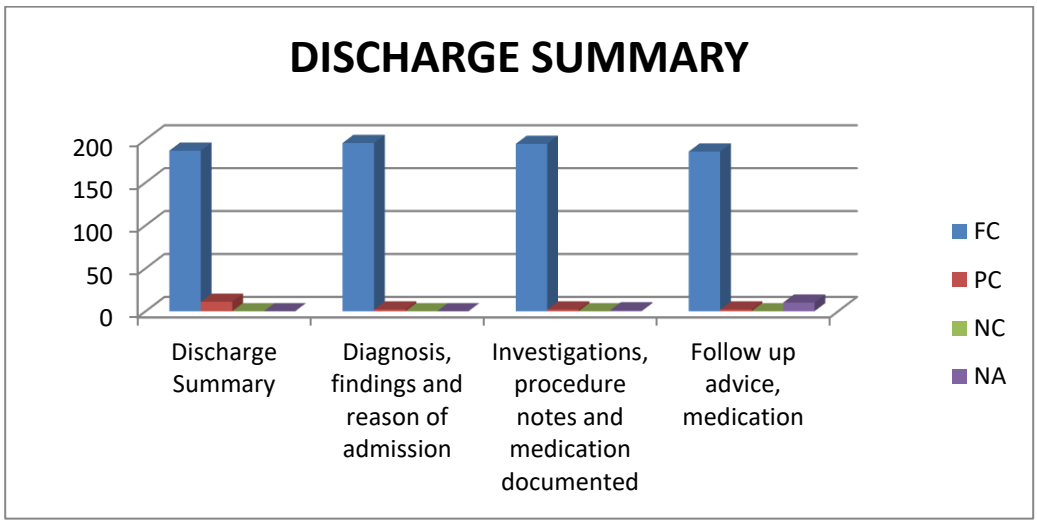

Figure .18

Interpretation:

- Out of 198 files, Discharge Summary were fully compliance (FC) in 187 files (94.4%), Diagnosis, findings and reason of admission were fully compliance (FC) in 196 files (99.0%), Investigations, procedure notes and medication documented were fully compliance (FC) in 195 files (99.0%) and Follow up advice, medication were fully compliance (FC) in 186 files (98.9%).

Others (Table – 19) Inactive files(198)

OTHERS	FC	PC	NC	NA
General consent form	174	24	0	0
Valuable handover form	151	44	3	0
Admission request	150	46	2	0
Financial councelling/ Estimate of expenses	128	3	67	0

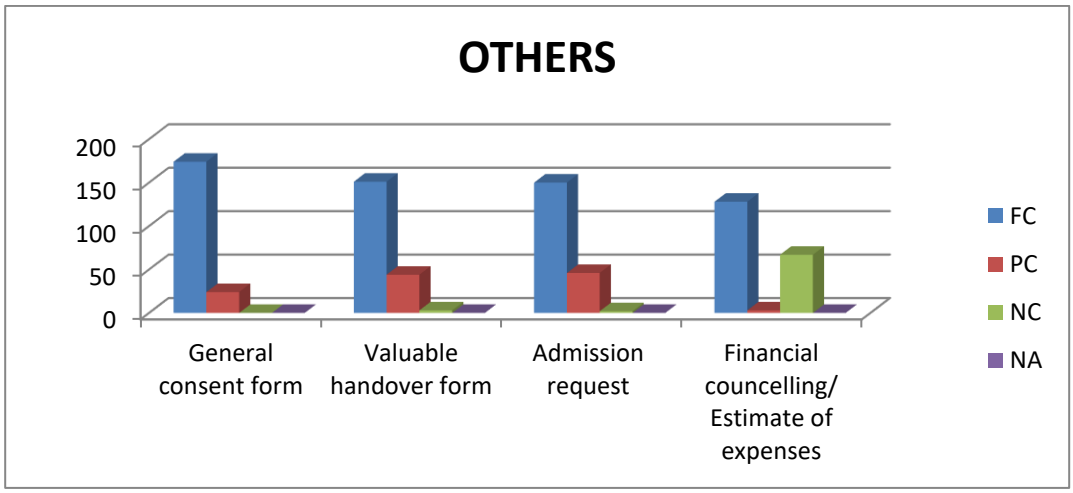

Figure .19

Interpretation:

- Out of 198 file, General consent form were fully complaince (FC) in 174 files (94.4%) , Valuable handover form were fully complaince (FC) in 151 files (99.0%) , Admission request were fully complaince (FC) in 150 files (99.0%) and, Financial councelling/ Estimate of expenses were fully complaince (FC) in 128 files (98.9%).

DISCUSSION

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

- Date,time,sign & name of Doctor present-Initial Assesment
- Consultant counter signed –Initial Assesment
- Date,time,sign & name of Doctor present –progress note(Doctor)
- Medicine name in capital-Drug chart
- Progress notes-Nurses

RECOMMENDATION

- Frequent audit should be conducted on floors for the completion of the records. After the audit is conducted, the nurse in charge of particular ward should be informed about the deficiencies, beside the reminder slips.
- The Medical Record department/personnel should identify incomplete records and send them to the concerned professional to complete and then only it should be filed
- Reminder slip of deficiencies should be given in spite for only document present or not.
- Importance of medical records should be emphasized in the induction programs and instill the purpose in new recruits.
- Training and motivation to the nursing staff to fill up their parts.
- Informed the doctors through medical superintendent about the issues.
- A reminder or information exchange session on the medical records completion can be kept in the CMEs of doctors/organizations.
- In each floor a nurse/ floor coordinator could be made accountable for checking if the documentation is complete or not.
- In order to make the staff of the hospital (doctors, nurses, social workers etc) aware about the documentation standards, medical record personnel should circulate standard guidelines list to every department**.**

CONCLUSION

Hospital accreditation and licensing of the healthcare services is only possible when the hospital assures and provides excellent services to the patient. This can only be achieved through the medical records of the patient maintained in the hospital. The completeness and accuracy of the information is the important criteria a hospital has to fulfil to get accredited with NABH.

The study at hospital showed that there was compliance in the surgery records sheet , anaesthesia record sheet, nursing records, consent forms etc. having almost met the standards set by NABH. There was deficiency noted in general consent form, valuable form, nutritional assessment, Nurses notes, drug chart, estimate of expense sheet and Signature of doctor's and consultant in initial assessment sheet, emergency sheet, doctors progress notes and drug charts. This needs to be carefully monitored and doctors made aware of their responsibility to completely fill each entries in these forms, which not only form the basis of documentation of care given and aids in the continuity of care, but also is an important document in case of any legal litigations.

Regular medical record audits and an ongoing training to all the members of the healthcare team could go a long way in ensuring complete and proper documentation of patient medical records.

LIMITATION

- The study is limited to Dr.B.L Kapur Hospital New Delhi, and therefore, the results of the study are applicable only to this hospital.
- The data obtained is based on the existing set-up, which prevails in the hospital at the time of the system study. .
- The NABH was an entirely a new fascinating thing to study and therefore it's possible to have some limitation in study.
- Time constraints.
- Sample size was small.
- Not allowed to talk to the doctors or nursing staff and other staffs to inquire about the deficiencies.

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ANNEXURE

Month:

MRD no.								
Specialty								
Date & Time of Audit								
Ward								
BED NO								
S.No.	**Parameter Audited**							
1	**Initial Assessment /IPD case note**							
	Chief complaints/Past history							
	Provisional diagnosis							
	Plan of care							
	Date,time,sign & name of Doctor present							
	Consultant counter signed							
	Nutritional assessment							
	psychosocial and immunization assessment (for paediatric pt.)							
2	**Emergency (if applicable)**							
	Initial assessment							
	History/Chief complaints Proper							

	Provisional diagnosis							
	Plan of care							
	Reason for referral/Speciality mentioned							
	Date,time,sign & name of Doctor present							
	MLC/AR entry Proper							
3	**Progress notes-Doctors:**							
	Re-assessed at appropriate intervals							
	Date,time,sign & name of Doctor present							
4	**Drug Chart**							
	Medicine name in capital							
	Route, Dose and Frequency written							
	Abbreviations used(Approved only)							
	Signature with name, Date and Time							
5	**Consents:**							
	Risk & Benefits explained & Documented							
	Name,signature,Time & BLK ID							
	Patient/ Surrogate							

	signature							
6	**Anesthesia record sheet:**							
	Pre-anaesthetic assessment done & plan documented							
	Pre-operative assessment done							
	Post operative monitoring done & documented							
7	**Surgery records**							
	Operative notes							
	Surgical safety checklist completely filled							
	Post operative care plan documented							
	Implant sticker in file							
8	**Nursing:**							
	Nursing initial assessment proper-All parameters (with plan of care)							
	Progress notes-Nurses							
	Re-assessment at appropriate intervals							
	Daily nursing Vital flow sheet							
	Fall risk assessment							

	Pain assessment							
9	**Discharge**							
	Discharge Summary							
	Diagnosis, findings and reason of admission							
	Investigations, procedure notes and medication documented							
	Follow up advice, medication							
10	**General consent form**							
11	**Valuable handover form**							
12	**Admission request**							
13	**Financial councelling/ Estimate of expenses**							

FULLY COMPLETE- FC, PARTIAL COMPLETE- PC, NOT COMPLETED- NC, NOT APPLICABLE-NA