ASSESSMENT OF ADHERENCE TO PROTOCOL FOR MEDICAL RECORD DOCUMENTATION IN ACCORDANCE WITH NABH GUIDELINES

Dissertation
In

Park Hospital , Gurgaon

(January 1- March 30, 2012)

By

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Under the guidance of

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Post Graduate Diploma in Hospital and Health Management

2010-12

International Institute of Health Management Research,

New Delhi

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Certificate of Internship Completion

Dated:- 02-05-2012

TO WHOM IT MAY CONCERN

This is to certify that **Ankit Khosla**, a student of Post- Graduate Diploma in Health and Hospital Management, of Institute of Health Management & research, New-Delhi has successfully completed 3 months internship in our organization from Jan 1st, 2012 to March 30th, 2012. During the internship he has worked on **"Assessment of Adherence to Protocol in Medical Record Documentation in Accordance with NABH Guidelines"** under the guidance of undersigned and his team. During the brief period of his association with our organization he was found to be hardworking, sincere, and diligent in conducting the said study.

We wish him good luck for his future assignments.

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Certificate of Approval

The following dissertation titled **"Assessment of Adhrence to Protocol in Medical Record Documentation in Accordance with NABH Guidelines"** approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

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Certificate from Dissertation Advisory Committee

This is to certify that **Ankit Khosla**, a student of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He is submitting this dissertation titled **"Assessment of Adhrence to Protocol in Medical Record Documentation in Accordance with NABH Guidelines"** 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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The data collection and my learning would not be possible without in depth discussions with the Medical record department team, the doctors at Park Hospital, also the nurses and their team leaders. I am appreciative of the support and assisstance they provided.

Again, this is not just to acknowledge the contributions but also to understand the fact that nothing can be accomplished alone.

Thanking you

Ankit Khosla

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Acronyms/Abbreviations used

NCR	National Capitol Region
ID	Identification
MRD	Medical Records Department
OPD	Out Patient Department
IPD	In Patient Department
OT	Operation Theater
HMIS	Hospital Management Information System
OCT	Optical Coherence Tomography
VED	Vital Essential Desirable
FIFO	First In First Out
ROI	Return on Investment
IMS	Information Management System
IOL	Intra Ocular Lens
CGHS	Central Government Health Scheme
TPA	Third Party Administrator
ISO	International Organization for Standardization
NABH	National Accreditation Board for Hospital and Healthcare Provoviders
JCAHO	Joint Commission of Accreditation of healthcare organizations.
3-D	Three Dimensional
MM	Millimeter
Phaco	Phacoemulsification
KPI	Key Performance Indicators
SOP	Standard Operating Procedure
ICU	Intensive Care Unit
CTVS	Cardiothoracic & Vascular Surgery

PART 1 - INTERNSHIP

1.1 INTRODUCTION

1.1.1 Objective of the internship

Knowledge is power"

For a MANAGEMENT student, this power of knowledge is unattainable unless an element of practical observation and practical performance is not added.

It is said that without theory, practice is blind and without practice theory is meaningless. Any class room coaching can be made effective if it is supplemented by practical exposure in an organization. To bridge the gap between theory and practical and for proper solution of health care problem practical knowledge is very important and to be a perfect administrator one must be well aware of practical environment.

- ✓ To complete my internship with full efficacy and efficiency.
- ✓ To understand working of whole hospital and seek opportunity that provides me real experience and to groom myself as a professional.
- ✓ The primary objective of the Intern program is to provide a student interested in the field of hospital working some experience and knowledge on the management and operations of a hospital.
- ✓ To accomplish the objective the student is expected to participate in variety of activities in the hospital and co-operate in the day to day working.

The duties require significant involvement in management activities the various responsibilities require the ability to work effectively with coworkers and to meet the demands of the public as well.

I was introduced to the hospital as a Management trainee in the department of hospital operations. Developing the **key performance indicators** for the clinical departments drafted with the input from the head of the departments and Staff. It involved more of clinical department work and began with developing KPI (key performance indicators for department like dermatology ENT, nephrology, neurosurgery, pain management, pulmonology and urology.

- ✓ **Clinical Audit** of dental, radiation oncology, lab, General Surgery, Nephrology
- ✓ Pain management, gastroenterology, urology, surgery and blood bank
- ✓ To check deviation from the standard operating procedure and norms prescribed by NABH.
- ✓ Check the deviations and take corrective and preventive actions.

I identified the problem areas and bottlenecks and suggested corrective and preventive action for these Problem Areas

My attempt would be successful and grateful if my project and project report serves the need and requirement of the organization in future.

The process of the Medical Record Audit

The process for medical record audit comprises of three components

- ✓ Developing the methodology for auditing of medical record of patients admitted in the hospital.
- ✓ This required an examination of current policies, procedures and documentation of medical records to assist development of the audit tool.
  The audit questions were shared and reviewed with department personnel prior to finalization.

- ✓ Assessment was done for medical records of selected specialty against the agreed set of audit questions. The total sample of 130 records was drawn from medical record department for the hospital admissions in the period of 1st Feb- 30th March 2012
- ✓ Analysis of documents was done and provided report of results.

Designation: Manager Operations

Duties & Responsibilities:

- Coordinate with various construction teams at **Park Hospital, Gurgaon**.
- Worked with **project planning** teams.
- Coordinate workforce management objectives with a focus on individual, departmental and hospital-wide initiatives and team concepts.
- Focus on **Patient satisfaction**.
- Coordinate **international patient desk** for international patients.
- Coordinate in **Equipment planning** also.
- Guide the process of root cause analysis to identify, track and resolve adverse events encompassing the development, implementation and monitoring of a corrective action plans.
- Responsible for branding, website planning and strategic decision making.
- Worked as base team with **Park Hospital, Gurgaon** hence has immense talent to perform multitasking.
- Worked with H.R. and Marketing team also during base team with Park Hospital, Gurgaon.
- Helped in **database management for marketing team and in recruitment process with H.R. team.**

1.2 PARK HOSPITAL – ORGANIZATION PROFILE

ORGANIZATION PROFILE

The Park has a strong legacy of more than 3 decades that redefines healthcare arena in a unique and larger perspective. Since its inception the group has always strived to take the healthcare services to a new level. This journey of healthcare excellence and highest level of patient satisfaction has seen many milestones on its way. Today the group boasts a panel of more than 100 doctors and an array of state-of-the-art healthcare facilities across its hospitals in West Delhi, South Delhi, Gurgaon, Faridabad and Panipat. Patients at Park include common people, corporate, government employees and many who's who of the society. Park envisions of providing latest and affordable services to the people of all social and economic backgrounds. With a passion to surpass patients' expectations and bring about a meaningful change in the lives of people, the Park is on its way to becoming a leading healthcare provider of north India.

Park Hospital Gurgaon is an ambitious initiative from the house of Park. Fully-equipped with all state-of-the-art medical facilities, this **250 bed** super-specialty hospital is the beginning of a new era in taking healthcare services in Gurgaon to a new level. Park Hospital Gurgaon envisions of providing a comprehensive spectrum of advanced medical & surgical interventions with a perfect mix of inpatient and outpatient services to people of all social and economic backgrounds. It is the onset of a new experience where patients not only get medical services as per international standards but also receive an empathetic and humane treatment by the professionals attending to them. It is about pursuing a dream called ‘wellness for all.’

THE PARK MISSION

“To deliver state-of-the-art personalized healthcare services to people of all social and economic background and achieve highest level of patient satisfaction.”

THE PARK VISION

“To be a leading name in the healthcare sector by providing holistic healthcare at affordable cost.”

ABOUT LOGO

P E R S O N A L I S E D

A L L S P E C I A L I T I E S

R E S O N A B L E C O S T

Q U A L I T Y S E R V I C E S

The two hands stand for care & help. Blue color signifies excellence and orange indicates the zeal for care. The logo also assure people that they are in safe and caring hands.

COMMITMENT TOWARDS QUALITY

At Park Hospital, we believe in our people, our systems and our commitment to quality and continuous improvement. It is our aim to deliver safe, cost-effective care to the community and the patients we serve. At Our Hospital we believe that the patient experience is comprised of outstanding quality and excellent customer service.

We are committed to provide our patients with the: Highest-quality, safest and most-satisfying care possible.

We continuously strive to improve the quality of our health care services by

- Adopting latest technology and equipments to strengthen our Medical processes and procedures to achieve the set objectives.
- Induction of regular training programs for staff.
- To meet the National and International Standards.

- Park Super Speciality Hospital, Gurgaon is in the process of applying for NABH Accreditation at the earliest.

- Hospital is one of the complex institutions, which are frequented by people from every walk of life. All of them produce waste, which is increasing in its amount and type due to advances in scientific knowledge and is creating its impact. Keeping in view inappropriate biomedical waste management, the Ministry of Environment and Forests notified the “Biomedical Waste (management and handling) Rules, 1998” in July 1998.

SALIENT FEATURES OF PARK HOSPITAL

- More than 25 departments, 100 doctors, 500 paramedical support staff available round the clock

- A branch of Park Group of Hospitals having branches in South Delhi, West Delhi, Faridabad and other upcoming hospitals in Panipat and Cancer Hospital in West Delhi

- Fully equipped 70 bedded ICU/ CCU complex with ultramodern intensive care facilities manned by intensivists, physicians and residents round the clock

- Department of Interventional Cardiology and Cardiothoracic Surgery equipped with latest GE Innova, IQ Cath Lab and Ultramodern Cardiothoracic Operation Theatres

- Park Mother's Nest- High end premium boutique birthing center with Labor Delivery Recovery (LDR) suite.

- Department of Neonatology comprising of all the ultramodern facilities with monitoring units, open and close Incubator, Ventilators, Analyzers, with dedicated team of Neonatologists and Paramedical staff.

- Park Trauma Center- Comprehensive integrated approach by team of Orthopaedicians, Neurosurgeons, General Surgeons and other paramedical staff to handle all kind of trauma cases.

- Fully functional Gastroenterology department with all ultramodern equipments manned by Gastroenterologist and Gastro Intestinal surgeon to deal with all kind of routine and emergency procedures.
- 24 x 7 Blood Bank services.
- Department of Radio Diagnosis equipped with advanced CT, MRI, Ultrasound, Color Doppler, and Digital X- Ray system 24 x 7

SERVICES AND DEPARTMENTS

- Anesthesia /Pain Management
- Blood Bank
- Cardiology and Cardio Thoracic Vascular Surgery
- Critical care
- Cancer and Oncology
- Dentistry
- Dermatology and Cosmetic Surgery (Plastic and Reconstructive Surgery)
- Emergency Medicine and Ambulance Services
- Endocrinology
- ENT (Ear , Nose and Throat)
- General and LaparoscopicSurgery (Minimal Invasive and Bariatric Surgery)
- Gastroenterology
- Gynecology and Obstetrics
- Internal Medicine

- Nephrology
- Neurology and Neurosurgery
- Ophthalmology
- Orthopedics
- Pediatrics
- Pulmonology and respiratory Medicine
- Urology
- 24 hour emergency and pharmacy
- Radiology Services and diagnostics

SERVICE LOCATION DISTRIBUTION

BASEMENT:

1) Radiology- X-Ray, Ultrasound, CT Scan, MRI
2) Pathology and Microbiology
3) Neurology Lab- EEG, EMG
4) OPD Chambers- ENT, Psychiatry and Psychology, Respiratory Medicine, Urology and Nephrology,
5) Ophthalmology
6) Dermatology
7) Blood bank
8) Physiotherapy

9) Dental

10) Accounts

11) IPD Billing

12) Medical Record Department and Store

13) Admin Offices

14) Conference Room and Auditorium

15) Gas Manifold

16) Restaurant

GROUND FLOOR:

1) RECEPTION (Front Desk)
2) TPA and International Patients Desk
3) Casualty
4) Admin Offices
5) OPD Chambers- Medicine, Surgery, Orthopaedics, Gastroenterology, Paediatrics, Neurology and Neurosurgery, Cardiology and Cardiothoracic Surgery, Obs & Gynae etc.
6) Mother's Nest- Obs & Gynae Wards, Labour Room, LDR (Birthing) Suites, NICU and Nursery.
7) Surgical ICU
8) Gastro Lab
9) OT Complex- 3 Major and 1 Minor Operation Theatre

FIRST FLOOR:

1) Inpatients Wards – Single Rooms and Twin Sharing Rooms, Suite Rooms
2) Medical ICU- I

SECOND FLOOR:

1) Inpatient Wards- General Wards, Single Rooms and twin sharing rooms.
2) Dialysis Unit
3) Heart Centre - Cardiac OT, Cath Lab, Heart Command, CCU and Medical ICU-II.

PARK GROUP - OTHER HOSPITALS:

1) Park Sunil Hospital (South Delhi) – 50 bedded
2) Park Hospital (West Delhi, Keshopur) – 300 bedded and NABH Accredited.

OTHER UPCOMING PROJECTS:

3) Park Hospital (Faridabad)
4) Park Hospital (Panipat)
5) Park Cancer Hospital (West Delhi)

PART 2 -
MEDICAL RECORD

1. INTRODUCTION

Medical record is an orderly written document encompassing the patient's identification data, health history, physical examination findings, laboratory reports, diagnosis, treatment and surgical procedures and hospital course. Medical record should contain sufficient data to justify the investigations, diagnosis, treatment, length of stay results of care and future course of action.

To the hurried Doctor, the medical record at times may appear typically symbolic of administrative red tape of complicated forms which consume a lot of time to fill in. At other times he/she fully realizes and appreciates that only thorough maintaining adequate and accurate medical records, the present and future health and welfare of the patient for whom he cares, can be protected, that research and improved education be fostered, that his own status and growth be enhanced. Its a well known fact that ***"People forget but records remember"*** (A Chattoraj et al,2005)

A well managed MRD leads to-

1. Better competitiveness
2. Workflow benefits
3. Better decision support
4. Easier reporting
5. Better information about patients
6. Improved quality of care
7. More money/savings/ROI

Benefits of medical records:

Medical record serves as an easy reference for providing continuity in patient care.

Medical record serves as a means of doctor's self assessment.

Medical records provide pertinent patient care information to authorize organizations.
The records are important to the public health authorities as they contain reliable information regarding morbidity and mortality patterns.

Medical record provides patient care information to third party payers.

Medical record render clinical and administrative data required for medical research purposes.

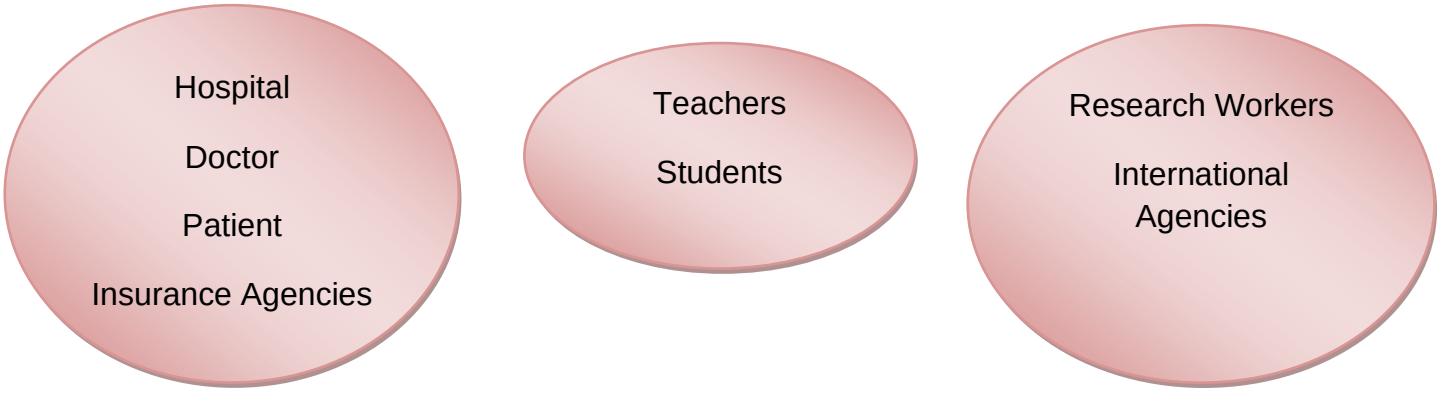
Medical records protect the patient, physician as well as the health care institution and its employees in the event of litigation.

To assure quality in maintenance of records and implicit quality in service provision, medical record auditing should be performed. Medical record auditing is one of the tools of auditing to assure quality and accuracy of the medical services through reviewing medical records on the basis of focused designed parameters.

Audit of medical records is a good way to ensure that the quality of information contained sufficient for ensuring effective continuity of care for patient. The audit aims to ensure that record contains appropriate information that provides clear information for ongoing care of the patient.
With demands to contain costs and improve efficiency hospitals are looking for ways reduce their exposure to potential liability suits through proper internal controls.

It is the most important phases of a hospital's administrative operation is its medical record department. Carelessness in the operation of this department may result in medical and financial liability. An operational audit of a hospital's medical records department can go a long way toward ensuring an orderly, efficient and potentially liability free operation.
Compliance with standards established by the Joint Commission on Accreditation of healthcare Organization (JCAHO) may provide a starting point for measuring a medical records department's effectiveness.

USERS OF MEDICAL RECORDS



2.1.1 PURPOSE OF THE STUDY –
Park Hospital boasts of excellence and quality. For improving their quality standards they want to go for NABH accreditation. Thus the existing MRD has to be benchmarked with the NABH standards for small healthcare organizations.(guidelines are attached in annexure). This prompted them to review and improve their MRD.

Preliminary Survey:
An internal auditor first must determine how the department under review should work.

An auditor should consult objectives, goals, and standards established by administrators for the department and the policies and procedures to meet those aims.
Objectives and goals for a medical records department should focus on achieving economic return and effectiveness. A department's standards most likely will be based on those established by International organization, including: a hospital should maintain medical records that are documented accurately and in a timely manner are readily accessible and permit prompt retrieval of information, including statistical data;
A medical record should contain sufficient information to identify a patient, support, diagnosis, justify treatment and document results accurately; Medical Records should be confidential, secure, current, authenticated, legible and complete. A medical records department should receive adequate direction, staffing and facilities to perform required functions and medical record personnel should have a defined role in hospital's overall quality assurance program and in committee functions.
Because a medical records department serves and interacts with most other hospital departments, communication with other areas is a necessary component of a medical record audit .While a medical records manager would be the major contributor to an audit questionnaire other department heads also should be questioned to detect interdepartmental problems.

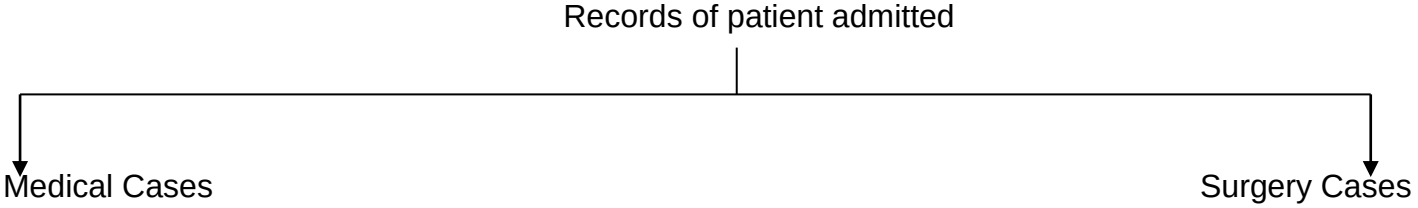
RATIONALE OF THE STUDY

As the hospital has to undergo NABH pre Assessment, so it had to work upon the non-conformities identified. One of the non conformities was improper maintenance of medical records from both sides the doctors and the nursing staff.
This was done to assess the existing deficiencies and take the corrective measures for proper medical record maintenance and to hasten these process immediate and simultaneous corrective actions can be taken for sustainable improvement.
This study will help in adequate management of the department working in reviewing the performance of the department and in providing better patient care.

OBJECTIVES

1. To study Medical Record Dept. of the hospital.
2. To audit manual medical records as per the guidelines laid for documentation under NABH
3. To highlight major observations to recommend implementable solutions.

SELECTION CRITERIA MAY INCLUDE



DATA COLLECTION METHOD

- ✓ Secondary data- Patient Medical Records
- ✓ Primary data
- Survey:
  To enumerate various types of forms in use in ward areas, OPD, different clinical department and laboratories.
- Checklist – keeping in mind the various quality standards, checklist will be prepared and will be filled by the data gathered.
- Interviewing the doctors and nursing staff.
- Direct Observation of the functioning of various departments.

DATA SOURCES

Data will be obtained from the following sources
Documents (MR files and forms, policies, procedures)
MR department persons & doctors.
Functioning of various departments.

ASSESSMENT COMPONENTS

Structure

Department policies and procedures

Functions

Filling record form
MR content and documentation

Literature Review

MEDICAL RECORD

The medical records or the health records as it is sometimes called is a patient identifiable compilation of narrative or descriptive information and the data that has been derived and recorded by any number or type of health care providers to document the nature and quality of care and services provided to a particular over a defined period of time and to identify the individual providers of such care and services. The medical records is written chronicle of medical ,nursing and other types of care that a patient has received or is expected to receive .This includes medical management prior to admission to an institution the medical and nursing regimen while in the institution or an anticipated course of treatment after discharge .

Standards and purposes of the medical records

The Standards and purposes of the medical records in hospitals and other health care facilities are largely prescribed by Joint Commission of Accreditation of Healthcare Organization (JCAHO). Selected JCAHO Standards and purposes are outlined below.

Joint Commission of Accreditation of Healthcare Organization

Standards

The record will confirm that the patient has been properly identified assessed and admitted to the institution.
The record will reflect timely and proper medical and nursing intervention and treatment based on medical diagnosis.
Such intervention and treatment will be completely and accurately documented.
All the record documentation will be retained and protected by the institution for the prescribed period of time.

Purposes

 Facilitate the best possible patient care
 Direct and document the medical regimen
 Direct and document the nursing process
 Documentation of patient care management and the patient's response to treatment, effectiveness of medical and nursing interventions.
 Provide a central repository of data to be communicated to all members of the health care team.

Standards

The JCAHO provides detailed requirements for the maintenance of medical records by hospitals. As with hospital medical records, private office record –keeping styles evolved during a period that demanded less comprehensive record keeping than is necessary today. However there is no comparable set of standards for the private office records of the physicians' .As a result there is a wide variation in the format, content and quality of these.

NABH standards

Standard –IMS 3
The organization has a complete and accurate medical record for every patient.

Objective:
a. Every medical record has a unique identifier.
b. Organizational policy identifies those authorized to make entries in the medical record.
c. Every medical record is dated and timed.
d. The author of entries can be identified.
e. The contents of medical records are identified and documented.
f. The records provides an up- to –date chronological account of patient care.

Standard –IMS 4

The medical record reflects continuity of care.

Objective

a. The medical records contain information regarding reasons for admission, investigations and plan of care.
b. Operative and other procedures performed are incorporated in the medical records.
c. When patient is transferred to another hospital the medical record contain date of transfer, the reason for transfer and name of the receiving hospital.
d. The medical record contains a copy of discharge note duly signed by the appropriate and qualified personnel.

e. In case of death the medical record contains a copy of death certificate, the cause, date and time of death.
f. Whenever a clinical autopsy is carried out the medical record contains a copy of the report of the same.
g. Care providers have access to current and past medical records.

Standards –IMS 5

Policies and procedures are in place for maintaining confidentiality and security of information.
a. Documented policies and procedures enlist for maintaining confidentiality, security.
b. Policies and procedures are in consonance with the applicable laws.
c. The policies and procedures incorporate safeguarding of data record against loss, tampering and destruction.
d. The hospital has an effective process of monitoring compliance of the laid down policy.
e. The hospital uses developments in appropriate technology for improving confidentiality, integrity and security.
f. Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient's authorization.
g. A documented procedure exists or how to respond to patient, physician and other public agencies requests for the access to information in medical records in accordance with local and national laws.

Standard –IMS 6

Policies and procedures exist for retention time of records, data and information.
Objective:
a. Documented policies and procedures are in place on retaining patient's clinical record, data & information.
b. The retention process provides expected confidentiality and security.
c. The destruction of medical records data and information is in accordance with the laid down policy.

Standard –IMS 7
The organization regularly carries out medical record audit.

Objective:
a. The medical records are reviewed periodically
b. The review uses a representative sample based on statistical principle.
c. The review is conducted by identified care providers

d. The review focuses on the timeliness, legibility and completeness of the medical records.
e. The review process includes records active and discharged patients.
f. The review points out and documents any deficiencies in records.
g. Appropriate corrective and preventive measures undertaken are documented.

Purposes

In addition to documenting patient care the record have also come to serve a number of other purposes. The record is a business document but first and foremost it is a medical document and second it is a legal document.

As a legal document it will provide evidence of the type and quality of care that the patient received at the hands of those caregivers whose orders, progress notes and various reports are included in it.

The principal function of the record is to facilitate planning and continuity in patient care. The objective is to provide consistency of interpretation and integrity of information. Non patient requirements can distract providers from the three purposes of the record.

These are:
1) Ensure continuity of care by all providers,
2) Provide instant access to the most current information and data on patient's status
3) Provide a means to audit the quality of such care.

Significance of Medical Records in Legal Proceedings

- ✓ Medical Record has become an important legal document. Medical Record is essential not only for the present and future care of the patient but also a legal document to protect the patient and the hospital.

- ✓ When a hospital admits a patient it enters into an explicit contract to render services necessary in the care and treatment of the patient. This necessitates keeping a chronological record of care and treatment rendered by the hospital personnel so that the results may be available for continuing care.

- ✓ In addition to being kept for patient care medical records are also kept as a guide for

doctors' and the education of nurses and other health personnel .Legally they are used to support the patient claim in case of injury for the protection of the attending doctor against claims of malpractices and fro the protection against criticism and claims for injuries and damages.

Legal Criteria for use of Medical Record as Evidence in Litigation

In order for a medical record to be introduced as evidence in litigation the following legal criteria must be met:

1) The record being presented to the court is in fact that of the individual named as a party in law suit the patient the plaintiff.
2) The various documents contained in the record were prepared concurrent with the events described in them or as close to those times as possible.
3) The record was prepared and maintained in accordance with all statutory requirements and in accordance with the policies and procedures of the institution.
4) The record was prepared by persons who had direct knowledge of those events described in it.
5) The record was created during the regular course of business.
6) The record was prepared and complete before litigation was initiated.
7) The documents contained in the record either original or duplicate are as far as possible of a quality as to be readable and identifiable as to content and source.
8) The record was obtained legally.

MEDICAL RECORD DEPARTMENT

Introduction

To begin we should take a brief look at the Medical Record Department (MRD). It is an extremely busy department and the work of medical record clerks very demanding. Although staffs are not directly involved in patient care the information recorded in the patient's medical record is an essential part of care. The MRD staff is required to perform an essential service within the hospital. Sometimes the nature of this work is not understood by the medical staff, hospital administrators and other hospital personnel and medical record clerks and MROs often feel isolated. In addition in many countries funding is inadequate making the effective running of the medical record seeming difficult. Medical record staff therefore must be resourceful and dedicated to working as it is an extremely important section of the hospital.

Functions of a Medical Record Department

The Medical Record Department staff under the leadership of the MRO or medical record clerk in –charge is responsible for the maintenance of medical records and medical record services. The hospital administration must provide security and sufficient storage space for medical records and adequate working area for medical record staff. The MRD staff must safeguard the medical record from tampering, loss and unauthorized use. They are responsible for seeing that the patient's right to privacy and the confidentiality of the information stored within the medical record is maintained at all times. The MRO is also responsible for the development and maintenance of policies and procedures relating to the medical record services of the hospital.

The major functions of a Medical Record Department include:
Development and maintenance of the master patient index for patient identification.
 Retrieval of medical records for the patient care and authorized use.
 Discharge procedure and completion of medical records after an inpatient has been discharged or died.
 Coding diseases and operations of patients discharged or died.
 Filing medical records
 Evaluation of the medical record service.
 Completion of monthly and annual statistics; and
 Medico legal issues relating to the release of patient information and other legal issues.
Associated with these functions there are an essential group of basic medical record procedures that should be performed by the staff of a Medical Record department. Failure to undertake any of these procedures could result in a poor medical record service. These medical record procedures are explained as you progress through this Manual.

Medical Record Department at Park Hospital
Medical Records at Park hospital are maintained on paper, electronic record has not yet been emphasized on.
The Department collects, manages, protects and disseminates the health information is complete and accurate.

Hours of Working
The Medical Records Department hours are from Monday to Saturday from 9:00 am to 5:00pm.
Functions
The Medical Records Department staff performs / manages the following areas
 Medical Record Review
 Release of information
 Birth Certificate
 Death Certificate

Record Processing

The record processing area is responsible for retrieving, assembling and analyzing medical records of patients discharged from the Hospital or seen in outpatient Ares. Records are retrieved daily from all inpatient units; assembled in a specific order and analytical for completion.

Release of Information

Patient's medical records are the physical property of the health care facility responsible, for its completion .However the information contained in the record belongs to the patient. The patient or their representative may have access to this information with a properly completed and signed authorization.

Birth Certification

A birth certificate is completed on all infants born at Park hospital. This information is then forwarded to the Municipal Corporation, Gurgaon.

Death Certificate

A death certificate is completed on all deceased patients at Park hospital. This information is then forwarded to Municipal Corporation, Gurgaon.

MEDICAL RECORD AUDITING

Background of the study

Documentation of medical recording began in ancient Egypt and contained details of surgery and prescription. There has always been a recognized need for those involved in healing or treatment to pass on details of successful procedures either by written methods or through oral tradition .individual practitioners most likely attempted to describe what they saw and what they did, but this was not widespread practice.

A book published in 1969 entitled Medical records; Medical education and Patient care introduced the method of structuring a record with the problem oriented medical record (POMR).

This included a format of recording information consisting of:

Problem List

 History

 Examination
 Laboratory findings
 Plan of care(diagnostic ,therapeutic and educational)
 Daily SOAP (Subjective, Objective, Assessment and Plan) progress note.

The problem list was kept in the front of the medical record and served as an index for the practitioner so that each chronic problem could be followed up until resolved. This
system influenced record keeping by recognizing four distinct elements of the clinical
medical decision making process:
 Collecting data
 Formulating problems
 Devising a management plan
 Reviewing the medical problems and revising the plan when necessary

The purpose of documentation

In the past practitioner used documentation in the medical records to document the patient's problems and conditions. However in recent years medical records have become tool to document medical histories as well as to provide a method by which health statistics are tracked ,act as a legal document ,justify to insurance companies the charges billed on the basis of medical care provided and assess quality of care. Medical records are currently kept in paper .Organization and maintenance of medical records is an important factor in providing quality of care. A well organized and well maintained medical record will provide a more care friendly source of information for internal staff, physician's auditors and insurance.

Medical Record Documentation and its Importance

Medical record documentation is required to record pertinent facts findings and observations about an individual's health history including past and present illness examinations, tests, treatments and outcomes. The medical record chronologically
documents the care of the patient and is an important element contributing to high quality care. An appropriately documented medical record can reduce many of the hassles associated with claims processing and may serve as an legal document to verify the care provided if necessary .Because payers have a contractual obligation to enrollees they may enquire reasonable documentation that services are consistent with insurance coverage provided.

The principle of documentation listed below is applicable to all types of medical and

surgical services in all settings.

1. The medical record should be complete and legible.
   - When notes are not legible and cannot be read clearly the service may be considered not properly documented and therefore not billable.
2. The documentation for each patient encounter should include.
   - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results.
   - The reason for encounter should support medical necessity and should be clearly stated in chief compliant
   - Assessment ,clinical impression or diagnosis
   - Plan of care
   - Date and legible identity of the observer

The date of services should be clearly indicated on each Patient encounter. Many states require initials and /or signatures while some will accept a signature stamp for the observer will accept a signature stamp for the observer.

3. If not documented, rationale for ordering diagnostic and other ancillary services should be easily inferred.
   - It is important that the reason for ordering tests and /or services be clearly stated in the chart note, even though the guideline indicated it may be inferred. Inferring the rationale for ordering tests, labs, etc, leaves it up to the reviewer to determine if the rationale is present, which makes the decision too subjective.
4. Past and present diagnoses should e accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified
   - Identifying patient with family history of a condition or past medical history in the chart note during the visit.
6. The patient's progress, response to and changes in treatment, and revisionof diagnosis should be documented.
7. Apply the principles to diagnosis coding to properly demonstrate medical necessity.

METHODOLOGY

Various tools were used for completing this project:

- Questionnare
- Survey
- Group Discussion

Sample Size: 130

Random sampling was done.

Sample was collected between 01/02/2012-30/03/2012

Sample was collected from 15 different departments namely:

1. General Surgery
2. Gynecology
3. Oncology
4. Medicine
5. Neurology
6. Pediatrics
7. Orthopedics
8. CTVS
9. Neurosurgery
10. Urology
11. Plastic Surgery
12. Nephrology
13. Psychiatry
14. Cardiology
15. ENT

Framework of the process followed for medical Record Audit

The process for the patient record audit consisted of following components:

- Development of the methodology for auditing of medical records of patients admitted in the hospital.
- This required an examination of current policies, procedures and documentation relating to documentation of medical records to assist development of the audit tool.
- The audit questions were the subject of comment from department personnel prior to finalization.
- Assessment of medical records of selected specialty against the agreed set audit questions. The total sample of 130 in patient records was drawn from medical record department.
- Analysis of documentation and data, and providing a report of the results.
- The audit assessed documentation of medical records. Patient records were examined for the following elements.

MEDICAL RECORD CRITERIA

IDENTIFICATION- Identification information should contain the following information on one single form:

- Name.
- Sex.
- Date of birth or age.
- Address.
- Next-of-kin, or emergency contact, with phone number.

HISTORY AND PHYSICAL- History and physical is to be conducted for patients seen more than three (3) times. Refer to preventive health guideline as to frequency and. And

content to be included in exams.

- Past medical history (for patients seen three or more times) is easily indentified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- Social/ psych/personal history should be documented. For patients 14 and older, social history shall include (for patients seen three or more times) a substance abuse query along with tobacco and alcohol usage.
- Family history is to be present in all members' charts, including children.
- Allergies/drug reactions should be prominently displayed in an easily accessible area. If patient has no known allergies this should also be noted.
- Current medications and pertinent past medications should be documented.
- And a current medication list is present.
- Height/ Weight/vital Sings should be documented.

OFFICE VISITS- All medical records will contain the following for patient office visits:

- Date of visit.
- Chief complaint, including history of problem and pertinent medications. Physical exam findings.
- Pertinent Vital Sings/Weight.
- Patient discharge instructions. This may be in the form of literature given, instructions, consultations, etc.
- The recommendation is that documentation of the follow-up required should be in the form of return visits noted in weeks, months.

OPERATIVE/DIAGNOSTIC/THERAPEUTIC/REFERRALS – All charts should contain the following for diagnostic studies, treatments plans, therapeutic services, ancillary services and referrals:

- Diagnostic results are initialed and dated by the physician.
- Consult/referral should have documentation of reason for referral(s). Acknowledgment of referral(s) should be noted.
- Follow up on consult referral recommendations should be present.

CHART FORMAT – Chart should be legible and aid in easy data retrieval. The following criteria should be present:

- All entries legible.
- All entries signed and dated.
- Every page should have patient name and identification.
- A problem list should be present which documents chronic or ongoing problems.

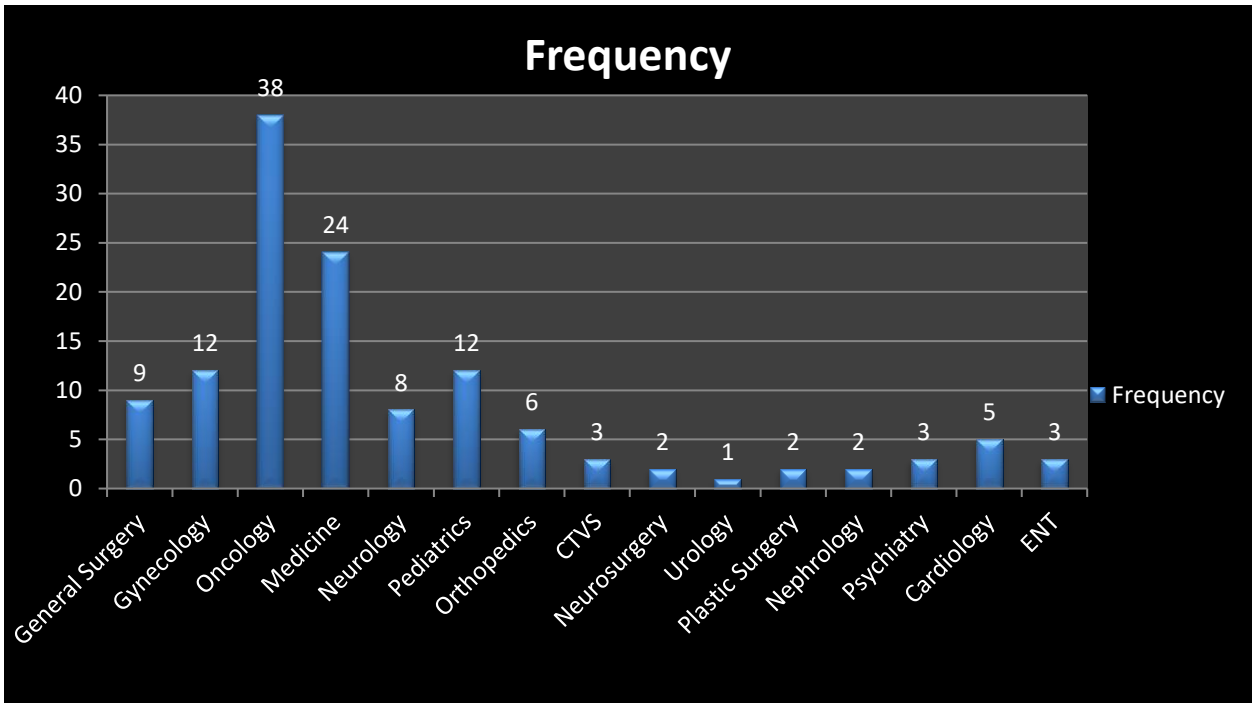
130 records were audited for the purpose of assessing medical records for proper documentation. Medical Records of 15 specialties were taken for the purpose of audit.
Out of the 347 in patients records 130 were picked up (40%) in a span of one month starting from **15th February -15th march**, for auditing.

Analysis of Data

Frequency Table

S.No.	Speciality	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
1	General Surgery	9	7.03	9	7.03
2	Gynecology	12	6.25	21	13.28
3	Oncology	38	29.69	59	42.97
4	Medicine	24	18.75	83	61.72
5	Neurology	8	6.25	91	67.97
6	Pediatrics	12	9.38	103	77.34
7	Orthopedics	6	4.69	109	82.03
8	CTVS	3	2.34	112	84.37
9	Neurosurgery	2	1.56	114	85.94
10	Urology	1	0.78	115	86.72
11	Plastic Surgery	2	1.56	117	88.28
12	Nephrology	2	1.56	119	91.41
13	Psychiatry	3	2.34	122	93.75
14	Cardiology	5	3.91	127	97.66
15	ENT	3	2.34	130	100.00

1. No. of records audited department wise



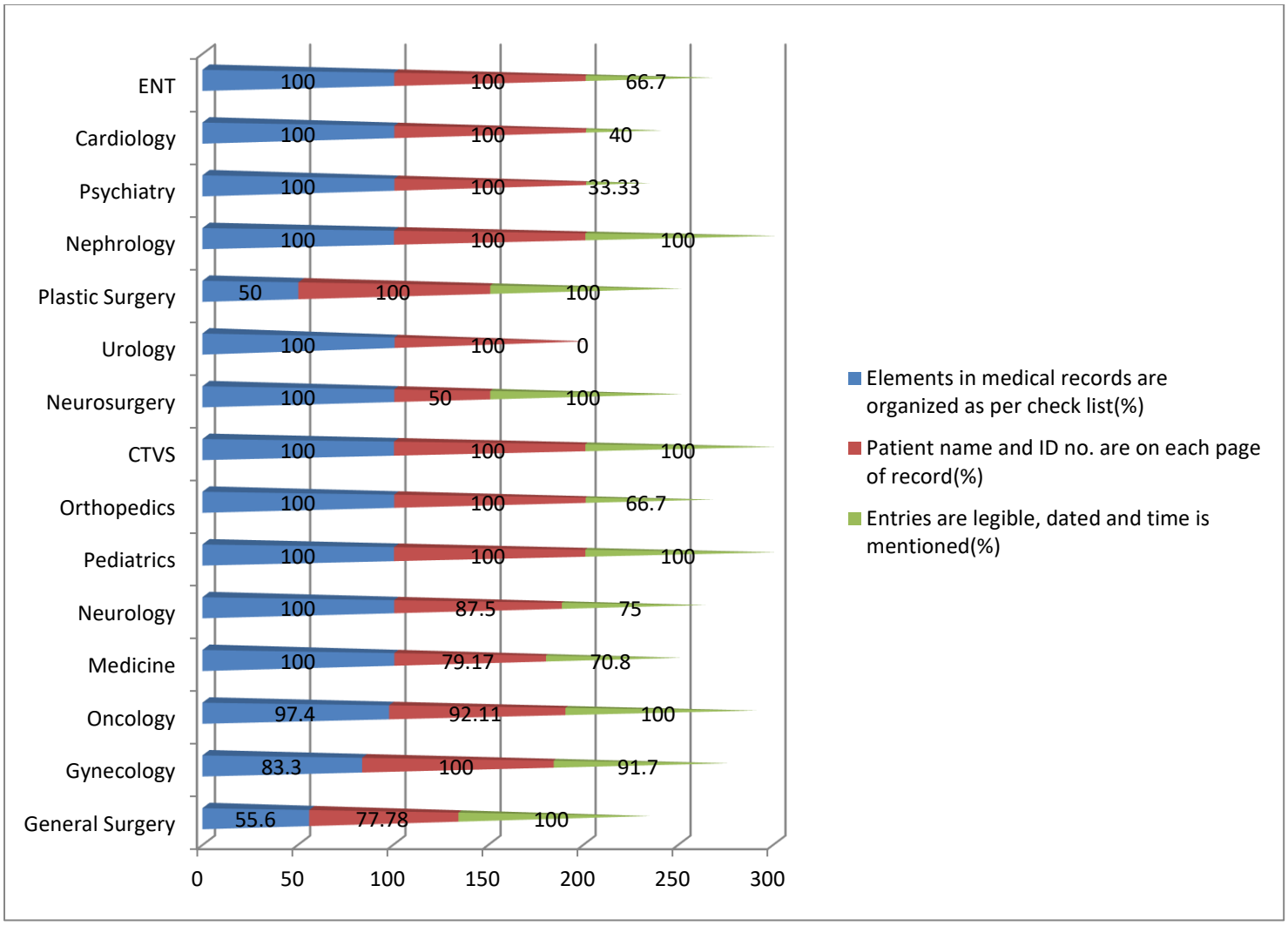
Data collection tool

Given that this audit is the study that has been conducted to assess the proper documentation of medical records for assuring continuity of patient's care, the audit tools have been designed to gather a wide range of information to inform the department and hospitals of the nature of medical record keeping and documentation. The data used to assist in the determination of documentation rating was derived from the medical record forms of discharged patients from 15 specialties only.
The audit tools are detailed in Annexure 1.

Interpretation:

- ✓ Above graph is formulated to know the sample size department wise.
- ✓ Graph depicts that maximum no. of cases studied were from oncology
- ✓ Minimum no. of cases under study were from urology.

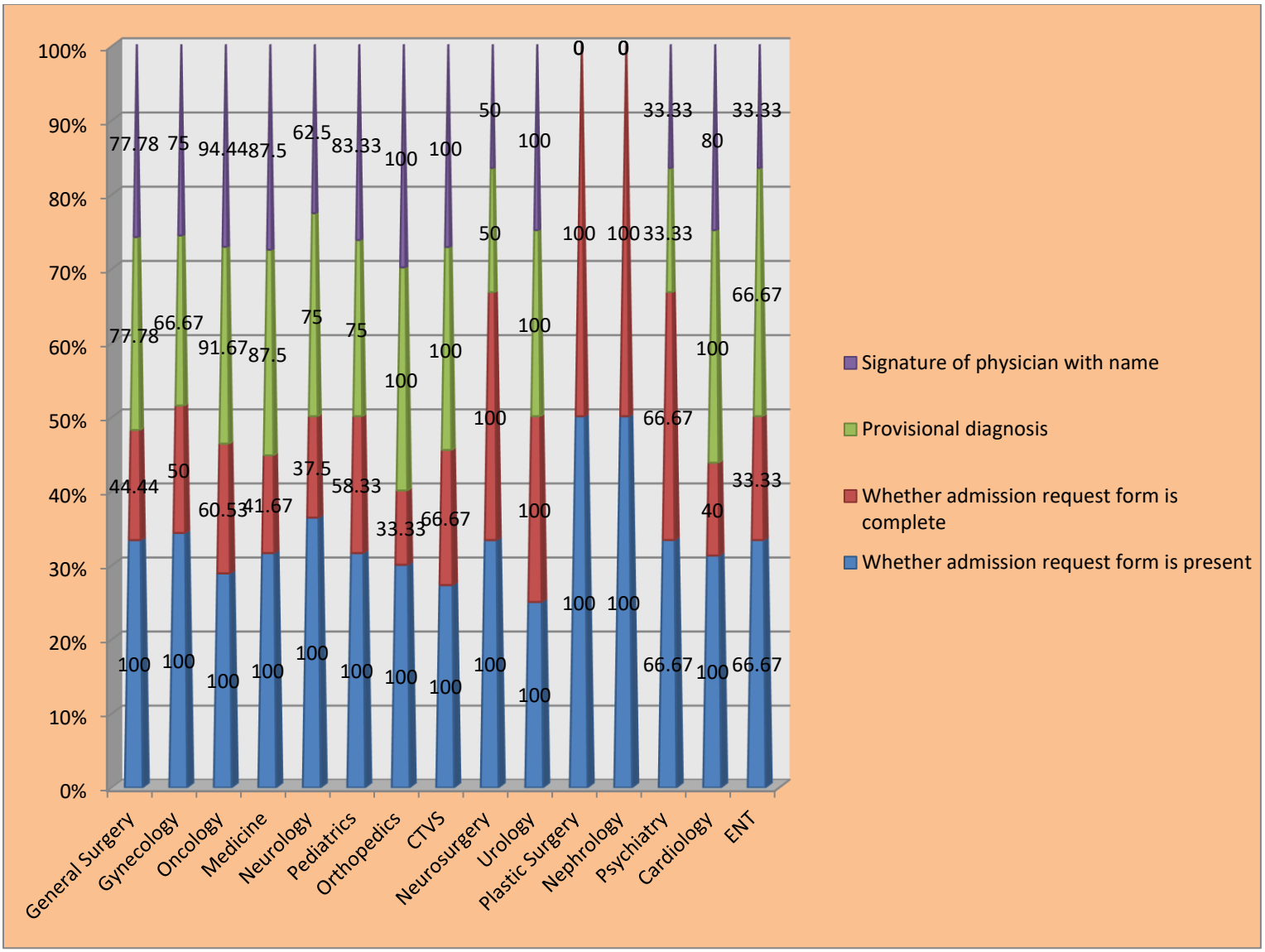
2. Results acc to specialities



Interpretation:

Above graph depicts that:

1. Elements in medical records are organized as per the checklist in most of the cases. Major problem was with Plastic Surgery and Gen Surgery.
2. Similarly for ‘ patient name and ID no. on each page of record’ were mentioned in most of the cases in most of the departments. Neurosurgery lacked behind in this regard.
3. For the last part, i.e. Legible entries with date and time was missing in most of the files. Even it was 0% for urology



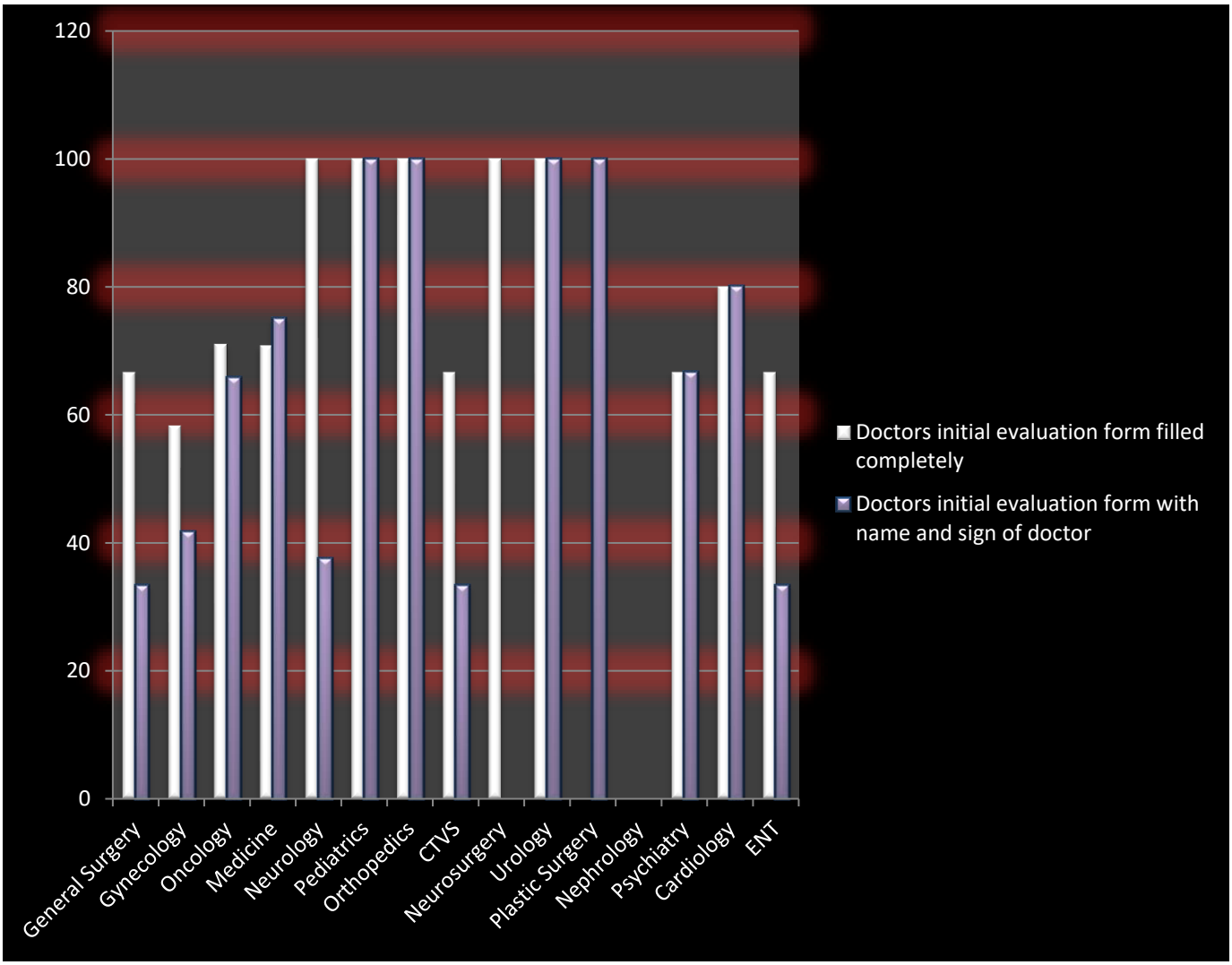
Interpretation:

1. Graph shows that admission request form is generally present in most of the files.

2. But its completion remained an issue in most of the cases.

3. Provisional Diagnosis is rarely present.

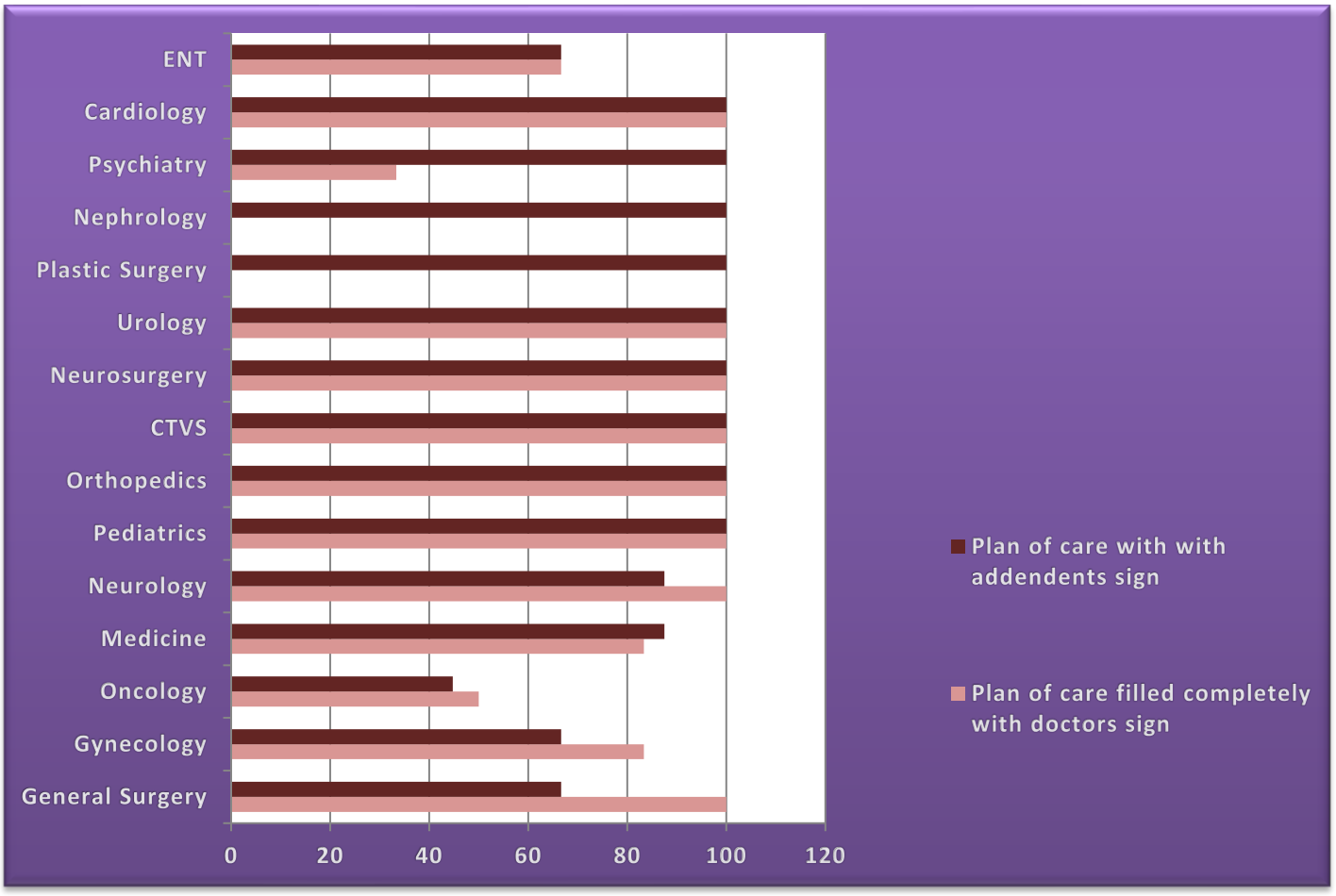
4. Physician name and signature is also mostly missing.



Interpretation:

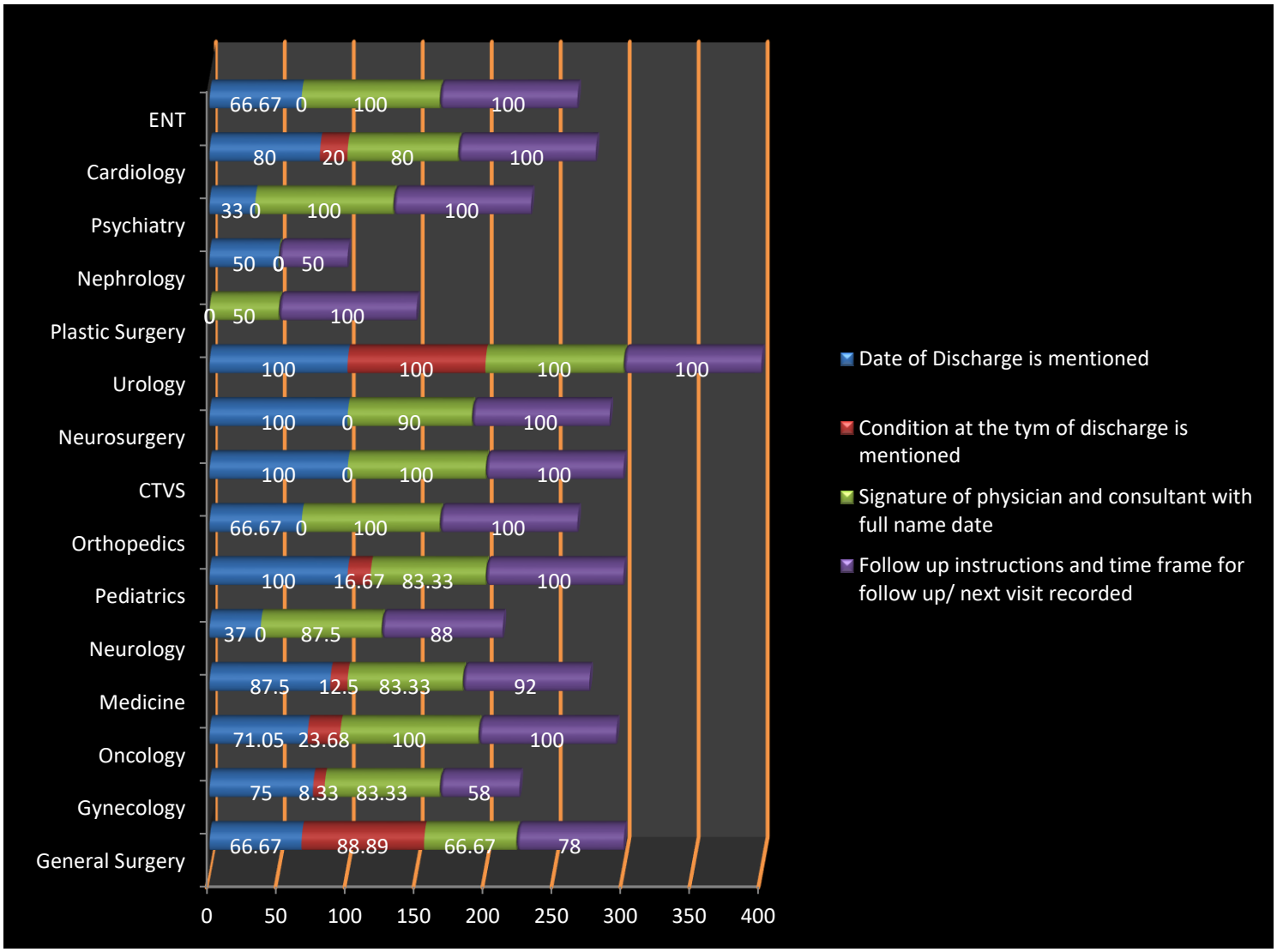
1.Initial evaluation form is completely filled only in paediatrics and orthopedics department.

2. Department of Plastic Surgery and Nephrology showed the poorest results.



Interpretation:

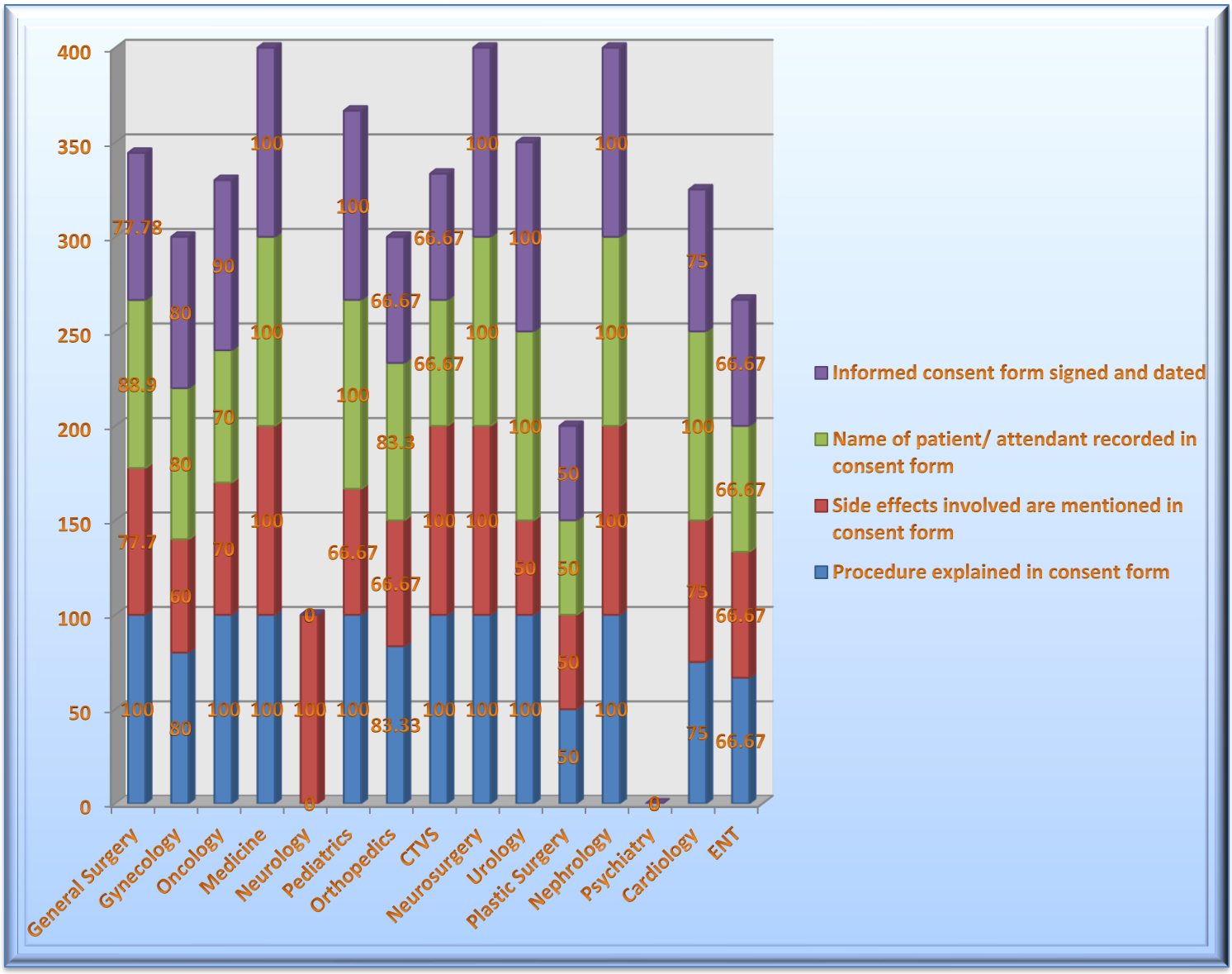
1. Plan of care was filled completely with attendents and doctors sign only in cardiology, urology, neurosurgery, CTVS, orthopedics and pediatrics



Interpretation:

1. The simplest thing i.e. Date of discharge is mentiponed in all the cases only for the urology, neurosurgery and CTVS.

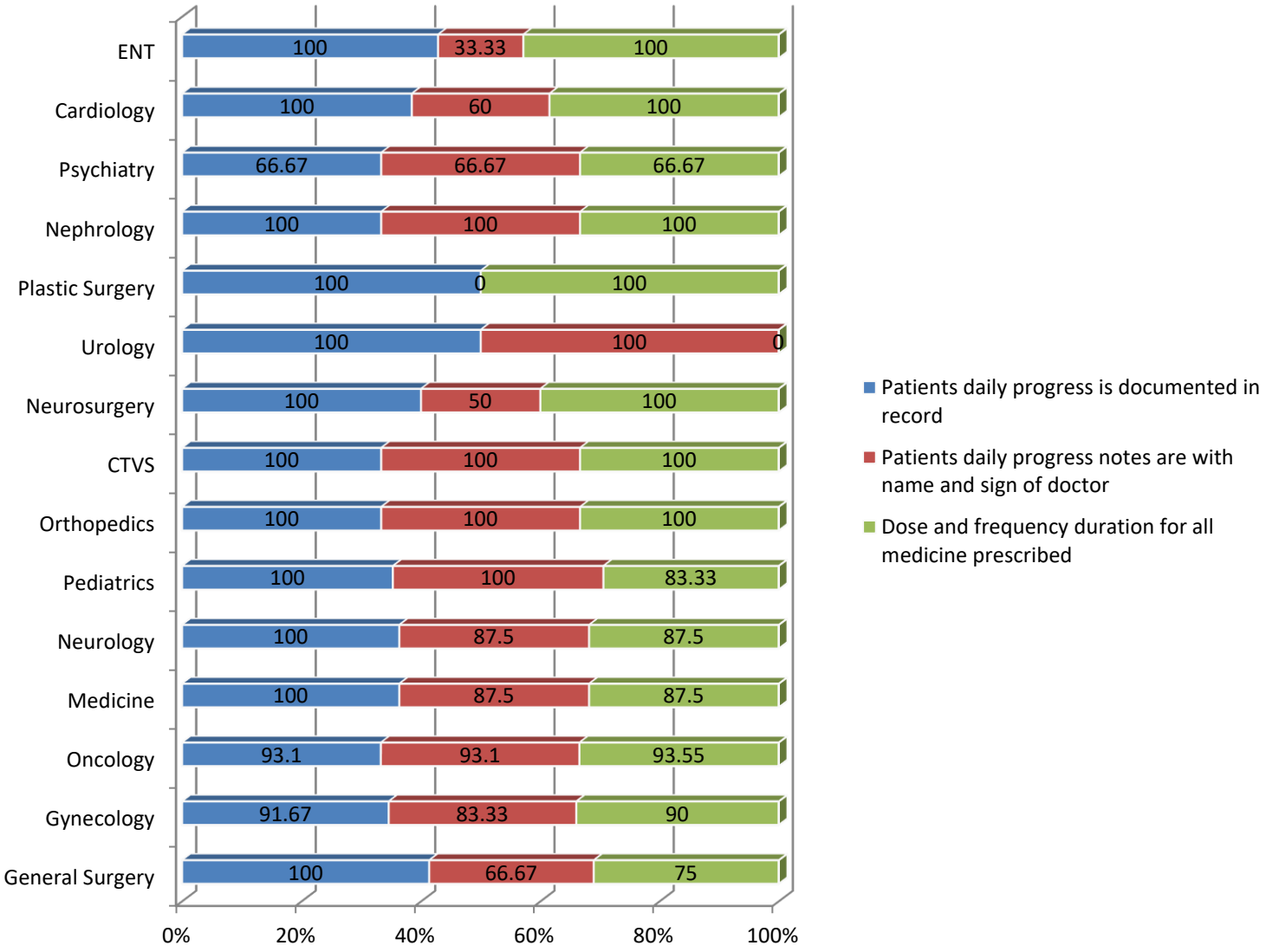
2. Condition at the time of discharge is rarely mentioned in the any of the files.



Interpretation:

1. Informed consent was usually signed but not dated.

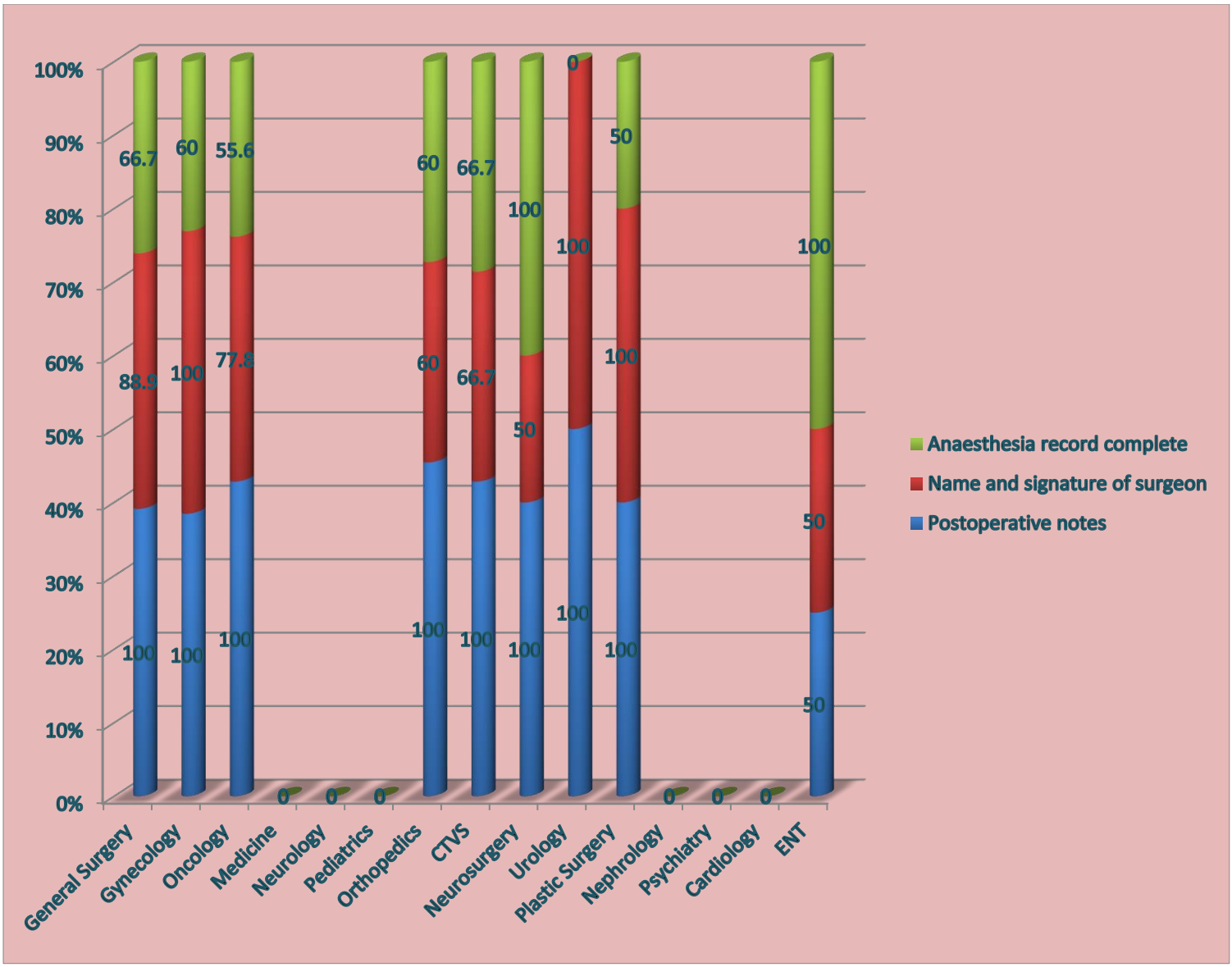
2. Psychiatric department was really a matter of concern.



Interpretation:

1. Dose and frequency duration for all medicines were not mentioned in any of the files for urology.

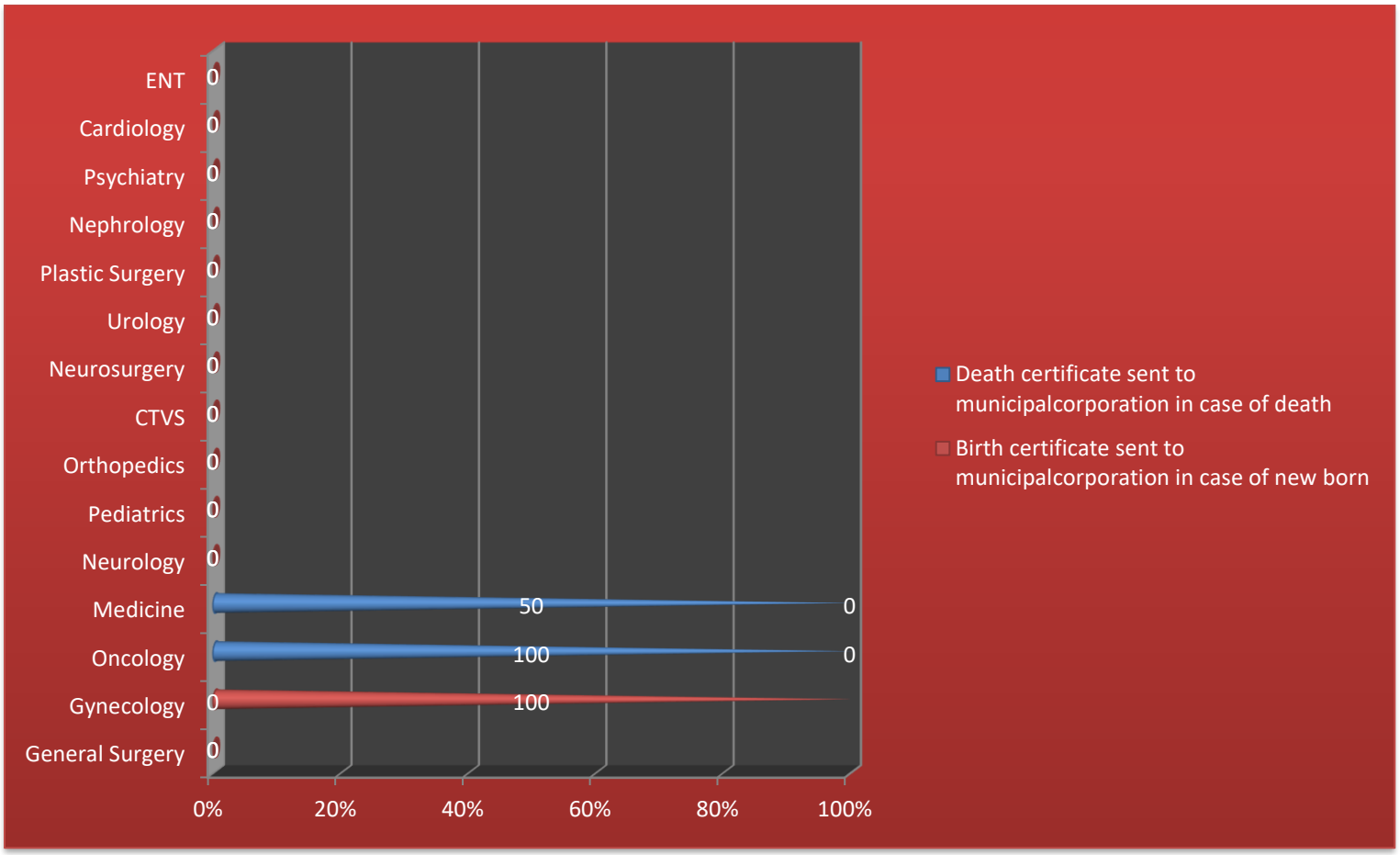
2. Patient daily progress notes are not mentioned in any of the files for plastic surgery cases.



Interpretation:

1. Anaesthesia records, post operative notes and name and sign of surgeon were not mentioned even in a single file for six departments.

2. Anaesthesia record is the main issue for all the departments.



Interpretation:

1. Death certificates and birth certificates were sent to municipal corporation with around 5-6 days delay. I have mentioned daily report.

Discussion

It appears that at present, many medical records are not sufficiently well- documented to provide adequate evidence of continuity of care. A study of 130 medical records on In patient at Pushpanjali Crosslay Hospital for assessing proper documentation of records revealed major shortcoming in the records:
I have tried to analyze the results **parameter wise** as well as **department wise**.
This will provide us two sets of data one would be which parameter or which documentation section should be looked into and which department is doing well and vice versa.
A scoring criteria is adopted which segregates the various parameters into 4 segments:
1) <60 % Poor.
2) 60 – 80 % Average.
3) 80 -95 % Good.
4) >95 % Excellent.

<60% POOR	Admission request form is complete	52.71%
	Doctor's initial evaluation form with name & sign of consultant	55.04%
	Condition at the time of discharge is mentioned or not	19.38%
	Birth certificate sent to municipal corporation	40%
60-80% AVERAGE	Entries are legible dated and time is mentioned	85.38%
	Doctor's initial evaluation form filled completely	74.42%
	Doctor's initial evaluation form with name & sign of doctor	63.57%
	Plan of care with attendant's sign & consent stamp	74.42%
	Plan of care filled completely with doctor's sign	75.97%
	Side effects involved are explained	76.79%
	Date of discharge mentioned	74.42%
	Allergies	77.59%
	Name and signature of surgeon	78.95%
	Anesthesia record complete(with name and signature of anesthetist)	63.18%
	Patient status at discharge	73.64%
	Death certificate sent to municipal corporation	66.67%
	Patient's name and ID no. are on each page of record	90.77%
	Admission request form is present	98.41%

80-95% GOOD	Provisional diagnosis	81.10%
	Signature of physician with name	81.10%
	Plan of care with attendant's sign & consent stamp	74.42%
	Procedure explained in the consent	91.02%
	Name of the patient/attendant recorded in the consent form	83.93%
	Consent form signed and dated	82.14%
	Patient's daily progress notes are with name & sign of doctor	84.33%
	Dose and frequency of all medicine prescribed	89.17%
	Signature of physician /consultant with full name	86.92%
	Follow up instructions and time frame for follow up recorded	91.54%
>95% EXCELLENT	Elements in medical records are organized as per checklist	93.85%
	Patient's daily progress is documented	96.69%
	Post operative notes	97.37%

The department wise analysis done is as follows:
Parameters which are highlighted which are 60% and below are poor.

1. Departments having less than four non conformities or less (good)

i. CTVS
ii. Urology

Departments having four to six non conformities or less (need to improve)

i. General Surgery
ii. Medicine
iii. Obstetrics & Gynecology
iv. Oncology
v. Neurology
vi. Pediatrics
vii. Orthopedics
viii Plastic Surgery

ix Psychiatry

x Cardiology

Departments having more than six non conformities or less (need urgent attention)

i. Neurosurgery
ii. Nephrology
iii. ENT

Recommendations

o The study needs **further exploration** as to identify the gaps in process flow department wise.
o **Repetitive information** should be avoided since it involves duplication of efforts and wastage of resources.
o For the same reasons the **forms should be redesigned** and redundant columns should be done away with.
o MR contents for discharged patients should be arranged prior to filing. And qualitative analysis of MR contents should be done a regular basis to monitor **completeness of information**.
o It is recommended that entries be recorded as closely as possible to the time of the encounter, when the detail is most fresh in the physician's mind. This will allow physicians to deep records that are **detailed, accurate and comprehensive.**
o It is recommended that the records **should be legible** and can be interpreted by the other non treating health professional. If there is difficulty with the legibility of the records, an alternate means of note taking should be considered properly (electronic medical records).
o In order to facilitate the implementation of the recommendations listed above, the formation of a **MR development committee** could greatly assist with the development of a standardized MR system and its implementation in the hospital. More specifically, the committee could review and authorize the MR Manual developed by, review and suggest changes on existing MR forms.

LIMITATION

In few specialties the records studied were very few in numbers thus not accurate to comment on that particular department.

Time not sufficient for going through the process flow of medical records of various departments to identify the exact area of intervention required.

ANNEXURES

Annexure 1

Medical Case sheet – Audit (For IPD Patient)						
Patient Name:		**Date of Admission:**				
Reg No. **IP No.**		**Date of Discharge:**				
Consultant Name / Unit: Dr.		**Date & Time of Audit:**				
Audit Points	**Yes**	**No**	**NA**	**Remarks**	**CAPA**	
1. Face Sheet					**Yes**	**No**
Consultant's sign						
Date of discharge						
Final diagnosis						
Elements in medical records arranged as per checklist						
Patient's name & ID are on each page of record						
2. Admission Slip						
Provisional Diagnosis						
Consultant's Name & Sign						
3. Discharge Summary						
Follow up instructions and time frame for follow up/next visit recorded						
Patient status at discharge						
Consultant's sign and name						
4.General Informed Consent Form						
Patient/ spouse, parent or guardian's name & sign						
All blanks filled						
5.Informed Consent						
Name of the procedure						
Surgeon's name						
Anesthetist's name						
Patient/spouse, parent or guardian's name & sign						

6.Estimate/Counseling Form						
Patient/Attendant's sign						
Consultant's name and sign						
7.Physician's Assessment and Treatment notes						
Emergency assessment sheet with signature						
Doctors' initial evaluation form All columns filled						
Admitting doctor's sign and name						
Consultant's sign and name						
8.Plan of care						
All columns filled						
Doctor's sign and name						
Patient/Attendant's sign						
Consent stamp						
9.Investigations Order Sheet						
Order with doctor's sign						
All columns filled with date and time						
10.Investigation report sheet						
All columns filled						
11.Physician's drug order cum drug order record						
Advising doctor's name						
All columns filled						
Medicine name in capital						
12.Physician's fluid cum non drug order record						
All columns filled						
13.Doctor's Progress Notes						
Doctor's name with sign						
Time with date						
14. Physiotherapy Assessment sheet						

All columns filled						
15.Nursing assessment and management records						
Nursing initial evaluation form filled with sign						
Pre operative nursing checklist -complete						
Clinical chart/Hourly vital sign chart Complete						
Intake output chart Complete						
Critical care chart in case of MICU patient						
Neurological chart(if required) complete with signature						
Nurses progress notes complete with signature date and time						
Nurses daily care plan (for dependant patients)						
Pressure sore tracking record Complete						
Diabetic Chart						
16.OT /Anesthesia records						
Pre operative evaluation questionnaire complete with signature						
Anesthesia record complete with signature						
Operations note complete						
With duration mentioned						
Recovery room chart						
17. Entries legible						
18.Activity track sheet						
Columns filled						
19.Statutory Report						
Is the Birth Certification form sent to Govt. Authority in case of new born						
Is the Death Certification form sent to Govt. Authority in case of death						

INFORMED CONSENT

(PERMISSION FOR OPERATION, PROCEDURE & ANAESTHESIA)

Regn. No.	
IP No./ Bed No.	
Date of Admission :	
Consultant Name :	

Authorization for medical treatment, administration of anesthesia and performance of surgical operation and diagnostic / therapeutic procedures.

1. I, the undersigned, a patient, NOK/Ward of the patient in Pushpanjali Crosslay Hospital, Vaishali authorize Dr. .. .. and whomsoever he may designate to administer such treatment as necessary and perform the following medical treatment, surgical operation and diagnostic / therapeutic procedures..... ....

   ....

2. The nature and purpose of the operation and/or procedure, the necessity thereof, the possible alternative methods of treatment, prognosis, the risks involved and possibility of complications known and unforeseen have all been fully explained to me to my satisfaction and I fully understand the same.

3. It has been explained to me that during the course of the above said operation/procedure, unforeseen conditions may be revealed/ encountered with, which may necessitate additional surgical or other emergency procedures, different from those contemplated and consented to at the time of initial diagnosis. I therefore authorize the above designed staff to perform such additional surgical or other procedures as they deem necessary or desirable.

4. I further give consent to administration of such drugs, infusions, plasma and blood transfusion, or any other investigation, treatment, procedure as deemed necessary in judgment of the medical staff.

5. I give consent to administration of any kind of anesthesia as deemed necessary by the anesthetist, the techniques and risks involved in the administration of which have been fully explained to me including any adverse reaction to the anesthetic drugs.

6. I state that I am having history of :

(a)	Heart disease	YES/NO	(g)	Jaundice	YES/NO
(b)	Hypertension	YES/NO	(h)	Sterold Therapy Past/Present	YES/NO
(c)	Diabetes	YES/NO	(i)	Alcohol Consumption	YES/NO
(d)	Respiratory problem	YES/NO	(j)	Known Allergies	YES/NO
(e)	Bleeding disorders	YES/NO	(k)	Complications of Previous Anesthesia (If any)	YES/NO
(f)	Seizure disorder	YES/NO	(l)	I am having Loose/False teeth	YES/NO
			(m)	Others	

7. I have also been explained that any operation or procedure involves risks and hazards which may be serious or even fatal. I hereby declare that in the event of any mishap, accident or complication I will not hold any member of the hospital team personally liable for any penal action.

8. I have been given an opportunity to ask any question and I have also been given the option to ask for any second opinion.

Patient's Name / IP No:

Inpatient File Checklist

S.No	Name Of Document	Attached	Not required
A	**Front Office**		
1	Face Sheet		
2	Estimate Form		
3	Admission Advice		
4	Informed consent / Surgical Consent		
B	**Physician's Assessment & Treatment notes**		
1	Emergency Assessment Sheet		
2	Doctor's Initial Evalution Form		
3	Plan of care		
4	Investigation Order Sheet		
5	Investigation Report Sheet		
6	Physician's Drug Order cum Administration Record		
7	Physician's fluid cum Non Drug order Record		
8	Physicians Progress Notes		
C	**Dietician's and Physiotherapy's Notes**		
1	Dietician Intial Evalution Form		
2	Physiotherapy Assessment sheet		
D	**Nursing Assessment and manag[illegible]ent records**		
1	Nursing Initial Evaluation form		
2	Pre - Operative Nursing Check list		
3	Clinical Chart / Hourly vital signs chart		
4	Intake Output Chart		
5	ICU Chart (For all ICU Patients)		
6	Neurological Chart (If Required)		
7	Nurses Progress Notes		
8	Nursing Daily Care Plan (for dependant patients)		
9	Pressure sore tracking record		
E	**OT / Anaesthesia records**		
1	Pre - Operative Evaluation Questionnaire		
2	Anaesthesia Record		
3	Operation Notes		
4	Recovery Room Chart (Post Anaesthesia Care Unit)		
F	**Billing Records**		
1	Activity Track Sheet		
2	Pharmacy Bills		
3	Test Reports (PCH,outside,Lab, Radiological)		

Please Note :- Every document is completed and every paper in patient's record file is date wise and in chronological order as per Inpatient file checklist. Extra blank papers should be removed from the file or cancelled by drawing a line across

Plan of Care

Bed No :
Consultant Name :
Date of Admission :

Date	

ttendant

ame :_____

lationship:_____

gnature:_____

Name & Signature of consultant
(Consent stamp)

Nursing Progress Notes

Date & Time	

Elements in medical records are organized as per checklist.

S.No.	Speciality	Yes	No	Total
1	General Surgery	5	4	9
2	Obs & Gynecology	10	2	12
3	Oncology	37	1	38
4	Medicine	24	0	24
5	Neurology	8	0	8
6	Pediatrics	12	0	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	1	1	2
12	Nephrology	2	0	2
13	Psychiatry	3	0	3
14	Cardiology	5	0	5
15	ENT	3	0	3
	TOTAL	**122**	**8**	**130**
	PERCENTAGE	**93.85**	**6.15**	**100.00**

Patient's name and ID no. are on each page of record.

S.No.	Speciality	Yes	No	Total
1	General Surgery	7	2	9
2	Obs& Gynecology	12	0	12
3	Oncology	35	3	38
4	Medicine	19	5	24
5	Neurology	7	1	8
6	Pediatrics	12	0	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	1	1	2
10	Urology	1	0	1
11	Plastic Surgery	2	0	2
13	Nephrology	2	0	2
14	Psychiatry	3	0	3
15	Cardiology	5	0	5
16	ENT	3	0	3
	TOTAL	**118**	**12**	**130**
	PERCENTAGE	**90.77**	**9.23**	**100.00**

Entries are legible dated and time is mentioned

S.No.	Speciality	Yes	No	Total
1	General Surgery	9	0	9
2	Obs& Gynecology	11	1	12
3	Oncology	38	0	38
4	Medicine	17	7	24
5	Neurology	6	2	8
6	Pediatrics	12	0	12
7	Orthopedics	4	2	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	0	1	1
11	Plastic Surgery	2	0	2
12	Nephrology	2	0	2
13	Psychiatry	1	2	3
14	Cardiology	2	3	5
15	ENT	2	1	3
	TOTAL	**111**	**19**	**130**
	PERCENTAGE	**85.38**	**14.62**	**100.00**

Whether Admission request form is present.				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	9	0	9
2	Obs& Gynecology	12	0	12
3	Oncology	38	0	38
4	Medicine	24	0	24
5	Neurology	8	0	8
6	Pediatrics	12	0	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	2	0	2
12	Nephrology	2	0	2
13	Psychiatry	2	1	3
14	Cardiology	5	0	5
15	ENT	2	1	3
	TOTAL	**128**	**2**	**130**
	PERCENTAGE	**98.46**	**0.15**	**100.00**

Whether Admission request form is complete

S.No.	Speciality	Yes	No	Total
1	General Surgery	4	5	9
2	Obs& Gynaecology	6	6	12
3	Oncology	23	15	38
4	Medicine	10	14	24
5	Neurology	3	5	8
6	Pediatrics	7	5	12
7	Orthopedics	2	4	6
8	CTVS	2	1	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	1	0	1
12	Nephrology	2	0	2
13	Psychiatry	2	1	3
14	Cardiology	2	3	5
15	ENT	1	2	3
	TOTAL	**68**	**61**	**129**
	PERCENTAGE	**52.71**	**45.19**	**100.00**

Doctor's initial evaluation form filled completely				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	6	3	9
2	Obs& Gynecology	7	5	12
3	Oncology	27	11	38
4	Medicine	17	7	24
5	Neurology	8	0	8
6	Pediatrics	12	0	12
7	Orthopedics	6	0	6
8	CTVS	2	1	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	0	1	1
12	Nephrology	0	2	2
13	Psychiatry	2	1	3
14	Cardiology	4	1	5
15	ENT	2	1	3
	TOTAL	**96**	**33**	**129**
	PERCENTAGE	**74.42**	**25.58**	**100.00**

Doctor's initial evaluation form with name & sign of doctor.				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	3	6	9
2	Obs& Gynecology	5	7	12
3	Oncology	25	13	38
4	Medicine	18	6	24
5	Neurology	3	5	8
6	Pediatrics	12	0	12
7	Orthopedics	6	0	6
8	CTVS	1	2	3
9	Neurosurgery	0	2	2
10	Urology	1	0	1
11	Plastic Surgery	1	0	1
12	Nephrology	0	2	2
13	Psychiatry	2	1	3
14	Cardiology	4	1	5
15	ENT	1	2	3
	TOTAL	**82**	**47**	**129**
	PERCENTAGE	**63.57**	**36.43**	**100.00**

Doctor's initial evaluation form with name & sign of consultant.				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	2	7	9
2	Obs& Gynecology	9	3	12
3	Oncology	18	20	38
4	Medicine	11	13	24
5	Neurology	3	5	8
6	Pediatrics	10	2	12
7	Orthopedics	5	1	6
8	CTVS	2	1	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	1	0	1
12	Nephrology	0	2	2
13	Psychiatry	2	1	3
14	Cardiology	4	1	5
15	ENT	1	2	3
	TOTAL	**71**	**58**	**129**
	PERCENTAGE	**55.04**	**44.96**	**100.00**

Provisional diagnosis.				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	7	2	9
2	Obs& Gynecology	8	4	12
3	Oncology	33	3	36
4	Medicine	21	3	24
5	Neurology	6	2	8
6	Pediatrics	9	3	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	1	1	2
10	Urology	1	0	1
11	Plastic Surgery	0	1	1
12	Nephrology	0	2	2
13	Psychiatry	1	2	3
14	Cardiology	5	0	5
15	ENT	2	1	3
	TOTAL	**103**	**24**	**127**
	PERCENTAGE	**81.10**	**18.90**	**100.00**

Signature of Physician with name				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	7	2	9
2	Obs & Gynecology	9	3	12
3	Oncology	34	2	36
4	Medicine	21	3	24
5	Neurology	5	3	8
6	Pediatrics	10	2	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	1	1	2
10	Urology	1	0	1
11	Plastic Surgery	0	1	1
12	Nephrology	0	2	2
13	Psychiatry	1	2	3
14	Cardiology	4	1	5
15	ENT	1	2	3
	TOTAL	**103**	**24**	**127**
	PERCENTAGE	**81.10**	**18.90**	**100.00**

Plan of Care filled completely with doctor's sign				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	9	0	9
2	Obs& Gynecology	10	2	12
3	Oncology	19	19	38
4	Medicine	20	4	24
5	Neurology	8	0	8
6	Pediatrics	12	0	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	0	1	1
12	Nephrology	0	2	2
13	Psychiatry	1	2	3
14	Cardiology	5	0	5
15	ENT	2	1	3
	TOTAL	**98**	**31**	**129**
	PERCENTAGE	**75.97**	**24.03**	**100.00**

Plan of care with attendant's sign& consent stamp				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	6	3	9
2	Obs& Gynecology	8	4	12
3	Oncology	17	21	38
4	Medicine	21	3	24
5	Neurology	7	1	8
6	Pediatrics	12	0	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	1	0	1
12	Nephrology	2	0	2
13	Psychiatry	3	0	3
14	Cardiology	5	0	5
15	ENT	2	1	3
	TOTAL	**96**	**33**	**129**
	PERCENTAGE	**74.42**	**25.58**	**100.00**

Date of discharge is mentioned				
S.No.	Speciality	Yes	No	Total
1	General Surgery	6	3	9
2	Obs& Gynecology	9	3	12
3	Oncology	27	11	38
4	Medicine	21	3	24
5	Neurology	3	5	8
6	Pediatrics	12	0	12
7	Orthopedics	4	2	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	0	1	1
12	Nephrology	1	1	2
13	Psychiatry	1	2	3
14	Cardiology	4	1	5
15	ENT	2	1	3
	TOTAL	**96**	**33**	**129**
	PERCENTAGE	**74.42**	**25.58**	**100.00**

Condition at the time of discharge is mentioned or not				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	8	1	9
2	Obs& Gynecology	1	11	12
3	Oncology	9	29	38
4	Medicine	3	21	24
5	Neurology	0	8	8
6	Pediatrics	2	10	12
7	Orthopedics	0	6	6
8	CTVS	0	3	3
9	Neurosurgery	0	2	2
10	Urology	1	0	1
11	Plastic Surgery	0	1	1
12	Nephrology	0	2	2
13	Psychiatry	0	3	3
14	Cardiology	1	4	5
15	ENT	0	3	3
	TOTAL	**25**	**104**	**129**
	PERCENTAGE	**19.38**	**80.62**	**100.00**

The procedure was explained in the consent form				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	9	0	9
2	Obs& Gynecology	4	1	5
3	Oncology	10	0	10
4	Medicine	2	0	2
5	Neurology	0	0	0
6	Pediatrics	7	0	7
7	Orthopedics	5	1	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	1	1	2
12	Nephrology	2	0	2
13	Psychiatry	0	0	0
14	Cardiology	3	1	4
15	ENT	2	1	3
	TOTAL	**51**	**5**	**56**
	PERCENTAGE	**91.07**	**8.93**	**100.00**

Side effects risk involved are explained in the consent form				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	7	2	9
2	Obs& Gynecology	3	2	5
3	Oncology	7	3	10
4	Medicine	2	0	2
5	Neurology	0	0	0
6	Pediatrics	7	0	7
7	Orthopedics	4	2	6
8	CTVS	2	1	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	1	1	2
12	Nephrology	2	0	2
13	Psychiatry	0	0	0
14	Cardiology	3	1	4
15	ENT	2	1	3
	TOTAL	**43**	**13**	**56**
	PERCENTAGE	**76.79**	**23.21**	**100.00**

Name of the patient /patient attendant recorded in the consent form				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	8	1	9
2	Obs& Gynecology	4	1	5
3	Oncology	7	3	10
4	Medicine	2	0	2
5	Neurology	0	0	0
6	Pediatrics	7	0	7
7	Orthopedics	5	1	6
8	CTVS	2	1	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	1	1	2
12	Nephrology	2	0	2
13	Psychiatry	0	0	0
14	Cardiology	4	0	4
15	ENT	2	1	3
	TOTAL	**47**	**9**	**56**
	PERCENTAGE	**83.93**	**16.07**	**100.00**

Informed consent form signed and dated				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	7	2	9
2	Obs& Gynecology	4	1	5
3	Oncology	9	1	10
4	Medicine	2	0	2
5	Neurology	0	0	0
6	Pediatrics	7	0	7
7	Orthopedics	4	2	6
8	CTVS	2	1	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	1	1	2
12	Nephrology	2	0	2
13	Psychiatry	0	0	0
14	Cardiology	3	1	4
15	ENT	2	1	3
	TOTAL	**46**	**10**	**56**
	PERCENTAGE	**82.14**	**17.86**	**100.00**

Allergies				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	6	3	9
2	Obs& Gynecology	8	4	12
3	Oncology	21	7	28
4	Medicine	20	3	23
5	Neurology	3	5	8
6	Pediatrics	11	1	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	1	1	2
12	Nephrology	2	0	2
13	Psychiatry	0	0	0
14	Cardiology	5	0	5
15	ENT	1	2	3
	TOTAL	**90**	**26**	**116**
	PERCENTAGE	**77.59**	**22.41**	**100.00**

Patient's daily progress is documented in record				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	9	0	9
2	Obs& Gynecology	11	1	12
3	Oncology	27	2	29
4	Medicine	24	0	24
5	Neurology	8	0	8
6	Pediatrics	12	0	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	2	0	2
12	Nephrology	2	0	2
13	Psychiatry	2	1	3
14	Cardiology	5	0	5
15	ENT	3	0	3
	TOTAL	**117**	**4**	**121**
	PERCENTAGE	**96.69**	**3.31**	**100.00**

Patient's daily progress notes are with name &sign of doctor				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	6	3	9
2	Obs& Gynecology	10	2	12
3	Oncology	27	2	29
4	Medicine	21	3	24
5	Neurology	7	1	8
6	Pediatrics	12	0	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	1	1	2
10	Urology	1	0	1
11	Plastic Surgery	0	2	2
12	Nephrology	2	0	2
13	Psychiatry	2	1	3
14	Cardiology	3	2	5
15	ENT	1	2	3
	TOTAL	**102**	**19**	**121**
	PERCENTAGE	**84.30**	**15.70**	**100.00**

Postoperative notes				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	9	0	9
2	Obs& Gynecology	5	0	5
3	Oncology	9	0	9
4	Medicine	0	0	0
5	Neurology	0	0	0
6	Pediatrics	0	0	0
7	Orthopedics	5	0	5
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	2	0	2
12	Nephrology	0	0	0
13	Psychiatry	0	0	0
14	Cardiology	0	0	0
15	ENT	1	1	2
	TOTAL	**37**	**1**	**38**
	PERCENTAGE	**97.37**	**2.63**	**100.00**

Name & Signature of surgeon				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	8	1	9
2	Obs& Gynecology	5	0	5
3	Oncology	7	2	9
4	Medicine	0	0	0
5	Neurology	0	0	0
6	Pediatrics	0	0	0
7	Orthopedics	3	2	5
8	CTVS	2	1	3
9	Neurosurgery	1	1	2
10	Urology	1	0	1
11	Plastic Surgery	2	0	2
12	Nephrology	0	0	0
13	Psychiatry	0	0	0
14	Cardiology	0	0	0
15	ENT	1	1	2
	TOTAL	**30**	**8**	**38**
	PERCENTAGE	**78.95**	**21.05**	**100.00**

Anesthesia record complete(with sing & name of anesthetist)				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	6	3	9
2	Obs&Gynaecology	3	2	5
3	Oncology	5	4	9
4	Medicine	0	0	0
5	Neurology	0	0	0
6	Pediatrics	0	0	0
7	Orthopedics	3	2	5
8	CTVS	2	1	3
9	Neurosurgery	2	0	2
10	Urology	0	1	1
11	Plastic Surgery	1	1	2
12	Nephrology	0	0	0
13	Psychiatry	0	0	0
14	Cardiology	0	0	0
15	ENT	2	0	2
	TOTAL	**24**	**14**	**38**
	PERCENTAGE	**63.16**	**36.84**	**100.00**

Dose & frequency duration for all medicine prescribed				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	6	2	8
2	Obs&Gynaecology	9	1	10
3	Oncology	29	2	31
4	Medicine	21	3	24
5	Neurology	7	1	8
6	Pediatrics	10	2	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	0	1	1
11	Plastic Surgery	2	0	2
12	Nephrology	2	0	2
13	Psychiatry	2	1	3
14	Cardiology	5	0	5
15	ENT	3	0	3
	TOTAL	**107**	**13**	**120**
	PERCENTAGE	**89.17**	**10.83**	**100.00**

Patient status at discharge				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	5	4	9
2	Obs&Gynaecology	7	5	12
3	Oncology	34	3	37
4	Medicine	16	8	24
5	Neurology	6	2	8
6	Pediatrics	6	6	12
7	Orthopedics	5	1	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	0	2	2
12	Nephrology	2	0	2
13	Psychiatry	2	1	3
14	Cardiology	4	1	5
15	ENT	2	1	3
	TOTAL	**95**	**34**	**129**
	PERCENTAGE	**73.64**	**26.36**	**100.00**

Signature of physician and consultant with full name				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	6	3	9
2	Obs&Gynaecology	10	2	12
3	Oncology	38	0	38
4	Medicine	20	4	24
5	Neurology	7	1	8
6	Pediatrics	10	2	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	1	1	2
10	Urology	1	0	1
11	Plastic Surgery	1	1	2
12	Nephrology	0	2	2
13	Psychiatry	3	0	3
14	Cardiology	4	1	5
15	ENT	3	0	3
	TOTAL	**113**	**17**	**130**
	PERCENTAGE	**86.92**	**13.08**	**100.00**

Follow up instructions and time frame for follow up/next visit recorded				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	7	2	9
2	Obs & Gynecology	7	5	12
3	Oncology	38	0	38
4	Medicine	22	2	24
5	Neurology	7	1	8
6	Pediatrics	12	0	12
7	Orthopedics	6	0	6
8	CTVS	3	0	3
9	Neurosurgery	2	0	2
10	Urology	1	0	1
11	Plastic Surgery	2	0	2
12	Nephrology	1	1	2
13	Psychiatry	3	0	3
14	Cardiology	5	0	5
15	ENT	3	0	3
	TOTAL	**119**	**11**	**130**
	PERCENTAGE	**91.54**	**8.46**	**100.00**

Death certificate sent to Municipal Corporation of Ghaziabad incase of death

S.No.	Speciality	Yes	No	Total
1	General Surgery	0	0	0
2	Obs&Gynaecology	0	0	0
3	Oncology	1	0	1
4	Medicine	1	1	2
5	Neurology	0	0	0
6	Pediatrics	0	0	0
7	Orthopedics	0	0	0
8	CTVS	0	0	0
9	Neurosurgery	0	0	0
10	Urology	0	0	0
11	Plastic Surgery	0	0	0
12	Nephrology	0	0	0
13	Psychiatry	0	0	0
14	Cardiology	0	0	0
15	ENT	0	0	0
	TOTAL	**2**	**1**	**3**
	PERCENTAGE	**66.67**	**33.33**	**100.00**

Birth certificate sent to Municipal Corporation of Ghaziabad incase of new born				
S.No.	**Speciality**	**Yes**	**No**	**Total**
1	General Surgery	0	0	0
2	Obs&Gynaecology	2	0	2
3	Oncology	0	0	0
4	Medicine	0	0	0
5	Neurology	0	0	0
6	Pediatrics	0	3	3
7	Orthopedics	0	0	0
8	CTVS	0	0	0
9	Neurosurgery	0	0	0
10	Urology	0	0	0
11	Plastic Surgery	0	0	0
12	Nephrology	0	0	0
13	Psychiatry	0	0	0
14	Cardiology	0	0	0
15	ENT	0	0	0
	TOTAL	2	3	5
	PERCENTAGE	40.00	60.00	100.00

S.No.	General Surgery	Yes	No	Total	%
1	Elements in medical records are organized as per checklist.	5	4	9	55.56
2	Patient's name and ID no. are on each page of record.	7	2	9	77.78
3	Entries are legible dated and time is mentioned.	9	0	9	100.00
4	Admission request form is present.	9	0	9	100.00
5	Admission request form is complete.	4	5	9	44.44
6	Doctor's initial evaluation form filled completely.	6	3	9	66.67
7	Doctor's initial evaluation form with name & signature of doctor.	3	6	9	33.33
8	Doctor's initial evaluation form with name & signature of consultant.	2	7	9	22.22
9	Provisional diagnosis	7	2	9	77.78
10	Signature of Physician with name.	7	2	9	77.78
12	Plan of care filled completely with doctor's sign.	9	0	9	100.00
13	Plan of care with attendant's sign.	6	3	9	66.67
15	Date of discharge is mentioned.	6	3	9	66.67
16	Condition at the time of discharge is mentioned or not.	8	1	9	88.89
18	Procedure was explained /documented in the consent form.	9	0	9	100.00
19	Side effects /risk involved are explained in the consent form.	7	2	9	77.78
20	Name of the patient/patient attendant been recorded in the consent form	8	1	9	88.89
21	Consent form signed and dated.	7	2	9	77.78
22	Allergies.	6	3	9	66.67
23	Patient's daily progress is documented in record	9	0	9	100.00
24	Patient's daily progress notes with signature & name of doctor.	6	3	9	66.67
25	Postoperative note.	9	0	9	100.00
26	Name & signature of surgeon.	8	1	9	88.89
27	Anesthesia record complete(chart with signature & full name of anesthetist)	6	3	9	66.67
28	Dose & frequency and duration for all prescribed medicine.	6	3	9	66.67
29	Patient status at discharge.	5	4	9	55.56
30	Signature of physician and senior consultant with full name and date.	6	3	9	66.67
31	Follow up instructions and time frame for follow up recorded	7	2	9	77.78

S.No.	Obstetrics& Gynecology	Yes	No	Total	%
1	Elements in medical records are organized as per checklist.	10	2	12	83.33
2	Patient's name and ID no. are on each page of record.	12	0	12	100.00
3	Entries are legible dated and time is mentioned.	11	1	12	91.67
4	Admission request form is present.	12	0	12	100.00
5	Admission request form is complete.	6	6	12	50.00
6	Doctor's initial evaluation form filled completely.	7	5	12	58.33
7	Doctor's initial evaluation form with name & signature of doctor.	5	7	12	41.67
8	Doctor's initial evaluation form with name & signature of consultant.	9	3	12	75.00
9	Provisional diagnosis	8	4	12	66.67
10	Signature of Physician with name.	9	3	12	75.00
12	Plan of care filled completely with doctor's sign.	10	2	12	83.33
13	Plan of care with attendant's sign.	8	4	12	66.67
15	Date of discharge is mentioned.	9	3	12	75.00
16	Condition at the time of discharge is mentioned or not.	1	11	12	8.33
18	Procedure was explained /documented in the consent form.	4	1	5	80
19	Side effects /risk involved are explained in the consent form.	3	2	5	60
20	Name of the patient/patient attendant been recorded in the consent form	4	1	5	80
21	Consent form signed and dated.	4	1	5	80
22	Allergies.	8	4	12	66.6667
23	Patient's daily progress is documented in record	11	1	12	91.6667
24	Patient's daily progress notes with signature & name of doctor.	10	2	12	83.3333
25	Postoperative note.	5	0	5	100
26	Name & signature of surgeon.	5	0	5	100
27	Anesthesia record complete(chart with signature & full name of anesthetist)	3	2	5	60
28	Dose & frequency and duration for all prescribed medicine.	9	1	10	90
29	Patient status at discharge.	7	5	12	58.33
30	Signature of physician and senior consultant with full name and date.	10	2	12	83.33
31	Follow up instructions and time frame for follow up recorded	7	3	10	70
32	Birth Certification form sent to Govt.authority in case of new born	2	0	2	100
33	Death Certification form sent to Govt.authority in case of new death.	0	0	0	0

S.No.	Oncology	Yes	No	Total	%
1	Elements in medical records are organized as per checklist.	37	1	38	97.37
2	Patient's name and ID no. are on each page of record.	35	3	38	92.11
3	Entries are legible dated and time is mentioned.	38	0	38	100
4	Admission request form is present.	38	0	38	100
5	Admission request form is complete.	23	15	38	60.53
6	Doctor's initial evaluation form filled completely.	27	11	38	71.05
7	Doctor's initial evaluation form with name & signature of doctor.	25	13	38	65.79
8	Doctor's initial evaluation form with name & signature of consultant.	18	20	38	47.37
9	Provisional diagnosis	33	5	38	86.84
10	Signature of Physician with name.	34	4	38	89.47
12	Plan of care filled completely with doctor's sign.	19	19	38	50
13	Plan of care with attendant's sign.	17	21	38	44.74
15	Date of discharge is mentioned.	27	11	38	71.05
16	Condition at the time of discharge is mentioned or not.	9	29	38	23.68
18	Procedure was explained /documented in the consent form.	10	0	10	100
19	Side effects /risk involved are explained in the consent form.	7	3	10	70
20	Name of the patient/patient attendant been recorded in the consent form	7	3	10	70
21	Consent form signed and dated.	9	1	10	90
22	Allergies.	21	7	28	75
23	Patient's daily progress is documented in record	27	2	29	93.1
24	Patient's daily progress notes with signature & name of doctor.	27	2	29	93.1
25	Postoperative note.	9	0	9	100
26	Name & signature of surgeon.	7	2	9	77.78
27	Anesthesia record complete(chart with signature & full name of anesthetist)	5	4	9	55.56
28	Dose & frequency and duration for all prescribed medicine.	29	2	31	93.55
29	Patient status at discharge.	34	3	37	91.89
30	Signature of physician and senior consultant with full name and date.	38	0	38	100
31	Follow up instructions and time frame for follow up recorded	38	0	38	100
32	Birth Certification form sent to Govt.authority in case of new born	0	0	0	0
33	Death Certification form sent to Govt.authority in case of new death.	1	0	1	100

S.No.	Medicine	Yes	No	Total	%
1	Elements in medical records are organized as per checklist.	24	0	24	100
2	Patient's name and ID no. are on each page of record.	19	5	24	79.17
3	Entries are legible dated and time is mentioned.	17	7	24	70.83
4	Admission request form is present.	24	0	24	100
5	Admission request form is complete.	10	14	24	41.67
6	Doctor's initial evaluation form filled completely.	17	7	24	70.83
7	Doctor's initial evaluation form with name & signature of doctor.	18	6	24	75
8	Doctor's initial evaluation form with name & signature of consultant.	11	13	24	45.83
9	Provisional diagnosis	21	3	24	87.5
10	Signature of Physician with name.	19	5	24	79.17
12	Plan of care filled completely with doctor's sign.	20	4	24	83.33
13	Plan of care with attendant's sign.	18	6	24	75
15	Date of discharge is mentioned.	21	3	24	87.5
16	Condition at the time of discharge is mentioned or not.	3	21	24	12.5
18	Procedure was explained /documented in the consent form.	2	0	2	100
19	Side effects /risk involved are explained in the consent form.	2	0	2	100
20	Name of the patient/patient attendant been recorded in the consent form	2	0	2	100
21	Consent form signed and dated.	2	0	2	100
22	Allergies.	21	3	24	87.5
23	Patient's daily progress is documented in record	24	0	24	100
24	Patient's daily progress notes with signature & name of doctor.	21	3	24	87.5
25	Postoperative note.	0	0	0	0
26	Name & signature of surgeon.	0	0	0	0
27	Anesthesia record complete(chart with signature & full name of anesthetist)	0	0	0	0
28	Dose & frequency and duration for all prescribed medicine.	21	3	24	87.5
29	Patient status at discharge.	16	8	24	66.67
30	Signature of physician and senior consultant with full name and date.	20	4	24	83.33
31	Follow up instructions and time frame for follow up recorded	22	2	24	91.67
32	Birth Certification form sent to Govt.authority in case of new born	0	0	0	0
33	Death Certification form sent to Govt.authority in case of new death.	1	1	2	50

S.No.	Neurology	Yes	No	Total	%
1	Elements in medical records are organized as per checklist.	8	0	8	100
2	Patient's name and ID no. are on each page of record.	7	1	8	87.5
3	Entries are legible dated and time is mentioned.	6	2	8	75
4	Admission request form is present.	8	0	8	100
5	Admission request form is complete.	3	5	8	37.5
6	Doctor's initial evaluation form filled completely.	8	0	8	100
7	Doctor's initial evaluation form with name & signature of doctor.	3	5	8	37.5
8	Doctor's initial evaluation form with name & signature of consultant.	3	5	8	37.5
9	Provisional diagnosis	6	2	8	75
10	Signature of Physician with name.	5	3	8	62.5
12	Plan of care filled completely with doctor's sign.	8	0	8	100
13	Plan of care with attendant's sign.	7	0	7	100
15	Date of discharge is mentioned.	3	5	8	37.5
16	Condition at the time of discharge is mentioned or not.	0	8	8	0
18	Procedure was explained /documented in the consent form.	0	0	0	0
19	Side effects /risk involved are explained in the consent form.	0	0	0	0
20	Name of the patient/patient attendant been recorded in the consent form	0	0	0	0
21	Consent form signed and dated.	0	0	0	0
22	Allergies.	3	5	8	37.5
23	Patient's daily progress is documented in record	8	0	8	100
24	Patient's daily progress notes with signature & name of doctor.	7	1	8	87.5
25	Postoperative note.	0	0	0	0
26	Name & signature of surgeon.	0	0	0	0
27	Anesthesia record complete(chart with signature & full name of anesthetist)	0	0	0	0
28	Dose & frequency and duration for all prescribed medicine.	7	1	8	87.5
29	Patient status at discharge.	6	2	8	75
30	Signature of physician and senior consultant with full name and date.	7	1	8	87.5
31	Follow up instructions and time frame for follow up recorded	7	1	8	87.5
32	Birth Certification form sent to Govt.authority in case of new born	0	0	0	0
33	Death Certification form sent to Govt.authority in case of new death.	0	0	0	0

S.No.	Pediatrics	Yes	No	Total	%
1	Elements in medical records are organized as per checklist.	12	0	12	100
2	Patient's name and ID no. are on each page of record.	12	0	12	100
3	Entries are legible dated and time is mentioned.	12	0	12	100
4	Admission request form is present.	7	5	12	58.33
5	Admission request form is complete.	12	0	12	100
6	Doctor's initial evaluation form filled completely.	12	0	12	100
7	Doctor's initial evaluation form with name & signature of doctor.	10	2	12	83.33
8	Doctor's initial evaluation form with name & signature of consultant.	10	2	12	83.33
9	Provisional diagnosis	9	3	12	75
10	Signature of Physician with name.	10	2	12	83.33
12	Plan of care filled completely with doctor's sign.	12	0	12	100
13	Plan of care with attendant's sign.	12	0	12	100
15	Date of discharge is mentioned.	12	0	12	100
16	Condition at the time of discharge is mentioned or not.	2	10	12	16.67
18	Procedure was explained /documented in the consent form.	7	0	7	100
19	Side effects /risk involved are explained in the consent form.	7	0	7	100
20	Name of the patient/patient attendant been recorded in the consent form	7	0	7	100
21	Consent form signed and dated.	7	0	7	100
22	Allergies.	11	1	12	91.67
23	Patient's daily progress is documented in record	12	0	12	100
24	Patient's daily progress notes with signature & name of doctor.	12	0	12	100
25	Postoperative note.	0	0	0	0
26	Name & signature of surgeon.	0	0	0	0
27	Anesthesia record complete(chart with signature & full name of anesthetist)	0	0	0	0
28	Dose & frequency and duration for all prescribed medicine.	10	2	12	83.33
29	Patient status at discharge.	6	6	12	50
30	Signature of physician and senior consultant with full name and date.	10	2	12	83.33
31	Follow up instructions and time frame for follow up recorded	12	0	12	100
32	Birth Certification form sent to Govt.authority in case of new born	0	3	3	0
33	Death Certification form sent to Govt.authority in case of new death.	0	0	0	0

S.No.	Orthopedics	Yes	No	Total	%
1	Elements in medical records are organized as per checklist.	6	0	6	100
2	Patient's name and ID no. are on each page of record.	6	0	6	100
3	Entries are legible dated and time is mentioned.	4	2	6	66.667
4	Admission request form is present.	6	0	6	100
5	Admission request form is complete.	2	4	6	33.33
6	Doctor's initial evaluation form filled completely.	6	0	6	100
7	Doctor's initial evaluation form with name & signature of doctor.	6	0	6	100
8	Doctor's initial evaluation form with name & signature of consultant.	5	1	6	83.333
9	Provisional diagnosis	6	0	6	100
10	Signature of Physician with name.	6	0	6	100
11	Plan of care filled completely with doctor's sign.	6	0	6	100
13	Plan of care with attendant's sign.	6	0	6	100
15	Date of discharge is mentioned.	4	2	6	66.667
16	Condition at the time of discharge is mentioned or not.	0	6	6	0
18	Procedure was explained /documented in the consent form.	5	1	6	83.333
19	Side effects /risk involved are explained in the consent form.	4	2	6	66.667
20	Name of the patient/patient attendant been recorded in the consent form	5	1	6	83.333
21	Consent form signed and dated.	4	2	6	66.667
22	Allergies.	6	0	6	100
23	Patient's daily progress is documented in record	6	0	6	100
24	Patient's daily progress notes with signature & name of doctor.	6	0	6	100
25	Postoperative note.	5	0	5	100
26	Name & signature of surgeon.	3	2	5	60
27	Anesthesia record complete(chart with signature & full name of anesthetist)	3	2	5	60
28	Dose & frequency and duration for all prescribed medicine.	6	0	6	100
29	Patient status at discharge.	5	1	6	83.33
30	Signature of physician and senior consultant with full name and date.	6	0	6	100
31	Follow up instructions and time frame for follow up recorded	6	0	6	100
32	Birth Certification form sent to Govt.authority in case of new born	0	0	0	0
33	Death Certification form sent to Govt.authority in case of new death.	0	0	0	0

S.No.	CTVS	Yes	No	Total	%
1	Elements in medical records are organized as per checklist.	3	0	3	100
2	Patient's name and ID no. are on each page of record.	3	0	3	100
3	Entries are legible dated and time is mentioned.	3	0	3	100
4	Admission request form is present.	3	0	3	100
5	Admission request form is complete.	2	1	3	66.67
6	Doctor's initial evaluation form filled completely.	2	1	3	66.67
7	Doctor's initial evaluation form with name & signature of doctor.	1	2	3	33.33
8	Doctor's initial evaluation form with name & signature of consultant.	2	1	3	66.67
9	Provisional diagnosis	3	0	3	100
10	Signature of Physician with name.	3	0	3	100
12	Plan of care filled completely with doctor's sign.	3	0	3	100
13	Plan of care with attendant's sign.	3	0	3	100
15	Date of discharge is mentioned.	3	0	3	100
16	Condition at the time of discharge is mentioned or not.	0	3	3	0
18	Procedure was explained /documented in the consent form.	3	0	3	100
19	Side effects /risk involved are explained in the consent form.	2	1	3	66.67
20	Name of the patient/patient attendant been recorded in the consent form	2	1	3	66.67
21	Consent form signed and dated.	2	1	3	66.67
22	Allergies.	3	0	3	100
23	Patient's daily progress is documented in record	3	0	3	100
24	Patient's daily progress notes with signature & name of doctor.	3	0	3	100
25	Postoperative note.	3	0	3	100
26	Name & signature of surgeon.	2	1	3	66.67
27	Anesthesia record complete(chart with signature & full name of anesthetist)	2	1	3	66.67
28	Dose & frequency and duration for all prescribed medicine.	3	0	3	100
29	Patient status at discharge.	3	0	3	100
30	Signature of physician and senior consultant with full name and date.	3	0	3	100
31	Follow up instructions and time frame for follow up recorded	3	0	3	100
32	Birth Certification form sent to Govt.authority in case of new born	0	0	0	0
33	Death Certification form sent to Govt.authority in case of new death.	0	0	0	0

S.No.	E.N.T	Yes	No	Total	%
1	Elements in medical records are organized as per checklist.	3	0	3	100
2	Patient's name and ID no. are on each page of record.	3	0	3	100
3	Entries are legible dated and time is mentioned.	2	1	3	66.7
4	Admission request form is present.	2	1	3	66.7
5	Admission request form is complete.	1	2	3	33.3
6	Doctor's initial evaluation form filled completely.	2	1	3	66.7
7	Doctor's initial evaluation form with name & signature of doctor.	1	2	3	33.3
8	Doctor's initial evaluation form with name & signature of consultant.	1	2	3	33.3
9	Provisional diagnosis	2	1	3	66.7
10	Signature of Physician with name.	1	2	3	33.3
12	Plan of care filled completely with doctor's sign.	2	1	3	66.7
13	Plan of care with attendant's sign.	2	1	3	66.7
15	Date of discharge is mentioned.	2	1	3	66.7
16	Condition at the time of discharge is mentioned or not.	0	3	3	0
18	Procedure was explained /documented in the consent form.	2	1	3	66.7
19	Side effects /risk involved are explained in the consent form.	2	1	3	66.7
20	Name of the patient/patient attendant been recorded in the consent form	2	1	3	66.7
21	Consent form signed and dated.	2	1	3	66.7
22	Allergies.	1	2	3	33.3
23	Patient's daily progress is documented in record	3	0	3	100
24	Patient's daily progress notes with signature & name of doctor.	1	2	3	33.3
25	Postoperative note.	1	1	2	50
26	Name & signature of surgeon.	1	1	2	50
27	Anesthesia record complete(chart with signature & full name of anesthetist)	2	0	2	100
28	Dose & frequency and duration for all prescribed medicine.	3	0	3	100
29	Patient status at discharge.	2	1	3	66.7
30	Signature of physician and senior consultant with full name and date.	3	0	3	100
31	Follow up instructions and time frame for follow up recorded	3	0	3	100
32	Birth Certification form sent to Govt.authority in case of new born	0	0	0	0
33	Death Certification form sent to Govt.authority in case of new death.	0	0	0	0