A study on medical record documentation in Compliance with NABH Guidelines

A dissertation submitted in partial fulfillment of the requirements

for the award of

Post-Graduate Diploma in Health and Hospital Management

by

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(PG/12/060)

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May, 2014

Internship Training at Primus Super Speciality Hospital

By

Dr. Parul Mendiratta

PGDHM

2012-2014

International Institute of Health Management Research

Internship Training

At

Primus Super Speciality Hospital

"A Study On Medical Record Documentation in Compliance with NABH Guidelines"

By

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Under the guidance of

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2012-2014

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Primus
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The Certificate is awarded to

Dr. Parul Mendiratta

In recognition of having successfully completed her

Internship in the department of

Quality

and has successfully completed her Project on

"A Study on Medical Record Documentation in Compliance with NABH Guidelines"

From **1st February 2014** till **30th April 2014**

In

Primus Super Speciality Hospital, Chanakyapuri, New Delhi-21

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

We wish her all the best for future endeavors

Dr. Sudhir Verma
Medical Superintendent

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TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Parul Mendiratta** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **Primus Super Speciality Hospital** from **1.02.2014 to 30.4.2014**.

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

The Internship is in fulfillment of the course requirements. I wish him all success in all his future endeavors.

05/05/2014

Dr. A.K. Agarwal
Dean, Academics and Student Affairs
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Certificate Of Approval

The following dissertation titled **"A study on medical record documentation in compliance with NABH Guidelines"** at **Primus Super Speciality Hospital, Chanakyapuri, New Delhi** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr Ravindra Agganwal	5/9/2014
Dr A.K. KHOKHAR	5/9/2014
Kirti Udaya	Kirti Udaya

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Parul Mendiratta,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. He/ She is submitting this dissertation titled **"A Study on Medical Record Documentation in Compliance with NABH Guidelines"** at **Primus Super Speciality Hospital, Chanakyapuri, New Delhi** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

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

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **" A Study on Medical Record Documentation in Compliance with NABH Guidelines"** and submitted by **Dr. Parul Mendiratta,** Enrollment No. **PG/12/060** under the supervision of **Dr.Sudhir Verma (Medical Superintendent) Primus Super Speciality Hospital, Chanakyapuri** and **Mrs. Kirti Udayai (Assistant Dean) IIHMR, New Delhi** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from **01.02.2014 to 30.4.2014** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Parul Mendiratta
Signature

Primus Super Speciality Hospital

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FEEDBACK FORM

Name of the Student: Dr. Parul Mendiratta

Dissertation Organisation: Primus Super Speciality Hospital

Area of Dissertation: Quality Department

Attendance: 97%

Objectives achieved: Project on "A study on Medical Record Documentation in Compliance with NABH Guidelines."

Deliverables: Clinical Audit, Trainings, Analysis Of Patient Feedback (VOC), Enhancing Operational Efficiency in various departments

Strengths: Hardworking, Good analytical skills, Punctual, Goal oriented, Strategic thinking

Suggestions for Improvement: Need to focus on strategic planning

Dr. Sudhir Verma

Signature of Organisation Mentor (Dissertation)

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Date: 29/4/14

Place: N-DELHI

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ACKNOWLEDGEMENT

I sincerely extend my appreciation and thanks to all who directly or indirectly helped in shaping up this dissertation work to its present form.

I convey my heartfelt thanks to my mentor in the hospital, Dr. Sudhir Verma, Medical Superintendent for his guidance and cooperation during the entire period of study without which it would have been difficult to carry out this study.

I express my sincere gratitude to my mentor in the Institute, Ms. Kirti Udayai, Associate Dean (Academics and Student Affairs), International Institute Of Health Management Research. Most of all, I pay my sincere offering to the almighty without whose grace I would not be able to add a new dimension to my life.

I would also thank my Institution and my faculty members without whom this project would have been a distant reality. I also extend my heartfelt thanks to my family and well wishers.

ABSTRACT

"A study on medical record documentation in compliance with NABH Guidelines"

Introduction: Medical record is a systematic documentation of a patient's personal and social data, history of his or her ailment, clinical findings, investigations, diagnosis, treatment given, and an account of follow-up and final outcome. A medical record enables healthcare professionals to plan and evaluate a patient's treatment and ensures continuity of care among multiple providers.

Methodology: The study is interventional. A pre formed checklist was prepared and criteria chosen are based on NABH standards. The study was divided in two phases:- Pre Intervention and Post Intervention where in patient records were assessed. A sample of 100 records were taken for Pre Intervention study of different departments. The non compliances were analyzed and interventions in form of counseling, training and informal interviews were done with all stakeholders. Another 100 records for Post Intervention study was taken to assess the improvements achieved.

Results: The results of the study showed improvements in the level of non compliances in the records assessed in Post Intervention phase. However, the areas which need more focus are Initial Assessment filled by Doctors, In Patient History sheet, Plan Of care, Entries of Patient Identification, Doctor's Progress Notes, Nursing Plan of Care, Pre Operative Instructions, Post Sedation Recovery Score Sheet, Post Operative charting.

Conclusion: Hospital accreditation and licensing of the healthcare services is only possible when the hospital assures and provides excellent services to the patient. This can only be achieved through the medical records of the patient maintained in the

hospital. The completeness and accuracy of the information is the important criteria in a hospital. Regular medical record audits, ongoing trainings and cooperation from all stakeholders could go a long way in ensuring complete and proper documentation of patient medical records.

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LIST OF ABBREVIATIONS

PSSH- Primus Super Speciality Hospital

OT- Operation Theatre

MRI- Magnetic Resonance Imaging

CT- Computed Tomography

ICU/CCU- Intensive Care Unit/ Coronary Care Unit

ENT- Ear Nose Throat

NABH- National Accreditation Board Of Hospitals

SOP's- Standard Operating Procedures

ISQUA- International Society for Quality in Health Care

FO- Front Office

MR- Medical Records

PART-1 INTERNSHIP REPORT

INTRODUCTION TO PRIMUS SUPER SPECIALITY HOSPITAL

Primus Super Speciality Hospital is the state of the art multi speciality hospital conveniently located in the heart of India's capital, New Delhi.

Primus Super Speciality Hospital has been designed and constructed using the most advanced medical technology, available in the world. The hospital is located in serene diplomatic area of Chanakyapuri. The infrastructure of the hospital and the quiet environment are conducive to faster recovery, health and well being.

Having Capacity of 250 beds, with prominent surgeons from across the globe excellent infrastructure and state of art advanced technology, Primus Super Speciality Hospital has set new benchmarks in Medical care and strives to become the best place for treatment of all Medical problems.

The trust and hope patients place in primus hospital says a lot about the people of primus hospital. It also says a lot about the expectations lived up to each time a patient comes through doors.

Primus staff members continuously work to improve the quality of care, improve systems, and improve the services provided. The outstanding staffs at primus hospital have been and continue to be the hallmark for this organization. We stand by the motto of health to all and are committed towards every social cause and upliftment of our country.

Infrastructure at Primus:

The hospital complies with international guidelines and follows the International Patient Service Protocols. The infection control norms will ensure the highest standards of healthcare and patient safety. Our aim is to bring the best of Medical practices worldwide to India and deliver them in an open, warm and patient centric atmosphere.

- Modular seamless operation theatres
- OT's with laminar air flow and laminar shields
- 1.5 Tesla MRI
- 64 slice spiral and cardiac CT Scan
- Bone densitometry
- VIP suits
- ICU/CCU backup
- Dialysis
- Mammography
- High Resolution Ultrasound
- Digital X-Ray

The department of Laboratory Medicine is open 24 hrs. a day every day of the year. It is a high tech lab that has fully automated instruments which are directly interfaced with the hospital information System and Laboratory Information System. It comprises of departments for:

- Biochemistry
- Haematology
- Serology
- Microbiology
- Electrophoresis
- Histopathology

- Cytology
- Clinical Pathology

Specialties:

- Anesthesia
- Blood bank
- Bone & Joint
    - Joint Replacement Surgery
    - Arthroscopy
    - Complex Fractures and Trauma Services
- Cosmetic Surgery
- Dental
- ENT & Cochlear Implant
- General surgery
- Institute Of Reproductive Medicine & IVF Center
- Institute Of Digestive & Hepatobilliary Sciences
- Internal medicine
- Neurosciences
    - Spine Surgery
    - Neuro Surgery
- Nephrology & Kidney Transplant
- Nutrition & Diet
- Ophthalmology
- Physiotherapy
- Surgical Oncology
- Sports Medicine And Rehabilitation
- Urology & Stone Center

PSSH LOGO

PSSH VISION

" To establish a network of World Class Centers in Healthcare by providing State of the Art facility and creation of ethical, compassionate patient care through professional excellence"

PSSH MISSION

"Our primary measure of success will be delivering a benchmark quality of medical Services."

"Our Organization will be run by responsive, caring and efficient people with a never- ending focus on service and medical excellence." (1)

Objectives of internship:

- To complete my internship with full efficacy and efficiency.

- To understand working of whole hospital and seek opportunity that provides me real experience.

- 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 quality and accreditation.

- As the hospital had just completed NABH Final Assessment and subsequent to that had to further work on the non conformities highlighted by the assessment team for further awarding the NABH Accreditation.

List of areas visited:

- Front Office
- Preventive Health Check up
- OPD
- Procedure Room
- Radiology
- Endoscopy
- Emergency Department
- Billing
- Laboratory
- Blood Bank
- Physiotherapy
- Intensive Care Unit
- Dialysis
- Wards
- Medical Record Department
- OT

Tasks Performed as Management Trainee-:

1. Visits to various departments and learning about their Scope of services, Departmental Organogram, working hours of the particular department, their manpower and equipment utilization, process flow of the department, various documents maintained by them, their set measurable standards (quality indicators) and the average number of patients visiting the department daily or monthly

2. Scheduling of an yearly training calendar to be conducted by the department of quality and also scheduling of the training sessions to be held interdepartmental.
3. Scrutinizing of in patient feedback forms and information captured thereby. Also conducting weekly meetings with various departmental heads on discussing their performance through weekly feedbacks, taking corrective actions on closing the complaints and improving the patient care.
4. Coordinating with quality cell with regards to capturing quality indicators pertaining to patient satisfaction.
5. Rounds with infection control nurse in casualty, Endoscopy, Procedure Room, ICU, Wards Dialysis, OT to audit for Infection Control Practices and make note of observations as regards to floor discipline, discrepancies and other aspects / issues need improvement.
6. Assisted quality manager in closing of Non conformities pointed in the NABH audit by collecting the various documents and evidence needed for the same.
7. Helped Fire Safety Officer in conducting fire mock drills for security staff.
8. Tracking the delay in Discharge Process and taking corrective actions for timely discharges by Coordinating with various departments.
9. Assisting in documentation of SOP's / Quality Policies and Manuals / Minutes of meetings for different departments
10. Making PowerPoint presentations in preparation and holding of Training classes.
11. Assisted in various audits.
12. Assisted in checking deviation from the standard operating procedure and norms prescribed by NABH.

Reflective Learning's:

- General working of various hospital departments.
- Insight into NABH audit and audits.
- Man Power management.
- Coordination with various quality initiatives within the hospital
- Documentation related to NABH and other related documents.
- Timeliness, patient focused approach.
- Reviewing of all the quality manuals and procedures.
- Regular training of nurses and other staff (housekeeping, security, dietary, cssd, laundry) related to fire safety, biomedical waste management, infection control etc.
- Recording of each and every event (sentinel/adverse, patient fall, disaster/emergency).
- Adhering to Quality Management process.
- Taking action when a non-conformance is detected.
- Developing Team spirit, leadership and motivation among the staff.

PART-II – DISSERTATION

1. Introduction

1.1 NATIONAL ACCREDITATION BOARD FOR HOSPITALS (NABH)

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

NABH is an institutional member of the International Society for Quality in Health Care (ISQUA). ISQUA is an international body which grants approval to Accreditation Bodies in the area of healthcare as mark of equivalence of accreditation program of member countries.

International Society for Quality in Healthcare (ISQua) has accredited "Standards for Hospitals" developed by National Accreditation Board for Hospitals & Healthcare Providers (NABH, India). The approval of ISQua authenticates that NABH standards are in consonance with the global benchmarks set by ISQua. The hospitals accredited by NABH will have international recognition

Accreditation

" A public recognition of the achievement of accreditation standards by a health care organization, demonstrated through an independent external peer assessment of that organization's level of performance in relation to the standards. "

Benefits of Accreditation

- Accreditation benefits all stake holders. Patients are the biggest beneficiary. Accreditation results in high quality of care and patient safety. The patients get services by credential medical staff. Rights of patients are respected and protected. Patient satisfaction is regularly evaluated.
- The staff in a accredited hospital are satisfied lot as it provides for continuous learning, good working environment, leadership and above all ownership of clinical processes.
- Accreditation to a hospital stimulates continuous improvement. It enables hospital in demonstrating commitment to quality care. It raises community confidence in the services provided by the hospital. It also provides opportunity to healthcare unit to benchmark with the best.
- Accreditation provides an objective system of empanelment by insurance and other third parties. Accreditation provides access to reliable and certified information on facilities, infrastructure and level of care. (2)

NABH 3rd Edition has been unveiled which contains:

- 10 Chapters
- 104 Standards
- 636 Objective Elements

From the 10 CHAPTERS:

5 are Patient Centered:

- Access, Assessment and Continuity of Care
- Care of Patients

- Management of Medication
- Patient Rights and Education
- Hospital Infection Control

5 are Organization Centered:

- Continuous Quality Improvement
- Responsibilities of Management
- Facility Management and Safety
- Human Resource Management
- Information Management System

1.2 MEDICAL RECORDS

Historical Background

Patients records are believed to have been kept in ancient India by individual physicians in emperor Ashoka's time (200 BC). In Seventeenth century, St. Barthalomew's hospitals in London first started to keep written records, which was later followed by some hospitals in USA. However, the impetus to the idea of proper written records came in USA from American College or Surgeons and American college of Physicians in the beginning of the last century. (3)

In India, The Mudaliar Committee (1963) first stressed its importance (4) and the subsequent review committee (5) for health and hospitals (Jain Committee, 1968) lamented poor state of medical records and strongly recommended establishment of proper medical record section in every hospital.

McGibony considered medical records as a clinical, scientific, administrative and legal document relating to patient care in which are recorded sufficient data written

in the sequence of events to justify diagnosis and warrant treatment and end results. (6)

Introduction

Medical record is a systematic documentation of a patient's personal and social data, history of his or her ailment, clinical findings, investigations, diagnosis, treatment given, and an account of follow-up and final outcome.(7)

The quality of a patient record depends largely on the individuals making record entries. All healthcare practitioners and others who enter information into patient records must understand the importance of creating complete and accurate records, as well as the legal and medical implications of failing to do so.

A medical record enables healthcare professionals to plan and evaluate a patient's treatment and ensures continuity of care among multiple providers. The quality of care a patient receives depends directly on the accuracy and legibility of the information the medical record contains.(8)

Maintaining a complete record is important not only to comply with licensing and accreditation requirements, but also to enable a healthcare provider to establish that a patient received adequate care. Statutes, accreditation standards, and professional associations frequently impose standards relating to the legibility, accuracy, and completeness of medical records.(9)

Purpose and Scope of Medical Record

The hospital medical record serves various purposes. It is useful:-

1. **To the patient**: The basic purpose of maintaining the medical record is to improve the patient care. It is a written document in support of the care rendered to a patient on scientific basis.
    - Its serves to document the history of patient's illness and also the clinical story of the patient in hospital.
    - It servers to avoid omissions and repetition of investigations and treatment procedures, particularly drugs.
    - It helps in continuity of medical care.
    - It serves as evidence in court of law.
    - Provides compensations in case of disability
    - It helps patient for certain medical and sickness certificates or disability benefits under various schemes.
2. **To the clinicians:** It helps clinicians in:
    - Planning treatment modalities for patient.
    - Quality Assurance.
    - Assurance of continuity of care.
    - Evaluation of medical practice.
    - To help in continuing medical education and research.
    - Protection of clinician in the event of legal disputes.

3. **To the hospital and hospital administration:**
    - Type and quality of work undertaken.
    - Evidence of quantum and quality of care rendered.
    - Evaluate work and performance of clinicians.
    - Evaluate services of hospital.

- Planning of hospital, extension of facilities or introduction of new facilities

4. **To Public Health Authorities:** It provides important data in situation analysis or community diagnosis for planning of various health programs and health care delivery system for the community. It provides data, which are hospital based.
    - Prevalence rate of disease
    - Incidence rate of disease
    - Disability rates
    - Death Rates

5. **To medical Education and research:** Various epidemiological studies cannot be conducted without the help and support of medical records. Various interventional studies like Randomized Clinical Trial(RCT) are based upon medical records which are the most important tools of the evidence based medicine. The results of clinical trials are heavily dependant upon the meticulously maintained medical records.

Medico legal Importance of Medical Records

The medical records should be meticulously written and all the details should be written in a lucid manner, legible and easily understandable. To meet the legal requirements and avoid complications, the records must fulfill the following criteria:

- It should be complete in all aspects.
- It should provide adequate information in respect of medical care rendered to the patient.

- Information must be accurate, it should not be based upon presumption; it must be factual.
- It should be legible and the document must be signed by the concerned clinicians.

The medical record of a patient contains the documents

Functions of Medical Records Department

- Assembling of the medical records
- Quantitative analysis of the records
- Deficiency Check
- Completion of incomplete records
- Coding
- Indexing
- Analysis and statistics
- Reporting
- Numbering and filing
- Storage and retention of records
- Retrieval of records (3)

1.3 RATIONALE OF THE STUDY

In the last NABH survey, there were significant non compliances in the patient medical record documentation. This study 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.

2. Review of Literature

Ian Pullen, John Loudon (2006) in the journal of "Improving standards in clinical record- keeping" said that clinical records are the most basic of clinical tools. They form a permanent account of individual considerations and the reasons for decisions. Essential for effective communication and good clinical care, they are often accorded low priority, are poorly maintained and not readily available. Independent inquiries and the courts have repeatedly criticized the quality of records and the resulting failings of care. (10)

Researchers, practitioners, and hospital administrators view recordkeeping as an important element leading to continuity of care, safety, quality care, and compliance. (11-14)

Karkkainen and Eriksson note that, although standardized forms of documentation can enhance concise and directed information, poorly designed forms may enhance document content but do little to support patient-centric care. The challenge is to design systems that are patient focused but also reap the benefits of standardization in terms of more accurate, precise, and up-to-date information transfer among all members of the interdisciplinary team. (15)

The issue of completeness is important; Croke (16) cites failure to document as one of the six top reasons that nurses face malpractice suits. In terms of overall completeness, Stokke and Kalfoss (17) found many gaps in nursing documentation. Care plans, goals, diagnosis, planned interventions, and projected outcomes were absent between 18 percent and 45 percent of the time.

The patient record serves as a communication tool between caregivers, provides justification for reimbursement of services, and serves as a medico legal document(18)

.Prior studies support the belief that physician's handwriting is often illegible (19-22). Lack of a legible physician signature can lead to inaccurate documentation, improper billing, potential legal issues, lost time and money, and frustration for members of the healthcare team.(23-27)

Susan J Burnett et al (2011) says that there is a need for a systematic, regular audit of the prevalence of missing clinical information. Only then will we know the impact on clinical decision making and patient care of new technology, service re organizations and, crucially given the present financial climate, temporary or reduced staffing levels. (28)

Physicians act as the author of individual patient medical records and define the majority of patient specific information. It is essential that all patient medical records are complete and accurate. They are relevant to the care of each individual patient. The most effective ways of encouraging residents to learn, understand and implement best practice in medical record documentation is to develop systems and processes that are shared across the hospital between practitioners, administrators and information management specialists. These processes could include new forms for easy completion, open communication with senior colleagues and education campaigns. It is therefore essential to develop a more sophisticated portfolio of strategies that involves these key stakeholders. (29)

Joseph Thomas (2009) says that medical recording needs the concerted effort of a number of people involved in patient care. The doctor is the prime person who has to oversee this process and is primarily responsible for history, physical examination, treatment plans, operative records, consent forms, medications used, referral papers, discharge records, and medical certificates. There should be proper recording of nursing care, laboratory data, reports of diagnostic evaluations, pharmacy records, and billing

processes. This means that the paramedical and nursing staff also should be trained in proper maintenance of patient records. (30)

.

3. Objectives

General Objective

To study the medical record documentation in accordance with NABH guidelines in Primus Super Speciality Hospital

Specific Objectives

- To find adherence of different departments in Primus Super Speciality Hospital of standards laid by NABH regarding the inpatient medical records.
- To enhance compliance towards documentation.
- To compare the pre intervention and post intervention status to measure the improvements made.
- To highlight major observations to recommend implementable solutions.

4. Methodology

4.1 Study Design:

Interventional Study

The study was in two phases:-

1. Pre Interventional:- 100 active files from all the in patient departments of hospital were studied to find any non compliances towards NABH standards.
2. Post Interventional:- 100 active files from all the in patient departments of hospital were studied to find the difference in the non compliances rates as compared to pre interventional study.

4.2 Study area:

Primus Super Speciality Hospital, Chanakyapuri, New Delhi

4.3 Study Duration:

The duration of the study was from 10th February 2014 till 6th April 2014

The pre interventional phase was from 10th February 2014 till 5th March 2014 after which the counseling sessions, informal interviews, meetings with the doctors were conducted.

The post interventional phase was from 12th March 2014 till 6th April 2014. During this period various changes were observed.

4.4 Study Population:

- Doctors
- Physiotherapists

- Staff Nurses
- Dieticians

4.5 Selection Criteria:

Active Medical Records of the patients in the patient areas were included in the study.

Records of the patients coming to day care and admissions less than 24 hours were not included in the study.

4.6 Sample Size:

A sample size of 200 records we re taken out of which 100 records were assessed in the pre intervention phase and another 100 were assessed during the post intervention phase for proper documentation.

Medical Records of 10 specialties were taken for the purpose of audit.

4.7 **Study Variables**

A pre defined criteria was set as per NABH standards on which the in patient medical records were analyzed. The data was fed into Microsoft Excel 2007 and analyzed on the basis of the following criteria.

Table 1: Study Variables

Category	Criteria
INITIAL ASSESSMENT	Registration Form completed with signature of admission office/FO and attached in patient file
	In patient History Sheet- Fully filled, dated, signed, legible within one hour of admission to the hospital
	Plan of care- the entire treatment plan is filled, dated, signed, legible within 24 hrs of admission to the hospital and countersigned by consultant
	Nursing Assessment- Initial assessment form filled within 24 hours of patient admission
	Nursing Plan of Care - treatment plan is fully filled, signed and dated
	Nutritional Assessment- Fully filled within 24 hrs of admission to the hospital
	Initial Assessment Form fully filled by the doctors
NOTES	All sheets mention patient identification number or name
	Doctors Progress notes with date, time & signature
	Nurses progress notes with date, time & signature
	Progress notes recorded daily- there is atleast one noting regarding condition of patient in every 24 hrs
	In patient medication sheet in one unifor location- All patient medication is written in physician order sheet in capital & duly signed
	Route of administration, Dose & frequency of dose/ any other instruction- all the orders regarding the medication contains details regarding the route of administration, when to give and how many times to give including any special instructions
	All entries in patient file signed
CONSENTS	General Consent duly dated & signed by the patient
	Informed & Special Consent form for performing procedures duly dated & signed by both patient and doctor incharge
	Specific Procedural information consent duly dated & signed by both patient and doctor incharge

	Name & Sign of the patient- consent of the treatment given by the patient him/herself if above 18 yrs of age in senses & not lunatic. In case of above condition not met, the consent has been taken from the surrogate
	Consent for Blood/ Components Transfusion with date, time with signature of patient/relative & their relation filled
	Anesthesia Consent form with name & signature of anesthesiologist
SURGICAL & ANAESTHETIC NOTES	Pre anesthetic assessment record duly filled and signed
	Preoperative instructions given & signed
	Operation Notes- All the surgery notes written & countersigned by the surgeon with time
	Post- Sedation Recovery Score sheet timed, dated, signature of duty nurse & Sr/Consultant
	Post operative charting fully filled & signed
	Surgical safety checklist duly timed, filled & signed by surgeon, Anaesthetist and scrub nurse

4.8 Data Collection Tools & Techniques:

Tool- A Checklist keeping in mind the various quality standards.

Technique- Interviewing all the stakeholders of the hospital was an ongoing process.

4.9 Data Analysis

The Data was fed into Microsoft Excel 2007 and analysis was done.

5. Study Findings

The total number of cases which were analyzed from different specialities:-

Table 2: Observed Cases- Total

Department	Total
Arthroscopy & sports Medicine	8
ENT	17
Gastroenterology	10
General Surgeon Laproscopic	22
Nephrology	12
Ortho Joint Replacement	73
Orthopaedic & Trauma	33
Paediatrics	4
Physician Internal Medicine	11
Spine Surgery	10
Total	200

Fig. 1:Total Cases Observed

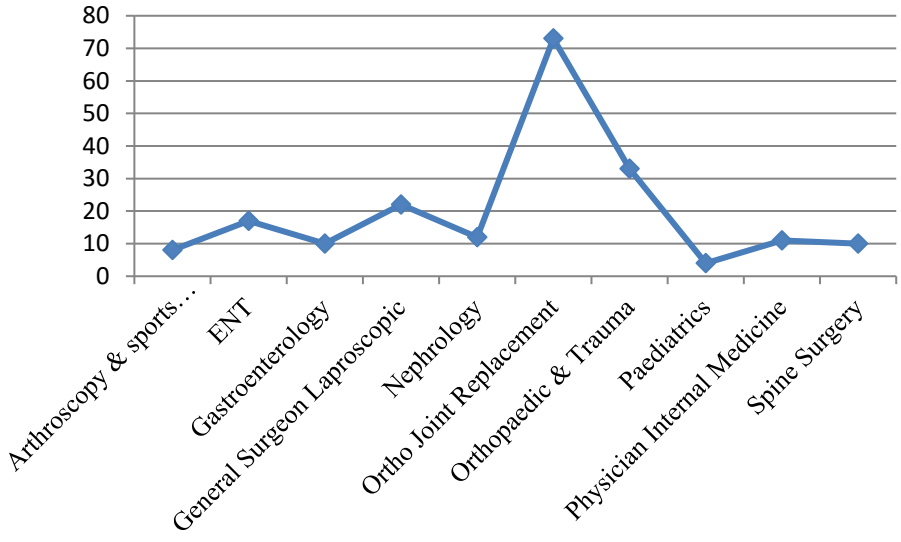


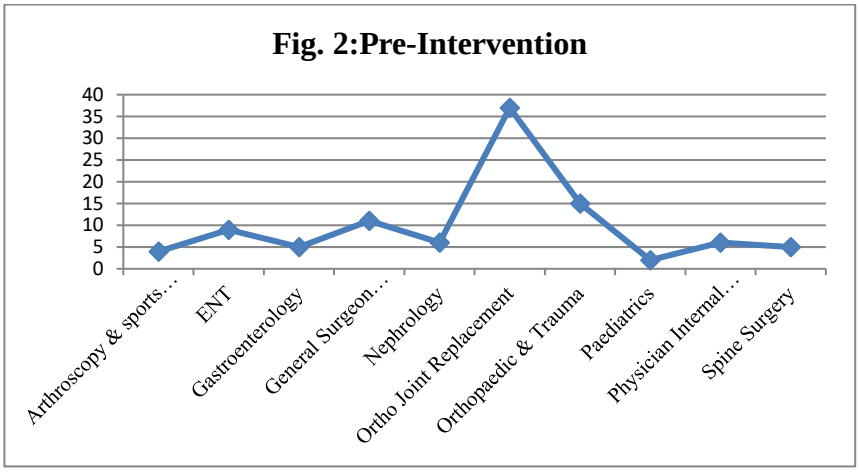
Figure 1 depicts total number of inpatient records that were analyzed during the study and maximum number of records were examined from Ortho and Joint Replacement followed by Orthopaedic & Trauma.

Pre intervention

Table 3: Observed Cases- Pre Intervention

Department	Pre-Intervention
Arthroscopy & sports Medicine	4
ENT	9
Gastroenterology	5
General Surgeon Laproscopic	11
Nephrology	6
Ortho Joint Replacement	37
Orthopaedic & Trauma	15
Paediatrics	2
Physician Internal Medicine	6
Spine Surgery	5
Total	**100**

Fig. 2:Pre-Intervention

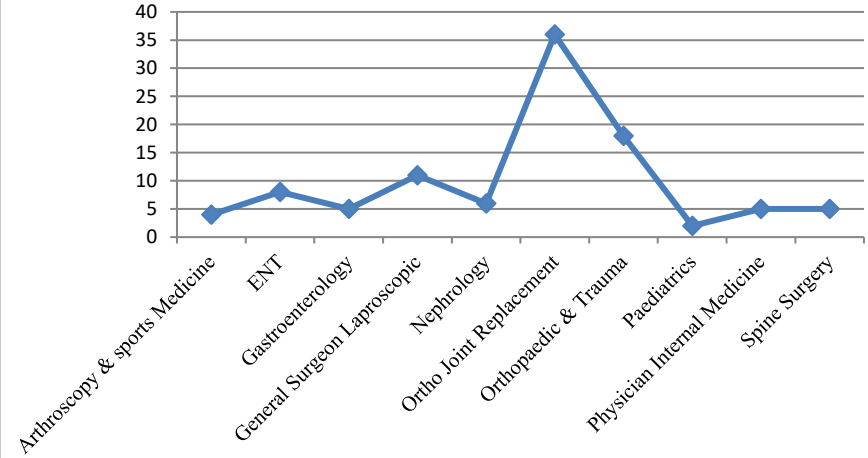


Post Intervention:

Table 4: Observed Cases- Post Intervention

Department	Post-Intervention
Arthroscopy & sports Medicine	4
ENT	8
Gastroenterology	5
General Surgeon Laproscopic	11
Nephrology	6
Ortho Joint Replacement	36
Orthopaedic & Trauma	18
Paediatrics	2
Physician Internal Medicine	5
Spine Surgery	5
Total	**100**

Fig. 3:Post-Intervention



The pre defined criteria was divided into 4 categories:

1. Initial Assessment
2. Daily Notes
3. Consents
4. Surgery

Table 5 : Pre Intervention Assessment

Description	Total Count	Compliance	Non Compliance	Not Applicable	% of Non Compliance
Initial Assessment					
Registration Form completed	100	99	1	0	1%
In patient History Sheet	100	42	58	0	58%
Plan of Care	100	56	43	0	43%
Nursing Assessment	100	85	15	0	15%
Nursing Plan of Care	100	69	31	0	31%
Nutritional Assessment	100	100	0	0	0%
Initial assessment by doctors	100	20	80	0	80%
Notes					
Patient identification	100	60	40	0	40%
Doctors notes	100	64	36	0	36%
Nurses notes	100	100	0	0	0%
Notes once in 24 hrs	100	100	0	0	0%
Medication sheet in capitals	100	100	0	0	0%
Details of medication	100	100	0	0	0%
Entries signed	100	99	1	0	1%
Consent					
General Consent	100	99	1	0	1%
Informed Consent	100	86	1	13	1%
Procedural Consent	100	33	4	63	4%
Consent by 18 yrs and above	100	100	0	0	0%
Consent for Blood	100	17	11	72	11%
Anesthesia Consent	100	55	26	19	26%
Surgical & Anaesthetic Notes					
PAC	100	80	1	19	1%
Pre op instructions	100	57	25	18	25%
OT Notes	100	74	7	19	7%
Post- Sedation Recovery	100	61	20	19	20%
Post op charting	100	60	21	19	21%
Surgical Safety checklist	100	79	2	19	2%

The first phase of the study was pre intervention phase was no intervention was done and the non compliances were observed in the in patient records assessed from the criteria mentioned above. The non compliances were observed in 80% Initial Assessment form filled by doctors, 58% In patient History Sheet- Fully filled, dated, signed, legible within one hour of admission to the hospital followed by 43% Plan of care- the entire treatment plan is filled, dated, signed, legible within 24 hrs of admission to the hospital and countersigned by consultant and 40% in all sheets mention patient identification number or name. All the concerned staff was targeted for intervention.

Intervention Phase:

The intervention phase was immediately after assessing the non compliances in the in patient record. The intervention was in form of informal interviews with all the concerned authorities like Medical Superintendent, Doctors, Nursing Superintendent. Also, On site counseling was done. Also their feedbacks were taken.

Informal Interviews with the resident medical officer and senior residents were done regarding the completion of inpatient history sheets, plan of care, initial assessment filled by doctors, progress notes and consents. Also, the nursing superintendent and nursing staff was interviewed and counseled about completion of nursing initial assessment, nursing plan of care and entries for patient identification. A discussion with anesthetists and surgeons was also done regarding the issues in documentation related to anesthesia consents and all the surgical related notes and to get them in proper adherence.

Table 6 : Post Intervention Assessment

Description	Total Count	Compliance	Non Compliance	Not Applicable	% of Non Compliance
Initial Assessment					
Registration Form completed	100	100	0	0	0%
In patient History Sheet	100	66	34	0	34%
Plan of Care	100	74	26	0	26%
Nursing Assessment	100	91	9	0	9%
Nursing Plan of Care	100	87	13	0	13%
Nutritional Assessment	100	100	0	0	0%
Initial assessment by doctors	100	26	74	0	74%
Notes					
Patient identification	100	75	25	0	25%
Doctors notes	100	83	17	0	17%
Nurses notes	100	100	0	0	0%
Notes once in 24 hrs	100	100	0	0	0%
Medication sheet in capitals	100	100	0	0	0%
Details of medication	100	100	0	0	0%
Entries signed	100	100	0	0	0%
Consent					
General Consent	100	100	0	0	0%
Informed Consent	100	87	0	13	0%
Procedural Consent	100	44	1	55	1%
Consent by 18 yrs and above	100	100	0	0	0%
Consent for Blood	100	30	6	64	6%
Anesthesia Consent	100	74	5	21	5%
Surgical & Anaesthetic Notes					
PAC	100	79	0	21	0%
Pre op instructions	100	65	14	21	14%
OT Notes	100	76	3	21	3%
Post- Sedation Recovery	100	66	13	21	13%
Post op charting	100	67	12	21	12%
Surgical Safety checklist	100	79	0	21	0%

The second phase of the study was post intervention phase where in patient records were assessed to check for the improvements in the level of compliance. All the areas of non compliances in pre intervention period were assessed and improvements are seen.

Table 7: Comparison of Pre Intervention and Post Intervention Results

Description	% of Non Compliance		
	Pre-Intervention	Post-Intervention	Change
Initial Assessment			
Registration Form completed	1%	0%	1%
In patient History Sheet	58%	34%	24%
Plan of Care	43%	26%	17%
Nursing Assessment	15%	9%	6%
Nursing Plan of Care	31%	13%	18%
Nutritional Assessment	0%	0%	0%
Initial assessment by doctors	80%	74%	6%
Notes			
Patient identification	40%	25%	15%
Doctors notes	36%	17%	19%
Nurses notes	0%	0%	0%
Notes once in 24 hrs	0%	0%	0%
Medication sheet in capitals	0%	0%	0%
Details of medication	0%	0%	0%
Entries signed	1%	0%	1%
Consent			
General Consent	1%	0%	1%
Informed Consent	1%	0%	1%
Procedural Consent	4%	1%	3%
Consent by 18 yrs and above	0%	0%	0%
Consent for Blood	11%	6%	5%
Anesthesia Consent	26%	5%	21%
Surgical & Anesthetic Notes			
PAC	1%	0%	1%
Pre op instructions	25%	14%	11%
OT Notes	7%	3%	4%
Post- Sedation Recovery	20%	13%	7%
Post op charting	21%	12%	9%
Surgical Safety checklist	2%	0%	2%

Graphical Representation of the Percentage Of Non Compliances in the Pre Intervention & Post Intervention Assessments:

Fig. 4:Initial Assessment

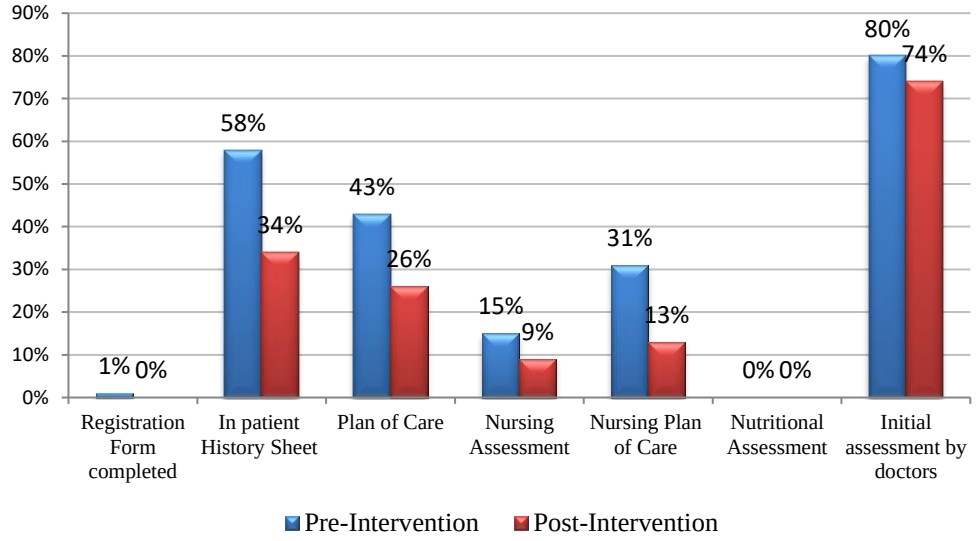


Fig. 5: Notes

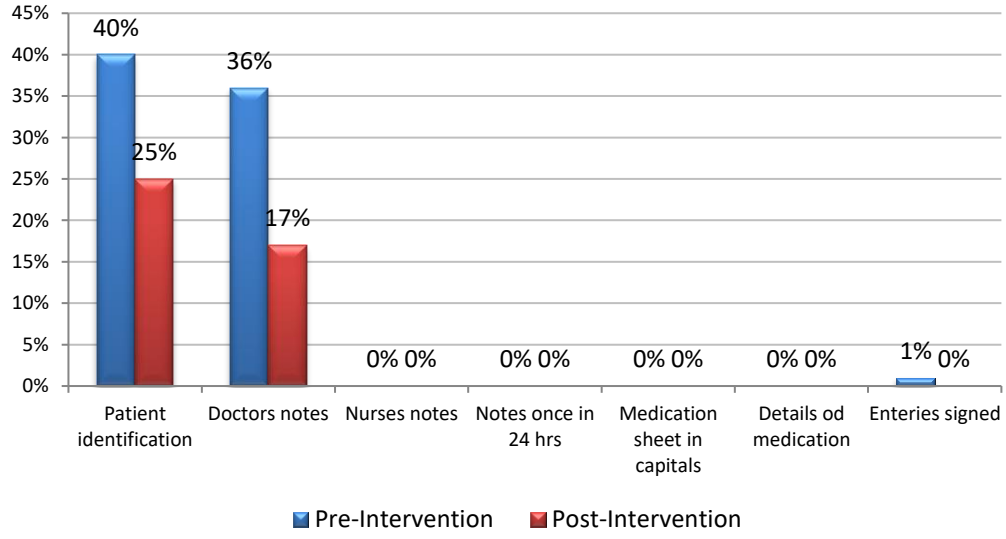


Fig. 6:Consents

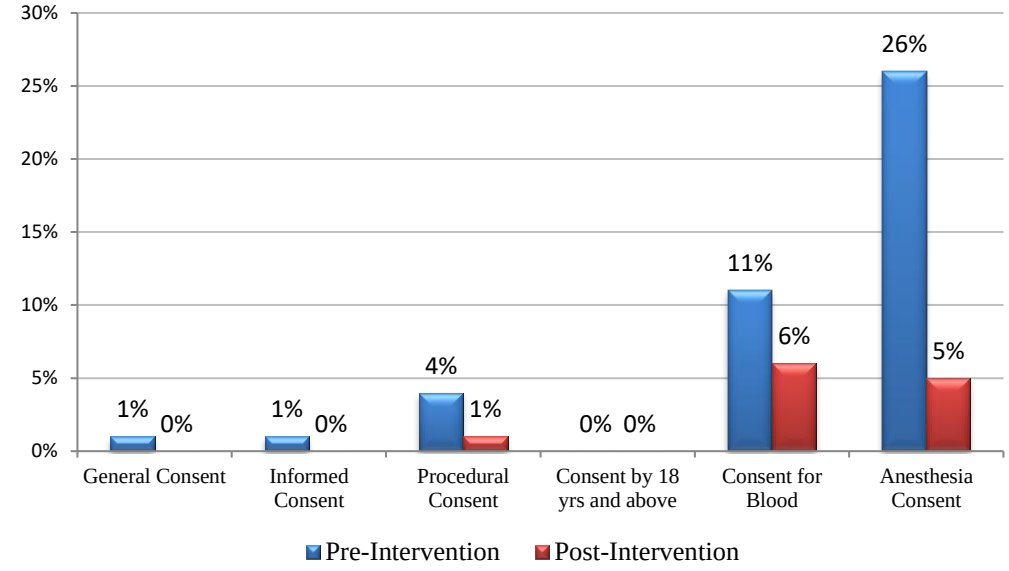
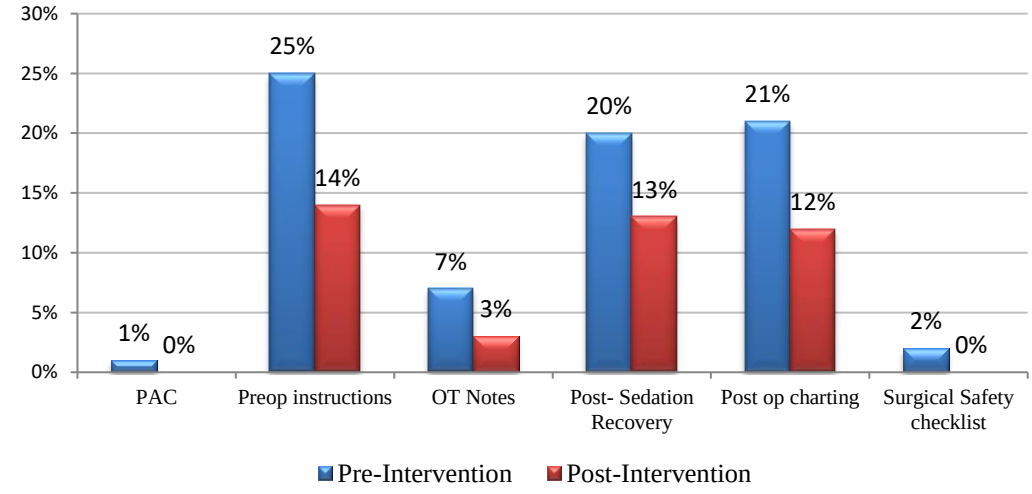


Fig. 7:Surgical & Anaesthetic Notes



The criteria to which compliance was found were as follows:-

1. Registration Form completed with signature of admission office/FO and attached in 100% of records.
2. Nutritional Assessment- Fully filled within 24 hrs of admission to the hospital in 100% of records.
3. Nurses progress notes with date, time & signature is in 100% of records.
4. Progress notes recorded daily- there is at least one noting regarding condition of patient in every 24 hrs in 100% of records.
5. In patient medication sheet in one uniform location- All patient medication is written in physician order sheet in capital & duly signed in 100% of records.
6. Route of administration, Dose & frequency of dose/ any other instruction- all the orders regarding the medication contains details regarding the route of administration, when to give and how many times to give including any special instructions is in 100% of records.
7. All entries in patient file signed in 100% of records.
8. General Consent duly dated & signed by the patient in 100% of records.
9. Informed & Special Consent form for performing procedures duly dated & signed by both patient and doctor in charge in 100% of records.
10. Name & Sign of the patient- consent of the treatment given by the patient him/herself if above 18 yrs of age in senses & not lunatic. In case of above condition not met, the consent has been taken from the surrogate in 100 % of records.
11. Pre anesthetic assessment record duly filled and signed in 100% of records
12. Surgical safety checklist duly timed, filled & signed by surgeon, Anesthetist and scrub nurse in 100% of records.

13. Nursing Assessment- Initial assessment form filled within 24 hours of patient admission in 91% of records.
14. Specific Procedural information consent duly dated & signed by both patient and doctor in charge in 99% of records.
15. Consent for Blood/ Components Transfusion with date, time with signature of patient/relative & their relation filled in 94% records.
16. Anesthesia Consent form with name & signature of anesthesiologist in 95% records
17. Operation Notes- All the surgery notes written & countersigned by the surgeon with time in 97% records.

The criteria to which improvement needs to be done are as follows:

1. Initial Assessment Form fully filled by the doctors with non compliance of 74%.
2. In patient History Sheet- Fully filled, dated, signed, legible within one hour of admission to the hospital with non compliance of 34%.
3. Plan of care- the entire treatment plan is filled, dated, signed, legible within 24 hrs of admission to the hospital and countersigned by consultant with non compliance of 26%.
4. All sheets mention patient identification number or name with non compliance of 25%.
5. Doctors Progress notes with date, time & signature with non compliance of 17%.
6. Nursing Plan of Care - treatment plan is fully filled, signed and dated with non compliance of 13%.
7. Preoperative instructions given & signed with non compliance of 14%.

8. Post- Sedation Recovery Score sheet timed, dated, signature of duty nurse & Sr/Consultant with non compliance of 13 %.
9. Post operative charting fully filled & signed with non compliance of 12%.

6. Discussion

- Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including the past and present illnesses, examinations, tests, treatments, and outcome. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care.

- Failing to document can jeopardize the continuity of patient care when failing to record all the patient data from assessment, diagnosis, notes, planning and implementing treatment.

- Thought there have been improvements in Initial Assessment Form filled by Doctors, In patient History Sheet, Plan of care, Patient identification sheets, Doctors Progress Notes, Nursing Plan of Care, Preoperative instructions, Post-Sedation Recovery Score sheet and Post operative charting but it requires more amount of focus and commitment by all the healthcare professionals

7. Conclusion

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

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

8. Recommendations

- 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).
- It is recommended that **repetitive information** should be avoided since it involves duplication of efforts and wastage of resources.
- It is recommended that **forms should be redesigned** and redundant columns should be done away with
- It is recommended that entries be recorded are **detailed, accurate and comprehensive**.
- To have a **periodic weekly auditing** to minimize chances of deficiency/misplacing and improving the standards of documentation.
- The Medical Record department/personnel should identify incomplete records and send them to the concerned professional to complete and then only it should be filed.
- Additionally, the nursing station staff may also take up the responsibility of ensuring that all the details of the patient in forms / records are complete, while they are in charge of that patient so that if any variations are found they can solved immediately. This will help minimize the movement of incomplete forms / records.
- **Periodic training sessions** and **workshops** should be organized by management in order to educate the staff about the importance of the documentation and update them on the latest in documentation methodologies/technologies.
- **Regular discussions** with the senior management on improvising the standards

of documentation.

- Formation of a **MR development committee** that could greatly assist with the development of a standardized MR system and its implementation in the hospital. Also, the committee could review and authorize the MR Manual developed, review and suggest changes on existing MR forms.

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10. Annexure

Primus Superspeciality Hospital

Medical Record Audit Sheet

	Filled	Not Filled	NA
Registration Form completed with signature of admission office/FO			
Prescription/Casualty note Doctor's advice for admission present			
Estimate Form Filled and signed by attendant /patient			
Photocopy of FRRO & intimation to International Help Desk			
Room Allotment HIS/Physical status match by admission staff			
Face sheet- All entries verified along with signature of admitting staff			
Patient counseled about treatment/surgery/blood transfusion etc.			
Attendant Briefing Checklist Admission with Signature of attendant			
Advance Deposit- Cash/credit Received			
Patient care/ Coordination delegated to			
Signature of Head of admissions with time			
Plan of care- the entire treament plan is filled within 24 hrs of admission to the hospital and countersigned by consultant			
Charge Sheet with date, time, consultant's name & Signature			
Radiology Investigation Chart with date, Name of test, Time of test request sent and Time of reports received filled			

In patient History Sheet- Fully filled, timed, dated and signed within one hour of admission to the hospital			
Informed & Special Consent form for performing procedures duly dated & signed by both patient and doctor incharge			
Specific Procedural information consent duly dated & signed by both patient and doctor incharge			
Name & Sign of the patient- consent of the treatment given by the patient him/herself if above 18 yrs of age in senses & not lunatic. In case of above condition not met, the consent has been taken from the Surrogate			
Consent for Blood/ Components Transfusion with date, time with signature of patient/relative & their relation filled			
Anesthesia Consent form with name & signature of anesthesiologist			
Preoperative instructions given & signed			
Operation Notes- All the surgery notes written & countersigned by the surgeon with time			
Pre anesthetic assessment record duly filled and signed			
Post- Sedation Recovery Score sheet timed, dated, signature of duty nurse & Sr/Consultant			
Post operative charting fully filled & signed			
Surgical safety checklist duly timed, filled & signed by surgeon, Anaesthetist and scrub nurse			
ICU chart duly filled & signed			
Doctors Progress notes with date, time & signature			
Nurses progress notes with date, time & signature			

Progress notes recorded daily- there is at least one noting regarding condition of patient in every 24 hrs			
All sheets mention patient identification number or name			
In patient medication sheet in one uniform location- All patient medication is written in physician order sheet in capital & duly signed			
Route of administration, Dose & frequency of dose/ any other instruction- all the orders regarding the medication contains details regarding the route of administration, when to give and how many times to give including any special instructions			
Nursing Assessment- Initial assessment form filled within 24 hours of patient admission			
Nursing plan of care dated, timed with patient problem, Intervention mentioned & signed			
All entries in patient file signed			