# "Study on Adherence of Medical Records to the NABH Standards in The Mission Hospital, Durgapur"

**A dissertation submitted in partial fulfillment of the requirements for the award of**

**Post-Graduate Diploma in Health and Hospital Management**

**By**

**Susheel Kumar Gunde**

**PG/11/102**


**International Institute of Health Management Research**

**New Delhi – 110075**

**May 2013**

THE MISSION HOSPITAL
DURGAPUR
IN PASSIONATE PURSUIT OF PERFECTION

02.05.2013

## Certificate of Internship Completion

## TO WHOM IT MAY CONCERN

This is to certify that Mr. Susheel Kumar Gunde has successfully completed his 3 months internship in our organization from 05.02.2013 to 02.05.2013. During this intern he has worked on **"Study on Adherence of Medical Records to the NABH Standards"** under the guidance of me and my team at The Mission Hospital, Durgapur.

We wish him/her good luck for his/her future assignments

Signature

Name: Sylvester Shih

Designation: Senior Manager- HR & Admin, NABH Coordinator

Hospital : Plot No. 219(P), Immon Kalyan Sarani, Sector-2C, Bidhannagar, Durgapur-713212, West Bengal
Phone : 0343-2535555, 2535544, 6455555, Cell : 9233355555, Fax : 0343-2532550
Email : hospital@themissionhospital.in, Website : www.themissionhospital.com

## Certificate from Dissertation Advisory Committee

This is to certify that **Mr. Susheel Kumar Gunde** , a graduate student of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He is submitting this dissertation titled **"Study on Adherence of Medical Records to the NABH Standards in The Mission Hospital, Durgapur"** 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.

Faculty Mentor: Dr. Pawan Kumar Taneja

Designation: Professor

IIHMR

*New Delhi*

Date:

Organizational Advisor: Sylvester Shih

Designation: Senior Manager- HR & Admin, NABH Coordinator

Organization: The Mission Hospital

Address: Durgapur

Date: 02.05.13

I-Card
LIB-Card

## Certificate of Approval

The following dissertation titled "Study on Adherence Of Medical records to the NABH Standards in the Mission Hospital, Durgapur" is hereby 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

| Name | Signature |
|---|---|
| DR. BRITENDER SINGH DHILLON | 4/5/13 |
| PROF. MINAKSHI GAUTAM | Mgautam. |
| DR A.K. KHOKHAR | |

THE MISSION HOSPITAL
DURGAPUR
IN PASSIONATE PURSUIT OF PERFECTION

# FEEDBACK FORM

**Name of the Student:** Mr. Susheel Kumar Gunde

**Dissertation Organisation:** The Mission Hospital

**Area of Dissertation:** Medical Records Department

**Attendance:** Satisfactory

**Objectives achieved:** Yes

**Deliverables:** Study on Adherence of Medical Records to the NABH Guidelines

**Strengths:** Good analytical skills, able to make use of statistical tools.

**Suggestions for Improvement:** Needs to be proactive, to be punctual and disciplined.

**Signature of the Officer-in-Charge/ Organisation Mentor (Dissertation)**

**Date:** 02.05.2013

**Place:** Durgapur (WB)

Hospital : Plot No. 219(P), Immon Kalyan Sarani, Sector-2C, Bidhannagar, Durgapur-713212, West Bengal
Phone : 0343-2535555, 2535544, 6455555, Cell : 9233355555, Fax : 0343-2532550
Email : hospital@themissionhospital.in, Website : www.themissionhospital.com

## TABLE OF CONTENTS

# STUDY ON ADHERENCE OF MEDICAL RECORDS TO THE NABH STANDARDS


## Abstract:

According to the NABH standards, the initial assessment for inpatients should be documented within the 24 hrs after the procedure/assessment is done and in a proper sequence so that it becomes easy to keep the medical record of the patient in prescribed manner, and subsequent pains of searching the concerned medical staff and making them complete the records is minimized. Regular audits are carried out for this purpose by staff of the hospital to keep a regular check on the completion of the documentations like signature on the plan of care, date, time and signature on the physicians order and consent form etc.

A checklist was prepared for assessing the percentage of compliance in the files of the IPD patients. This checklist has all the indicators pertaining to the Medical Records as per the NABH standards,

- **Consent Forms**: if the consent forms are properly filled and signed by the concerned personnel(doctors, nurse and patient/patient party) ; Indicator no. 63 from NABH 3rd edition.
- **Discharge Summary**: percentage of discharged patient's files have discharge summary ; indicator no. 61 from NABH 3rd Edition.
- **Nursing Admission Assessment**: percentage of patients who have undergone Nursing admission assessment after getting admitted in the ward (out of the sample size).
- **Nutritional Screening**: percentage of patients for whom screening for nutritional needs has been done (out of the sample size); indicator no.3 from NABH 3rd Edition.
- **Date Time and Consultant's Signature on the Progress Notes**: percentage of files where in care plan with desired outcomes is documented and counter signed by the clinician; indicator no. 2 from NABH 3rd Edition.
- **Nursing Care Plan**: percentage of cases where nursing care plan is documented; indicator no. 4 from NABH 3rd Edition.
- **Missing Records**: percentage of missing records; indicator no. 64 from NABH 3rd edition.

Random visits to the Medical Records Department as well as to the IPD floors were carried out and the level of the compliance in randomly selected files were checked in duration 2 months, with the help of the checklist. A reminder note of the deficiencies in the file was also kept in the file as a reminder for the concerned personnel and the data was analyzed for the total percentage of compliance in the Medical Records.

It was found that overall compliance percentage of IPD files in the month of March was found to increase to 77% from 61.14% in the month of February, following the interventions. Recommendations were made according to the findings.

## ACKNOWLEDGEMENT

It is a privilege to present my project entitled " **Study on Adherence of Medical Records to the NABH Standards** ". In this project an honest effort is made by me to analyze the organization and audit of medical records. My acknowledgement goes to the following persons though not necessarily in the order I am stating.

I would like to thank **Mr. Sylvester Shih, Senior HR manager & Quality Co-ordinator ,** my mentor, without his help; it would not have been possible to understand the hospital to the extent as I could be able to understand now. I owe a great debt to **Dr. Piyush Prakash Sinha** for showing his interest and sharing his valuable views in spite of his busy schedule. Last but not the least, I would like to thank **Mr. Harendra Kumar Diwakar, Executive-Medical Records Department,** for sparing his time when I needed his help. It has been my privilege to work under their dynamic supervision in the hospital.

I am highly grateful to all the departmental heads and staff for giving me time in spite of their hectic schedule. Without their active cooperation and participation it would not have been possible to accomplish my task.

My sincere thanks to **Dr. Pawan Taneja, Professor, IIHMR, New Delhi,** my mentor, for his/her helpful attitude and valuable suggestions always. I would not forget to take a moment to thank our beloved sir **Dr. Rajesh Bhalla, Dean Academics, IIHMR, New Delhi**, for his motivation through out the course.

Apart from all, I would like to thank my Parents for always being there for me and supporting me in every way possible.

# List of Figures

# List of Tables

## INTRODUCTION TO ORGANIZATION AND ITS PROFILE

The Mission Hospital, Durgapur (a unit of Durgapur medical centre pvt.Ltd.) is a 250 bedded, state-of-the art super specialty hospital ,with cutting edge technology. Built in an area spanning three acres it offers an array of facilities- digital flat panel cath lab (Philips FD10c), seven major operation theatres with laminar and HEPA filters,80 bedded critical care unit, dedicated mother and child care unit,24 hour accident emergency department ,blood bank.

This is a hospital with "futuristic" technology and enriched with "brilliant minds" behind the equipments.

The Mission Hospital started its operation from April 02, 2008. This hospital is the first super-specialty corporate hospital in Eastern India, outside Kolkata. The Mission Hospital is the first super-specialty Corporate Hospital of Durgapur which has taken an initiative to amalgamate and integrate the best in healthcare be it manpower or technology. This hospital has been set up with the vision of providing quality healthcare at affordable cost and within the reach of every individual. The hospital has been able to establish its presence in Durgapur and its neighboring areas through its patient centric and high quality care, and patients are benefiting from the facilities of the hospital .The Mission Hospital is committed to providing affordable, quality health care to patients by incorporating improvement in its day-to-day schedule.

**MISSION: "To become a centre of excellence in healthcare by bringing tertiary level healthcare to the people of Eastern India."**

**VISION: "To provide affordable quality health care to patients by incorporating improvement in its day to day schedule.''**

**Meaning of Hospital LOGO**

**For every patient the caring hands of the Doctors and Nurses symbolizes the precious LIFE.**

**The Mission's policy on quality is best explained by the following objectives :**

- Provide continuous and regular training for employees to bring out the best in them to achieve quality improvement in service.
- Understand the needs of the patients and uphold standards of professionalism to improve the level of patient satisfaction.
- Provide quality service that is responsive, efficient, courteous and helpful
- Based on our Mission Statement, our vision and values are:

- ✓ To build a first class patient focused service based on high quality and evidence based practice throughout the organization.
- ✓ To provide this service as close to the patient as possible, in a well managed and appropriate environment.

**To promote a culture that will:**

- Ensure high quality care/service is provided.
- Ensure that decisions regarding delivery of care/service are patient focused and evidence based.
- Support and invest in education and training, thereby promoting the continuous development of the workforce in order to maximize the potential of staff at all levels.

**Our goals are to: -**

- Continuously improve all our services through quality management
- Focus on our patients and deliver high quality service
- Involve all our partners in our quality improvement activities
- Empower employees to make appropriate decisions
- Have the highest degree of respect for one another and value diversity
- Use training, teamwork and open communication to enable all employees to achieve their full potential
- Recognize and reward employees' contributions

- Take all reasonable steps to ensure that patients, visitors, staff and all others in contact with the Hospital are afforded the safest possible environment.
- Maintain the highest ethical standards in protecting the public and the environment Measure the effectiveness of our activities and monitor progress towards achieving our Vision
- We deliver patient care of the highest order at the most affordable rates without compromising on quality. Our focus is always on ethical and service-oriented growth.

**DIFFERENT TYPE OF SERVICES PROVIDE BY THE MISSON HOSPITAL**

- Cardiothoracic surgery, cardiology and electro-physiology.
- Pulmonology and critical care unit area.
- Orthopedics, joint replacement and complex trauma.
- Neurosurgery and neurology.
- Urology.
- Anesthesia.
- Gastroenterology.
- General and Laparoscopic surgery.
- Gynecology and Obstetrics.
- Pediatrics and Neonatology.
- Nephrology.
- Accident and Emergency'
- Plastic Surgery.
- Maxillofacial Surgery.
- Hematology.
- ENT
- Radiology.
- Pathology, Microbiology, Biochemistry.

**INTENSIVE CARE UNIT**

- Medical Intensive Care Unit.
- Surgical Intensive Care Unit.
- Coronary Care Unit.
- Neonatal Intensive Care Unit.
- Dialysis.

**OTHR SUPPORTIVE SERVICES**

- Pharmacy Services.
- Laboratory and Radiology.
- Medical Record.
- Blood Bank.
- Ambulance Services.

**OUT SOURCED SERVICES**

- Canteen.
- Laundry.
- House Keeping.
- Lab and Radiology.
- Security Services.
- Biomedical Waste Disposal.

**AREAS OF EXCELLENCE:**

**Department of accident and emergency:** An important part of our services is the trauma care. A Dedicated team of **Accident & Emergency doctors** man the unit 24/7 and provide trauma care. The department is manned by a group of doctors who have fellowship in Emergency Medicine. The other staffs include RMO's, paramedics and nurses trained in trauma care. We are equipped to handle any trauma, be it neuro-trauma, stroke surgery or multiple fractures. Through prompt evaluation, life-threatening injuries are identified and treated immediately under the direction of a dedicated team of trauma surgeons.

**The department of cardiology & electro-physiology:** This department offers the most comprehensive range of Interventional Cardiology Services performed by Interventional Cardiologists, recognized for their experience, expertise and skills. The hospital is equipped with the latest generation of flat panel Cath Labs with digital images, which is one of the most advanced cath lab machine and is the only machine to be installed outside Kolkata.

**The department of cardio-thoracic and vascular surgery:** has successfully operated upon a number of complicated coronary artery bypass surgeries, valve replacements, valve repairs,

infant and pediatric complex congenital cardiac surgeries already, since its inception on 2nd April, 2008.

But what sets this department apart from other hospitals is the successful neonatal and pediatric cardiac surgical programme, which is being run. We have already performed hundreds of complex cardiac surgeries that require very high degree of technical dexterity, knowledge about infant physiology and dedicated intensive care and infrastructure. There has been very little mortality till date in this specialty**.**

**The department of neurosciences** is equipped with facilities at par with the best in the country. It offer and perform delicate and the most modern procedures on a regular basis viz. pediatric neuro-surgery, brain tumor surgery, vascular neurosurgery, stroke surgery, neuro-trauma, infection (eg neuro-tuberculosis), spine surgery, peripheral nerve surgery.

**The department of orthopaedics & joint replacement surgery** is the only centre in this region to offer an array of high-end surgeries. The Joint Replacement team provides state-of-the-art surgical care employing up-to-date techniques for the treatment of hip and knee afflictions.

**Department of internal medicine and critical care** is the most expensive, technologically advanced and resource intensive area, concerned with the provision of life support or organ support systems in patients who are critically ill and who usually require intensive monitoring.

**The department of transfusion medicine** (Blood Bank) is the only centre in this region with high end and advanced technology. The department is linked with all clinical specialties of surgery and medicine. It also deals with stem cell collection and storage, cord blood banking, regenerative medicine by transfusion of haematopoietic progenitor cells to the patient to regenerate damaged tissue anywhere in the human body (e.g., cardiac, neurons etc.) and gene therapy.

**The department of urology & andrology** provides Comprehensive urology Services as well as andrology facilities. The department is one of the few in the entire state that provides full range

of urology services. Endo Urology, Urolithiasis, Uro Oncology, Andrology, Urodynamics, Transplantation, Microsurgery and Implant Surgery.

**The department of nephrology** is the only centre in this region to provide the services in this speciality for managing patients with all sorts of kidney diseases. The department offers and performs all diagnostic and therapeutic procedures for adults and children.

**The department of gastroenterology & gastro surgery** is the only centre in this region to provide the services in this specialty for managing patients with all sorts of gastrointestinal, liver and pancreatic diseases. The departments offer and perform all diagnostic and therapeutic upper & lower endoscopies and ERCPs with video scopes for adults and children.

**Department of plastic & reconstructive surgery:** The department offer General Plastic Surgery, Cranio - Maxillofacial surgery (Facial Clefts-cleft lip, cleft palate, Facial Microsomia, Mouth and jaw tumour, Craniofacial trauma/ injuries), Aesthetic (cosmetic) Plastic Surgery (Rhinoplasty or "Nose Job", Face Lift, Blephroplasty i.e. Removal of wrinkles from the upper/lower eyelids, Brow Lift, Breast Reduction/ Breast Augmentation, Abdominoplasty, Liposuction), Micro and Hand Surgery, Head and Neck Reconstruction, Acute burns and Post Burn problem solution.

**The department of imaging services** offers advanced diagnostic and therapeutic services compared to anywhere in the world. The Department of Imaging Services is a highly specialized, full-service department which strives to meet all patient and clinician needs in diagnostic imaging and image-guided therapies in close proximity with the various other departments. Each unit of the department viz. General Radiology, Mammography, Ultrasound, Doppler, CT Scan, MRI Scan, Angiography or Nonvascular Interventions is self sufficient as regards to skill and equipments.

**The department of pediatrics and neonatology** is another specialized area, which is of utmost importance. The department is well equipped and has 10-bedded Neonatal ICU with dedicated

team of experienced neonatologist and nursing staff. The NICU is well equipped with ventilators, radiant warmers, multi-parameter monitors, phototherapy units etc. The department also has a 10-bedded paediatric ward to take care of children.

**The department of laboratory services** at The Mission Hospital, Durgapur has been established with a view to provide wide range of Laboratory investigations, necessary for patient care. It consists of disciplines of Biochemistry, Clinical Pathology, Haematology, Immunology, Microbiology, Molecular diagnostics, Serology, Endocrinology, Nutrition and Metabolism, Infectious diseases, Histopathology, Cytopathology and Immuno-Histochemistry.

The laboratories are equipped with state-of-the-art equipments. To operate these sophisticated gadgets the laboratories have a team of efficient, motivated, knowledgeable and qualified Doctors and technical staff. All the blood samples of Laboratory investigations are collected using **Pneumatic Chute System**, which is the first of its kind in eastern India.
We also offer services in the field of General Medicine, General & Laparoscopic Surgery, Obstetrics & Gynaecology, Anaesthesiology, Dermatology, Ophthalmology, ENT, etc. to name a few.

## DAILY ROUTINE AND MANAGERIAL TASKS PERFORMED IN THE ORGANIZATION

In the organization, I was engaged in the NABH accreditation process. As part of quality team, on a daily basis I was supposed to,

- Collect data pertaining to indicators from different departments and coordinate with the HODs as to what to be done, in case the data is not available.
- After the data was collected, had to analyze the data and present the findings to sum up the results.
- Updated the department manuals of different departments, according to the NABH guidelines.
- Conducted the Audit of Medical Records.
- Conducted prescription audit.

## DEPARTMENTS VISITED

- Pharmacy
- MGPS
- Laundry
- CSSD
- Canteen
- ICUs
- HVAC
- House Keeping

CHAPTER 1

# STUDY ON ADHERENCE OF MEDICAL RECORDS TO THE NABH STANDARDS IN THE MISSION HOSPITAL, DURGAPUR

## Introduction

A medical record, health record, or medical chart is a systematic documentation of a patient's medical history and care. The term 'Medical record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical Record is intensely personal document and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

Medical Records are traditionally compiled, stored and maintained by MRD of The Mission hospital from 2008. Terminal Digit System of file is most secure and safe system as far as the identification of the file is concerned.

The information contained in the medical record allows health care providers to provide continuity of care to individual patients. The medical record also serves as a basis for planning patient care, documenting communication between the health care provider and any other health professional contributing to the patient's care, assisting in protecting the legal interest of the patient and the health care providers responsible for the patient's care, and documenting the care and services provided to the patient. In addition, the medical record may serve as a document to educate medical students/resident physicians, to provide data for internal hospital auditing and quality assurance, and to provide data for medical research. Personal health records combine many of the above features with portability, thus allowing a patient to share medical records across providers and health care systems.

## RATIONALE

- Medical records are a reflection of medical care provided to the patient in the course of stay in the hospital.
- Knowing the current status of patient care that is provided is the pre-requisite for betterment of the same.
- Accrediting bodies responsible for rating a health care organization use contents of the medical records to evaluate services to patients.
- Hence Medical Records are audited to check whether they comply to the standards set by the accreditation bodies.
- Apart from this, Medical record audits aid in improving the validity of clinical audits. For clinical audit results to be authentic, data has to be there. But if data itself is absent, outcome of the clinical audit cannot be authenticated. Hence auditing the medical records for availability of data can point out the deficiencies there by the aiding in solving the issue and ultimately increasing the validity of clinical audits.

Considering all these reasons, the current study has been undertaken.

## LITERATURE REVIEW:

"Information is an important resource for effective and efficient delivery of health care. Provision of health care and its continued improvement is dependent to a large extent on the information, generated , stored and utilized appropriately by the organizations"- NABH 3rd Edition.

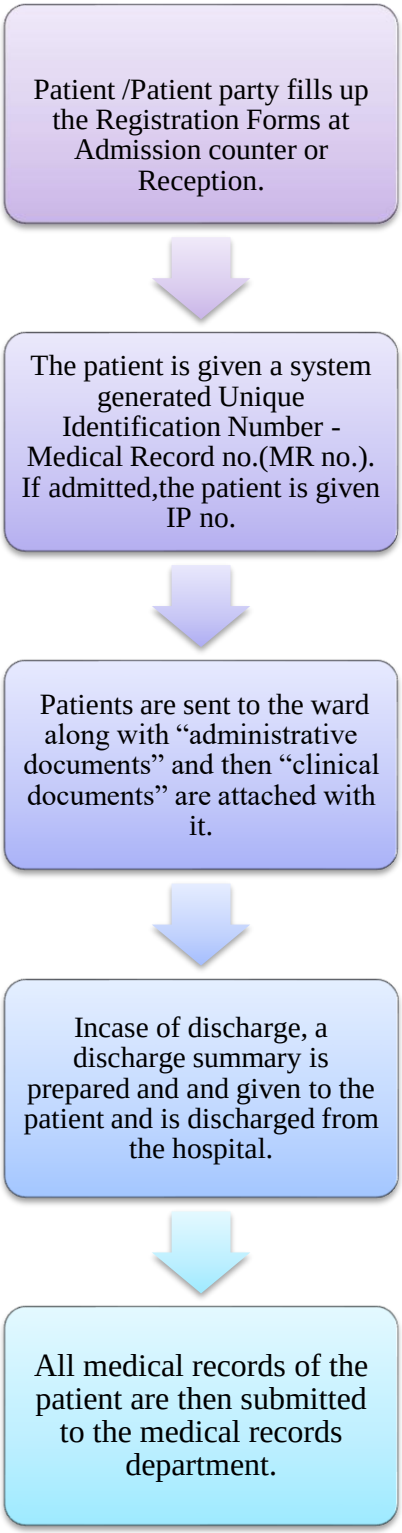
A medical record audit is best for assessing patient care measures. Medical Records audit can initiate a quality improvement cycle (Plan, Do, Study, Act) , as suggested by *Shewart* over 60 years ago. By doing a Medical Record audit health care providers have to "own" their patient care. They cannot blame data collection for deficiencies. In some studies, results of audits have shown that the completeness of documentation affects validity of audit. This shows that clinical audit depends on the completeness of the documents. Hence the study is conducted to check the completeness of the documents.

A book on "Practical Guide to the Evaluation of Clinical Competence" has been authored by Eric S. Holmboe, MD. 5th chapter in this book talks about different aspects of medical records audit, one of which is learning and evaluating by doing. This points out the importance of self-

audit by the care providers. Inputs of the current study has also been taken from a journal "An Approach to Records Management Audit" written by Dr. Allister Farell. This journal explains about every detail of records auditing like- Planning and preparing an audit, establishing an audit program, Scope of the audit, selecting the samples, etc.

In the year 2001, a study on "Auditing Nurse Content in Patient Records" was conducted by Ehrenberg A, Ehnfors M, Smedby B in Department of Public Health and Caring Sciences, Sweden. This study emphasizes that audits of patient records were performed using four different approaches with varying aims- Formal Structure, Process comprehensiveness, Knowledge-based, and Concordance with actual Care. The current study uses formal structure as well as concordance with actual care approaches.

**Process flow of Medical Records in The Mission Hospital** *(figure 1)*



The most basic rules governing access to a medical record dictate that only the patient and the health care providers directly involved in delivering care have the right to view the record. The patient, however, may grant consent for any person or entity to evaluate the record.

The Medical Record File should have various Documents:

1. Complete identification and demographic data
2. Medical History
3. Nurses Admission Assessment
4. Informed Consent to the extent required by Hospital Policy(routine and special both)
5. Progress Notes (including routine and specialized)
6. Reports of multiple investigation
7. Record of Medical treatments advised
8. Details of procedures and operations done
9. Anesthesia Record
10. Nurses Notes
11. Discharge Summary

*1) Identification and demographic data:*

The data which is entered immediately at the first contact with the patient which remains unaltered like name, age, address, telephone number etc

*2) History and physical examination:*

This includes chief complaints, history of present sickness with duration, past history including duration, social and family history, systems review, current medications and dosages, known allergies, physical examination and provisional diagnosis

**Under the NABH standard CQI3h**, The indicator states that - History form should have plan of care written and signed by the consultant within 24hrs which should include curative, preventive, rehabilitative care. The indicator shall be captured during the stay of the patient and not from the medical record department. It shall be collected on a monthly basis. The

sampling base shall be patients who have completed 24 hours of stay in the hospital and immediate corrections should be initiated, when gaps are seen on a real time basis.

3) *Nurses Admission Assessment:*

This includes the physical examination of the patient for its vitals by the nursing staff, after the patient gets admitted in the hospital.

4) *Informed consent:*

- Prior to admission for inpatient treatment – General Consent Form
- Before any invasive or surgical procedure - Consent for Anaesthesia, Consent for procedure and treatment, Consent for Bone Marrow Examination, Consent for Serology Testing, Consent for Mechanical Ventilator and procedure in intensive care unit, ERCP Consent, Endoscopy Consent.
- In case of discharge against medical advice – DORB Consent Form

5) *Progress notes:*

Progress of the patient should be daily documented by the consultants and junior medical staff.

The doctors have separate specimen signature in which they should print their names and Signature along with date and time at least once to be easily identifiable. In case of death, the events preceding the death, date and time of death, and signature and name of physician who pronounces the death have to be documented.

6) *Report of Investigations:*

Duplicate copies of patients reports or summary of all reports from Lab, Radiology (CT,MRI, X-Ray), Cardiac Lab, Neurophysiology lab and Pulmonary function lab shall be filed on the left side inside the file.

7) *Record of Medical Treatment:*

Physician orders shall be legible, dated, time and signed by ordering physician. Verbal or Telephonic orders must be entered on the chart and authenticated within 24 hours of giving them. The drug administration chart will be maintained and authenticated by administrating nurse.

8) *Details of operations and procedure:*

Immediately after surgery or any invasive procedure the treating consultant or the Junior \Medical staff shall write operative notes on the prescribed form " OPERATIVE NOTES" which shall contain preoperative diagnosis , a description of the findings, the technical procedures used, the specimens removed, the post operative diagnosis and other columns and shall be authenticated by the operating consultant.

9) *Anesthesia Record:*

The anesthesiologist must record and authenticate a pre procedure and post anesthesia recovery room notes in the patients health record.

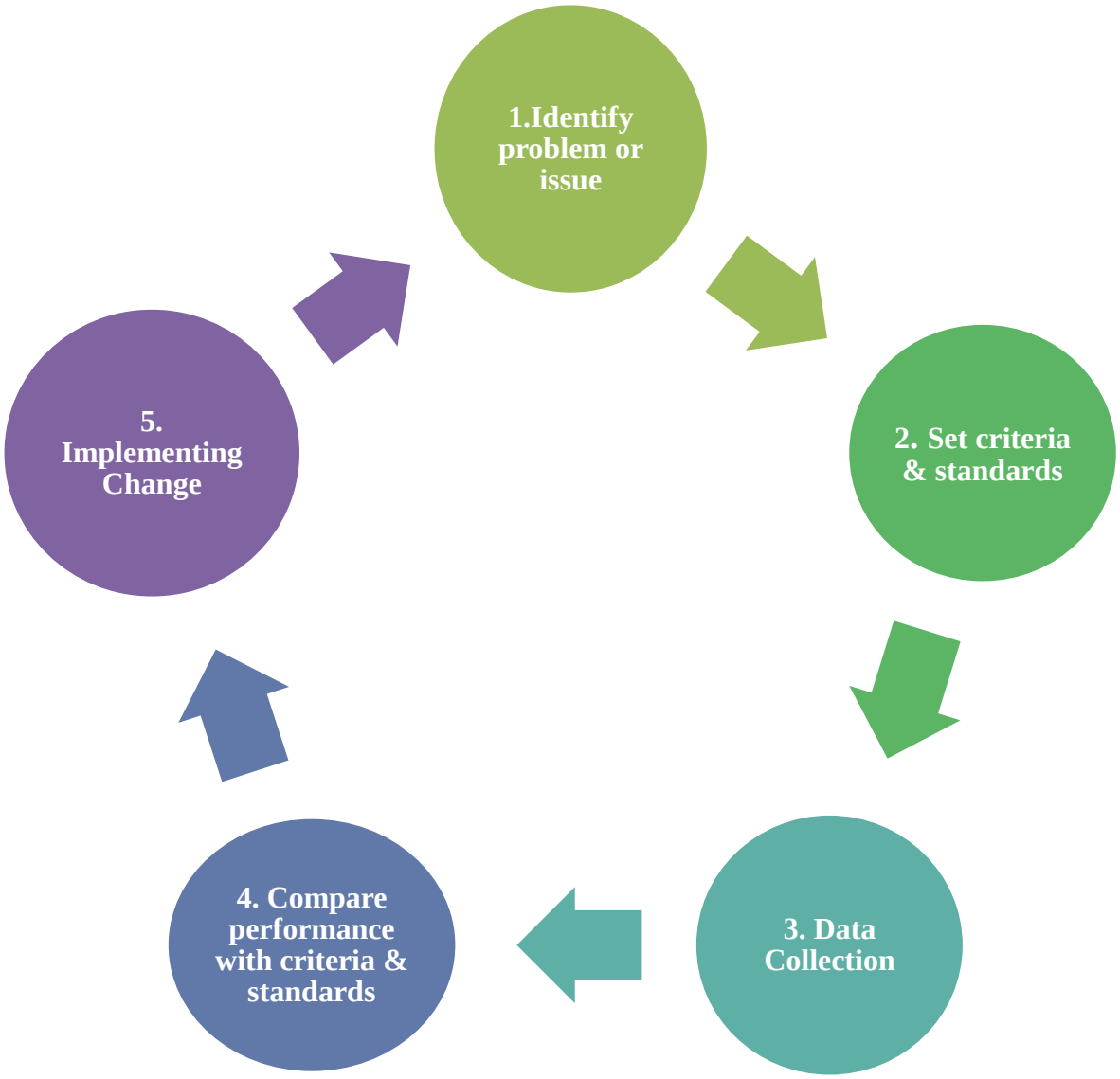
10) *Nursing Notes:*

In case of inpatients, relevant nursing notes in prescribed formats shall be legibility and promptly written and signed

12) *Discharge Summary:*

In case of discharge of inpatient patients, the JMS shall write or dictate a concise narrative summary on prescribed form which includes Final and associate diagnosis, Chief complaint and history with duration, Pertinent physical findings, Pertinent investigation data, Course in hospital, Operative diagnosis and date, Complications, Condition at the time of discharge, Treatment and Advice. The discharging physician shall record the condition of the patient on discharge as well as treatment advised and specific instruction to the patient.

**Steps of Audit** *(figure 2)*



1. **Identify the problem:** In the current study, the Problem area is the Medical Records. Audit has to be conducted to check whether they adhere to the NABH standards or not.
2. **Set criteria and standards:** NABH states that medical records have to be audited periodically and this should include active as well as inactive files. Pertaining to Medical Records it has given 7 indicators,

- Consent Forms.
- Discharge Summary.
- ICD coding.
- Nutritional Screening/ Nutritional Therapy Plan.
- Date Time and Consultant's Signature along on Progress notes.
- Missing Records.
- Nursing Care Plan

Out of these indicators, ICD coding is not done in the hospital as there is no personnel with ICD coding experience. Hence this indicator is not applicable in the current study. This has been replaced by Nursing Admission Assessment as this depicts the initial care provided to the patient by the nurse, and the management wanted to know the level of compliance for this.

3. **Data collection:** Data was collected through a Checklist exclusively designed for the audit.
4. **Compare performance with criteria and standards:** The data was collected and analyzed as per the set criteria and standards. NABH has not given a bench mark as to how minimal the indicators can be.
5. **Implementing change:** After the February month's data was collected, the indicators were found to have scope for improvement. Hence interventions were suggested to improve them and implemented. Desirable trend was observed.

## GENERAL OBJECTIVE

To Identify the Gaps / compliance of IPD medical records in The Mission Hospital as per the NABH standards.

## SPECIFIC OBJECTIVES

1) To Check whether the following contents of medical record file are being filled in an appropriate manner,

- Consent Forms.
- Discharge Summary.
- Nursing Admission Assessment.
- Nutritional Screening/ Nutritional Therapy Plan.
- Date Time and Consultant's Signature along on Progress notes.
- Missing Records.
- Nursing Care Plan

2) To find out the regular problem areas in MRD file.
3) After completing the audit, to suggest some recommendations that will help the cause

CHAPTER 2

## METHODOLOGY

| | | | |
|---|---|---|---|
| **I** | **Study Period** | : | 8th February 2013 to 31st March 2013 |
| **II** | **Total Population Size** | : | 1940 |
| **III** | **Sample Size** | : | 551 files in IPD (273 files in February and 278 files in March) |
| **IV** | **Type Of Sampling** | : | Simple Random Sampling |
| **V** | **Confidence Level** | : | 95% |
| **VI** | **Confidence Interval** | : | 5% |
| **VII** | **Tools used** | : | Check List *(Annexure 1)* |
| **VIII** | **Data Source** | : | Primary data |

The study was conducted in a span of two months, i.e., from 8th February 2013 to 31st march 2013. The sample size was calculated using software templates based on standard statistics at a level of 95% and interval of 5%.

According to NABH standards, the medical records should be completed with all the details. A checklist was made including the details which are necessary in accordance with NABH guidelines. The data was collected with the help of this checklist.

Later the data was analyzed for the percentage of compliance of Medical Records to the NABH standards. February month's data was analyzed simultaneously and interventions were suggested and implemented for the month of March. Then the March month's data was analyzed and a trend analysis was done.

CHAPTER 3

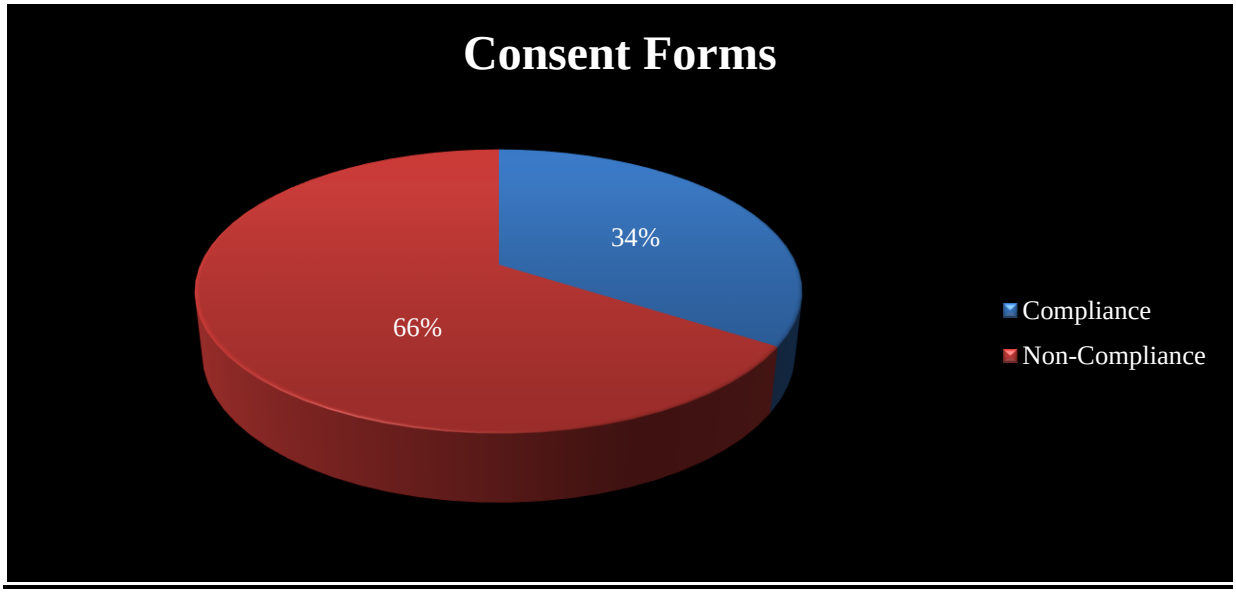
## RESULTS AND FINDINGS

### FEBRUARY *(Table 1)*

| Indicator | Compliant | Non-Compliant |
|---|---|---|
| Consent forms | 93 | 180 |
| Discharge Summary | 258 | 15 |
| Nursing Admission Assessment | 201 | 72 |
| Nutritional Screening/ Nutritional Therapy plan | 141 | 132 |
| Date Time and Consultant's Signature on Progress note | 267 | 6 |
| Nursing Care Plan | 216 | 57 |
| No.of Missing Records | 0 | |

**Consent forms:** *(Table 1.1)*

| TIME | COMPLIANCE | NON-COMOPLIANCE |
|---|---|---|
| **February** | **93** | **180** |



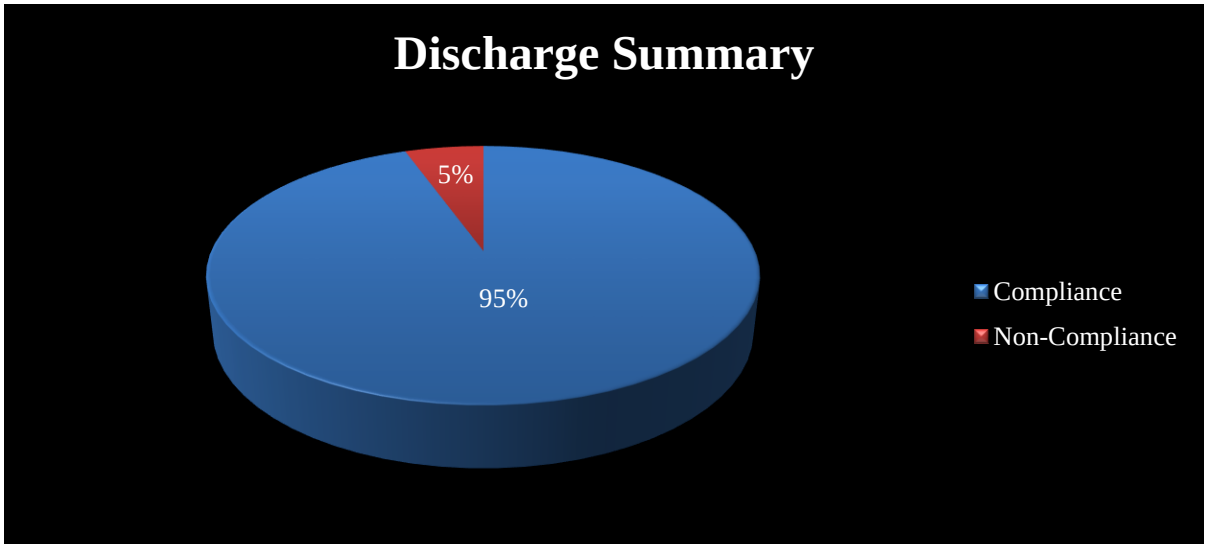

*(Figure 3)*

Out of 273 files audited in the month of February, 93 files had complete and proper consent forms. 180 files had either incomplete or improper consent forms.

This shows that only 34% of the files were compliant for Consent form.

**Discharge Summary:** *(Table 1.2)*

| TIME | COMPLIANCE | NON-COMOPLIANCE |
|---|---|---|
| **February** | **258** | **15** |




*(figure 4)*

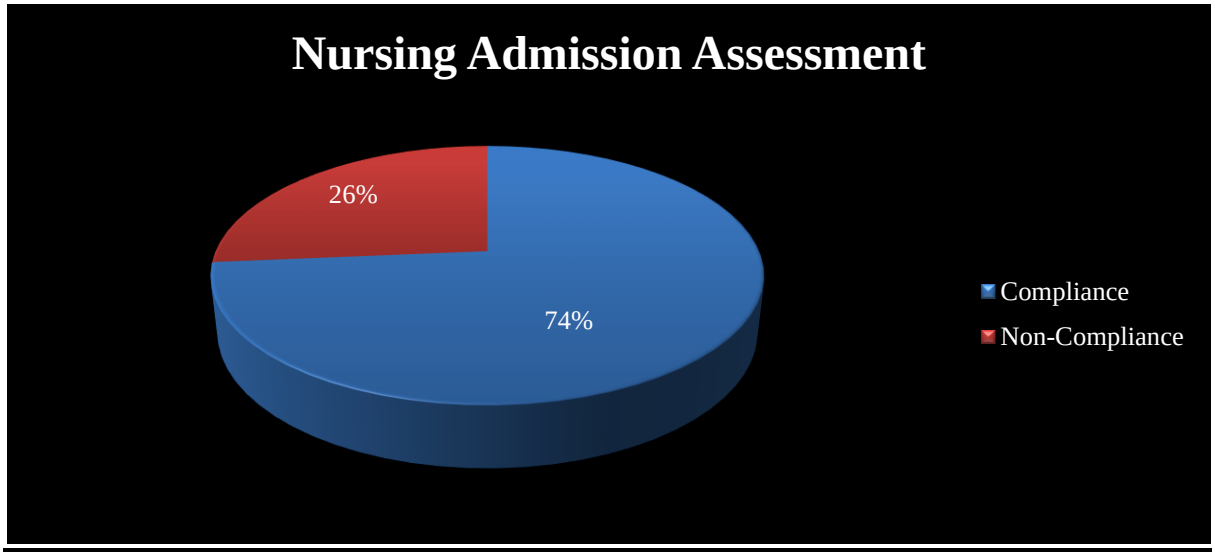
Out the selected sample size, 258 files had discharge summary. 15 files did not have the document.

This shows that the files were 95% compliant for discharge summary.

In The Mission Hospital, the discharge Summary is given only to patients who have normal discharge procedure. In rest of the cases, a hand written case summary is given.

**Nursing Admission Assessment:** *(Table 1.3)*

| TIME | COMPLIANCE | NON-COMOPLIANCE |
|---|---|---|
| **February** | **201** | **72** |



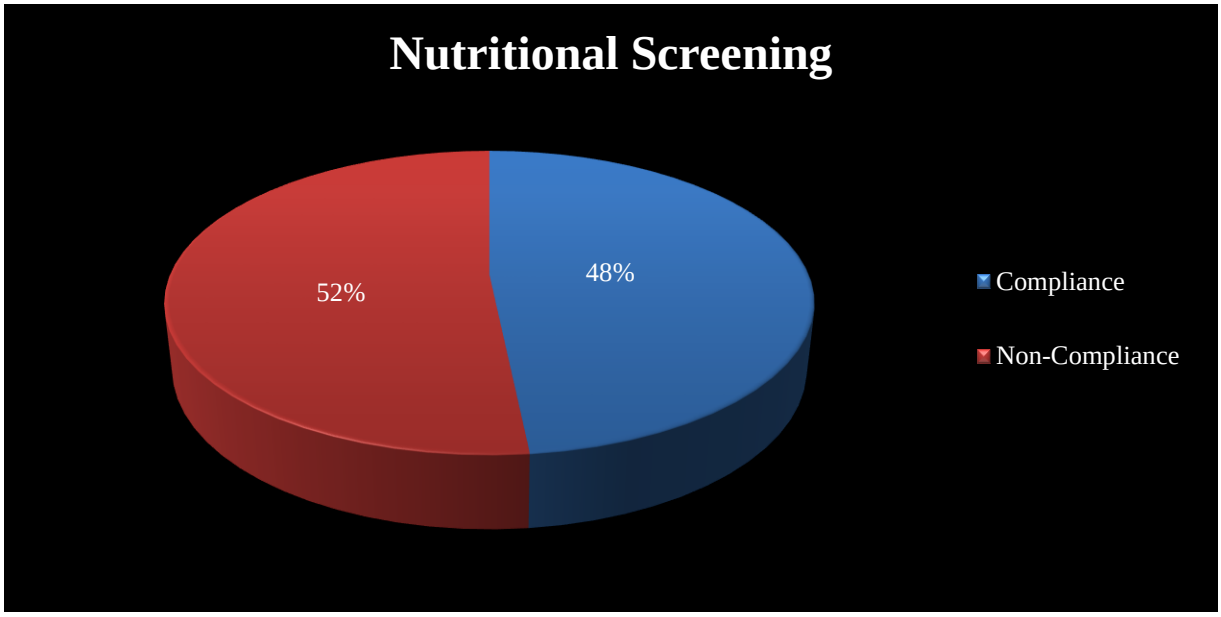

*(figure 5)*

In the month of February out of the selected 273 files, 201 files had completely filled and signed Nursing Admission Assessment forms. 72 files had incomplete Nursing Admission Assessment forms.

It can be inferred from the data that files were 74% compliant for Nursing Admission Assessment.

**Nutritional Screening/ Nutritional Therapy Plan:** *(Table 1.4)*

| TIME | COMPLIANCE | NON-COMOPLIANCE |
|---|---|---|
| **February** | **132** | **141** |




*(figure 6)*

Out of the sample size, only 132 files had Nutritional Screening done for the patients. 141 files were found to be deficit of Nutritional Screening.

This shows that the files were only 48% compliant for Nutritional Screening.

**Date Time and Consultant's Signature on the Progress Note:** *(Table 1.5)*

| TIME | COMPLIANCE | NON-COMOPLIANCE |
|---|---|---|
| **February** | **267** | **6** |

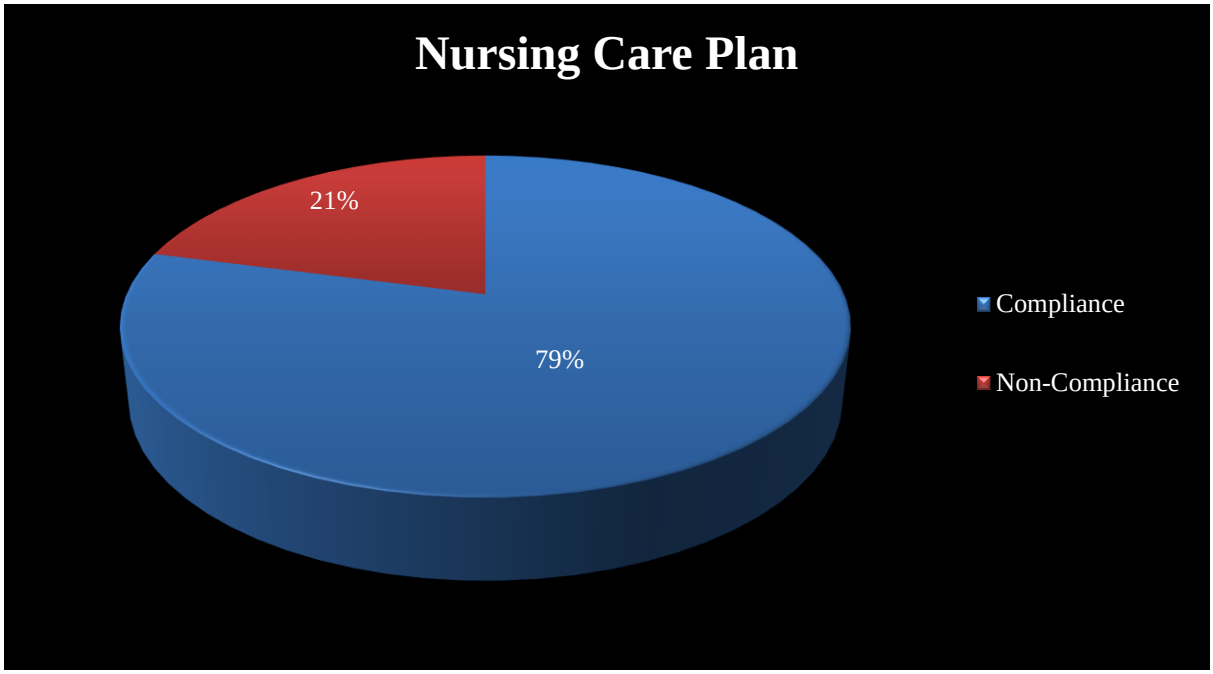

*(figure 7)*

Out of the selected 273 files, 267 files had progress notes countersigned by the consultant along with date and time. Only 6 files did not comply with it.

It can be derived from the data that the files were 98% compliant for Consultant's signature on progress notes (care plan) along with date and time.

**Nursing Care Plan:** *(Table 1.6)*

| TIME | COMPLIANCE | NON-COMOPLIANCE |
|---|---|---|
| **February** | **216** | **57** |

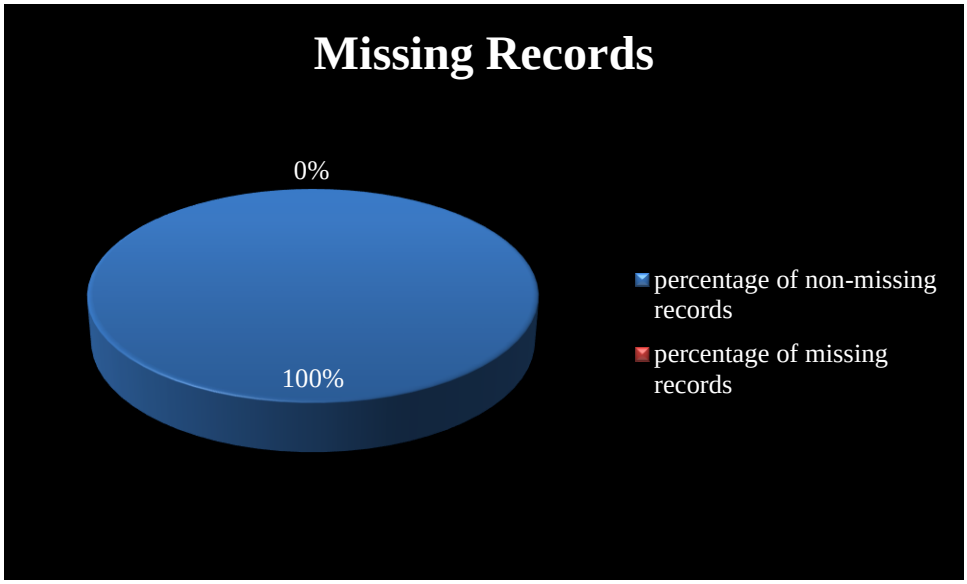



*(figure 8)*

Out of the sample size of 273, 216 files had properly filled in nursing care plan and signed by the concerned nurse. 21 files had incomplete nursing care plans.

This shows that the nursing care plan compliance percentage is 79%.

**Missing records:**




*(figure 9)*

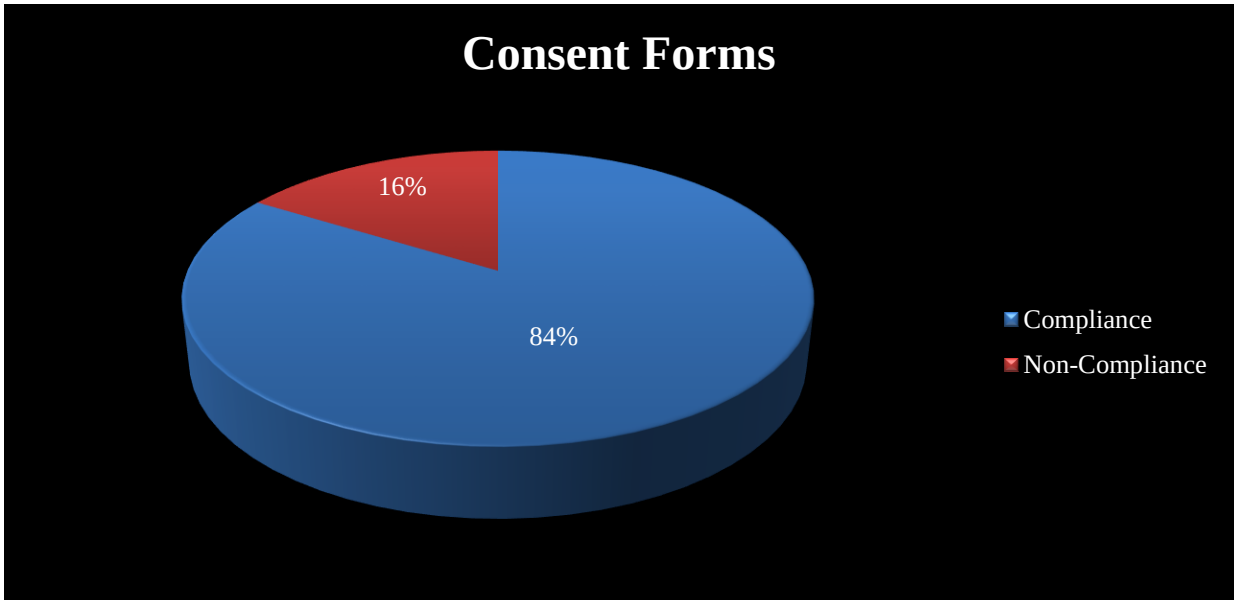
Total no. of missing records for the month of February was found to be zero. So the percentage of missing records would be 0% of the sample size.

**MARCH** *(Table 2)*

| **Indicator** | **Compliant** | **Non-Compliant** |
|---|---|---|
| Consent forms | 233 | 45 |
| Discharge Summary | 251 | 27 |
| Nursing Admission Assessment | 245 | 33 |
| Nutritional Screening/ Nutritional Therapy plan | 230 | 48 |
| Date Time and Consultant's Signature on Progress note | 272 | 6 |
| Nursing Care Plan | 266 | 12 |
| No. of Missing Records | 0 | |

**Consent form:** *(Table 2.1)*

| TIME | COMPLIANCE | NON-COMPLIANCE |
|---|---|---|
| **March** | **233** | **45** |



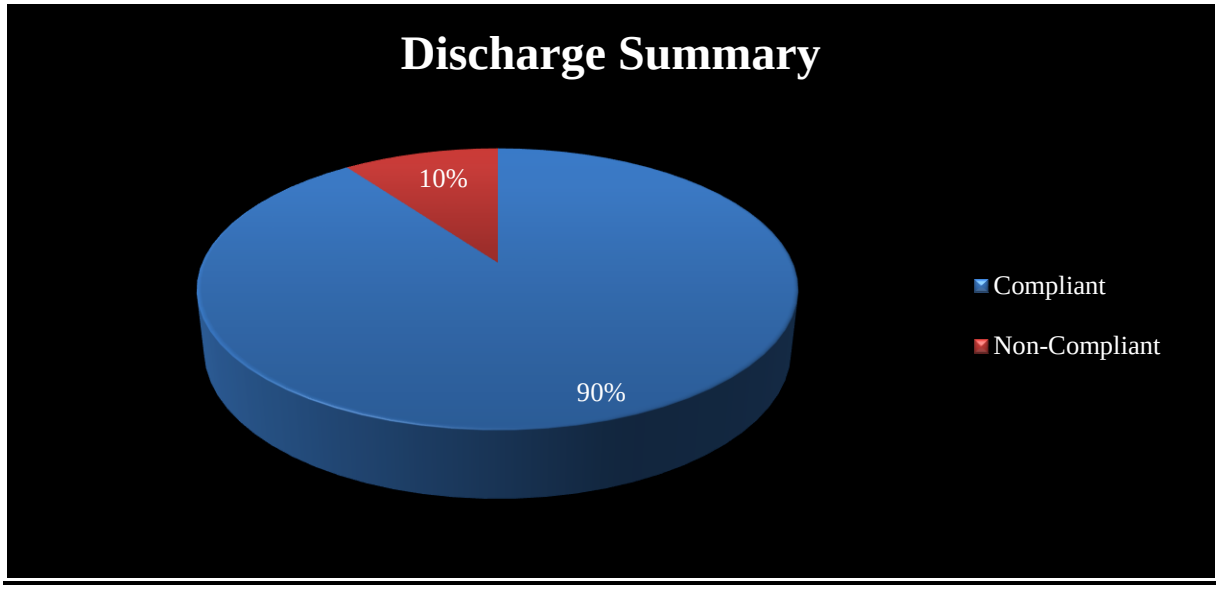

*(figure 10)*

Out of the selected sample size of 278, 233 files had all the required consent forms duly filled and signed by the concerned authorities. 45 files had improper or incomplete consent forms.

This shows that compliance level for Consent Form is 84%.

**Discharge Summary:** *(Table 2.2)*

| TIME | COMPLIANCE | NON-COMOPLIANCE |
|---|---|---|
| **March** | **251** | **27** |



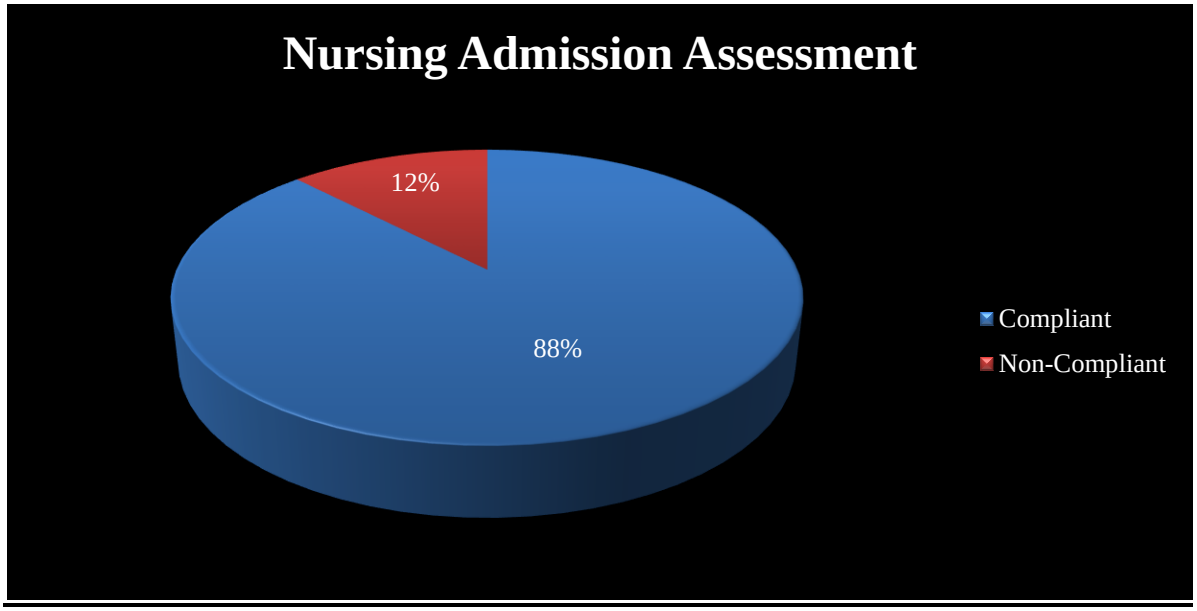

*(figure 11)*

Out of the 278 sample size, 251 files did not have the discharge summary. 27 files do not have the discharge summary, as they were LAMA cases.

Hence percentage of compliance for discharge summary is 90%.

**Nursing Admission Assessment:** *(Table 2.3)*

| TIME | COMPLIANCE | NON-COMOPLIANCE |
|---|---|---|
| **March** | **245** | **33** |



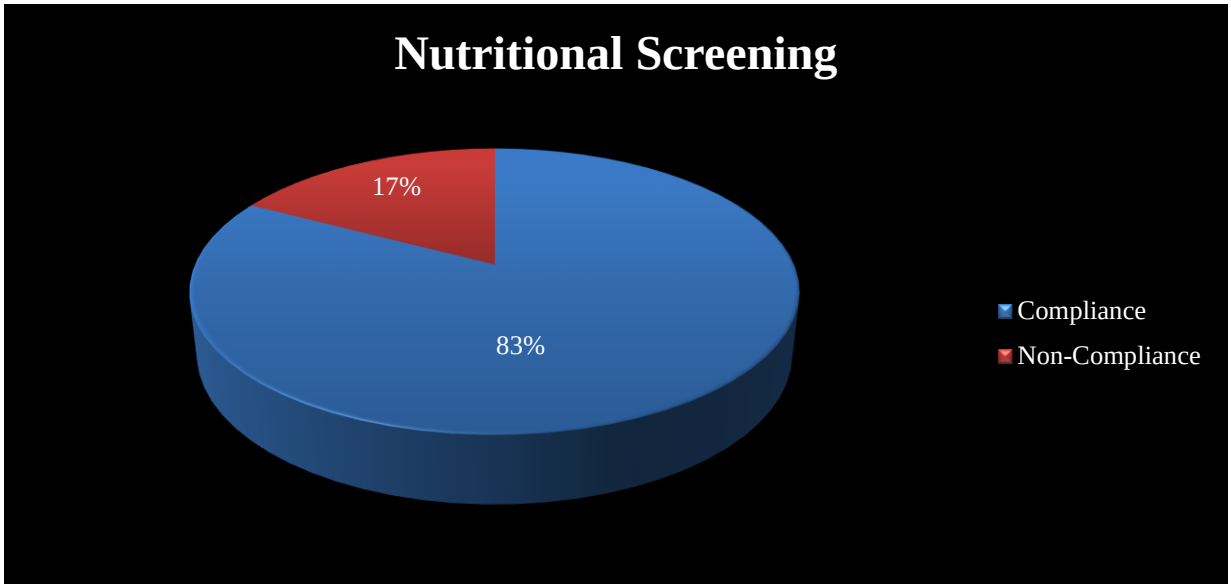

*(figure 12)*

Out of the selected sample size, 245 files had complete nursing admission assessment. 33 files had incomplete nursing admission assessment.

This shows that the compliance percentage for nursing admission assessment is 88%.

**Nutritional Screening/ Nutritional Therapy Plan:** *(Table 2.4)*

| TIME | COMPLIANCE | NON-COMOPLIANCE |
|---|---|---|
| **March** | **230** | **48** |



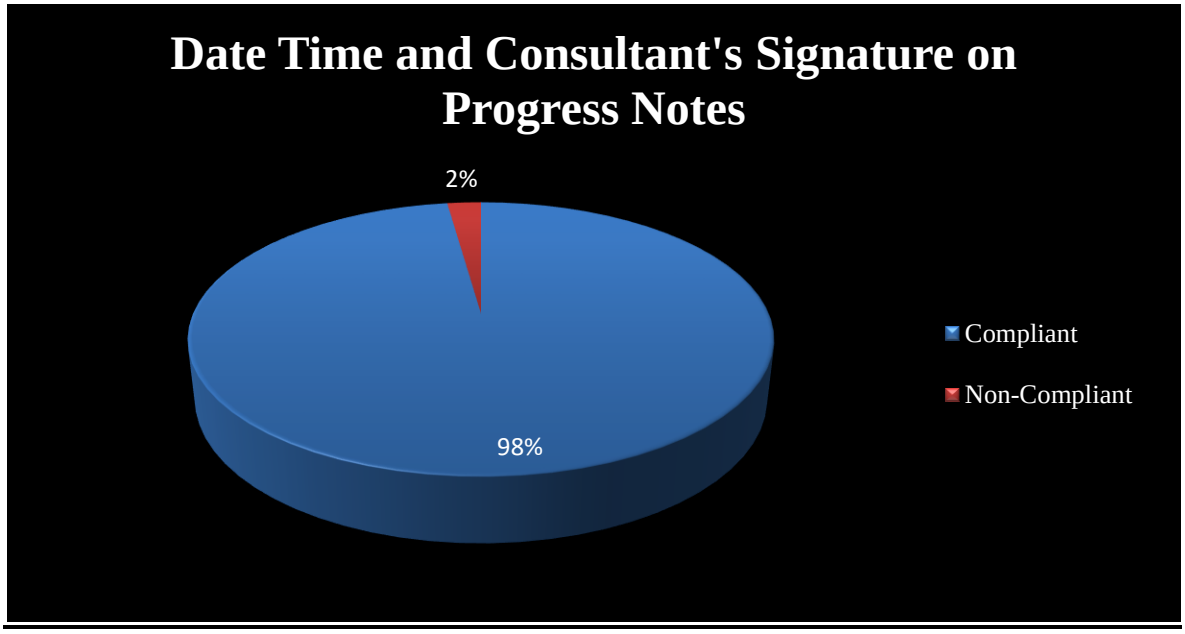

*(figure 13)*

Out of the 278 selected files, 230 files had Nutritional Screening done for the patients. 48 files didn't have nutritional screening done for the patients.

This depicts that the compliance percentage for Nutritional Screening is 83%.

**Date Time and Consultant's Signature on the Progress Notes:** *(Table 2.5)*

| TIME | COMPLIANCE | NON-COMOPLIANCE |
|---|---|---|
| March | 272 | 6 |



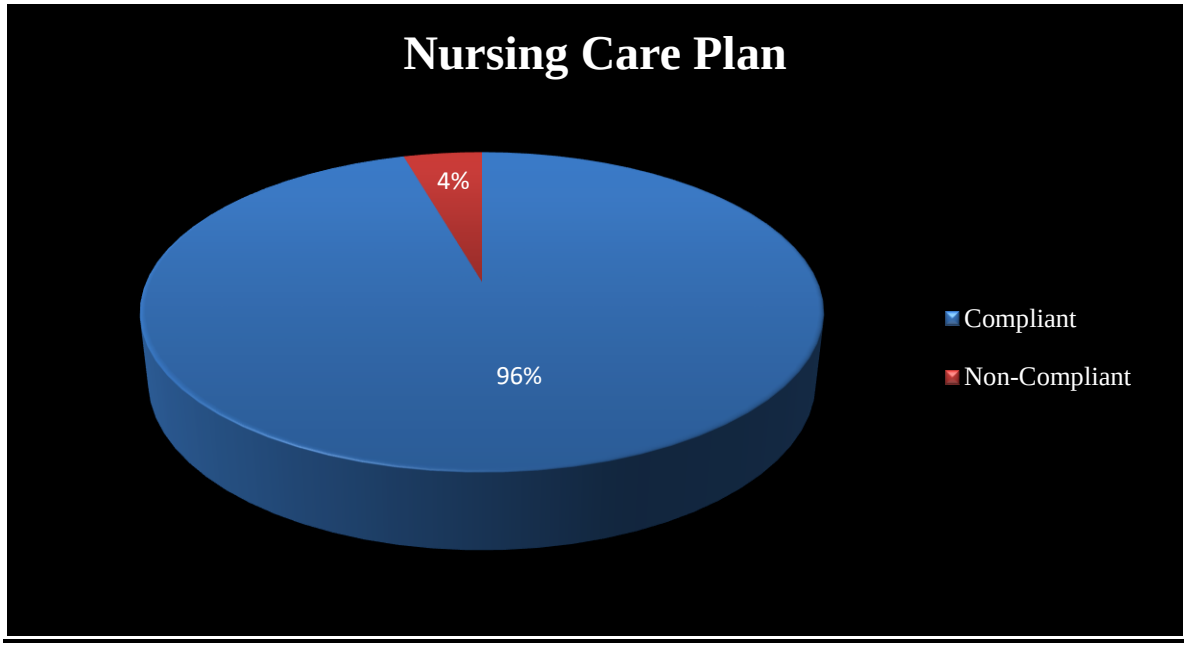

*(figure 14)*

Out of the selected sample size, 272 files had progress notes (care plan) counter signed along with date and time by the consultant. Only 6 files were found deficit of the same.

Thus the compliance percentage for Consultant's Signature on progress notes along with date and time was 98%.

**Nursing Care Plan:** *(Table 2.6)*

| TIME | COMPLIANCE | NON-COMOPLIANCE |
|---|---|---|
| **March** | **266** | **12** |




*(figure 15)*

Out of the selected 278 files, 266 files had complete nursing care plan duly filled and signed by the concerned nurse. Only 12 files had incomplete Nursing Care Plan.

This shows that the percentage of compliance for Nursing Care Plan is 96%.

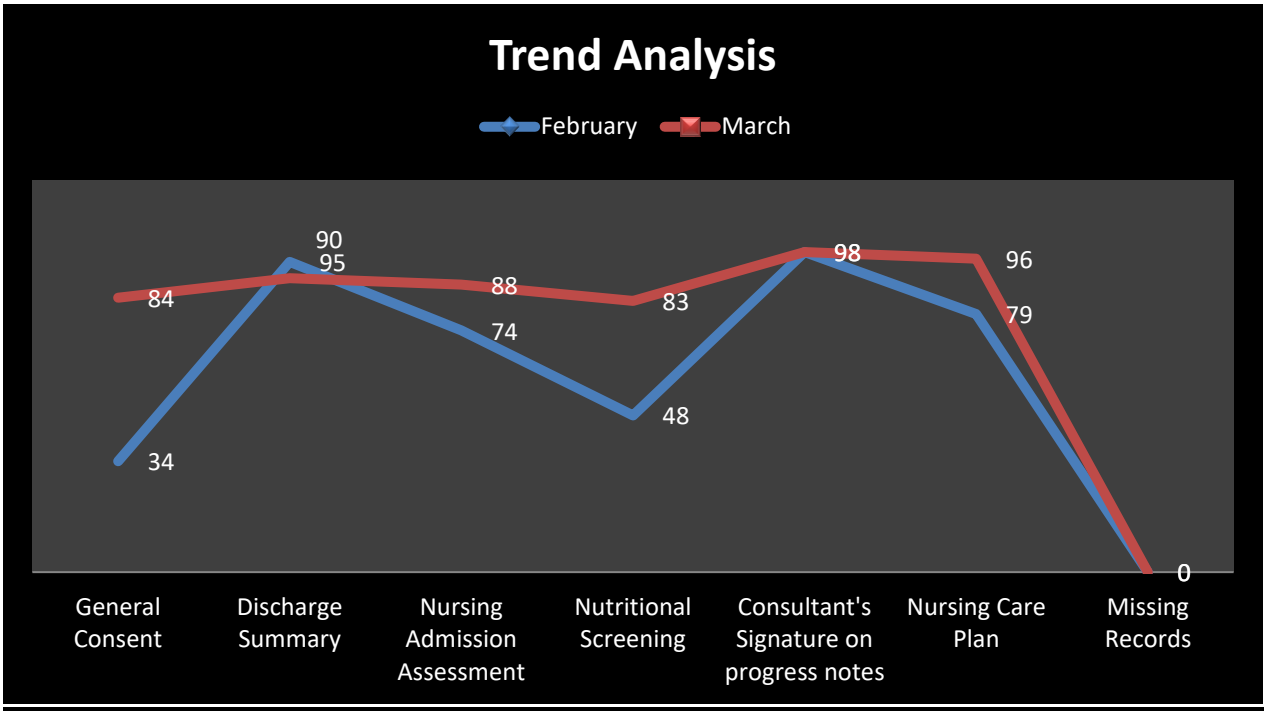
**Missing Records:**


*(figure 16)*

In the month of March, there was no incidence of missing record. Hence the percentage of missing records would be zero.

CHAPTER 4

**DISCUSSION**




*(figure 17)*

In the month of February, the total percentage of compliance for the month of February is 61.14%. This figure could be made better. Hence interventions were brought in to improve the indicators.

***Suggested Interventions:***

1) Training and motivation to the nursing staff to fill up their part, i.e., Nursing Care Plan and Nursing Admission Assessment.
2) Inform the concerned doctors through Medical Superintendent about the issue.
3) Training session for the Floor Coordinators to see to it that all the documents in the file are filled up on a daily basis. For this purpose, Bright yellow color sticky notes were given to them, to indicate the missing part of Documentation. They were supposed to fill the following details on the slip- (Annexure 2)

- Date
- Document which is incomplete

- Missing Content.
- Responsibility

By these interventions issues like communication error and incomplete documents could be tackled.

These training sessions and implementations were done in coordination with Medical Superintendent, Nursing Superintendent and In-Charge of floor Coordinators.

Following the interventions, the overall percentage of compliance in the month of March has increased to 77%. Thus there is a significant increase of 15.86% in level of compliance to the NABH standards in filling up of the Medical Records.

CHAPTER 5

# CONCLUSION & RECOMMENDATIONS

The result shows that there has been a substantial improvement in the indicators pertaining to medical records, post interventions. Hence it could be inferred that the interventions yielded the desired results.

1. Frequent audits should be conducted on the floors for the completion of the records. At least weekly once the audits should be conducted and a person has to be made responsible for the job. After the audit is conducted, the nurse in-charge of particular ward/ floor coordinator should be informed about the deficiencies, besides the reminder slips.
2. System of Reminder slip can be used to address the issue of incompleteness of medical records. This slip contains the details of deficiencies in the particular medical record, thus highlighting the deficiencies, aids in resolving the issue.
3. Importance of Medical Records should be emphasized in the induction programs and instill the purpose in new recruits.
4. A reminder or information exchange session on the medical records completion can be kept in the CMEs of Doctors/organizations.
5. In each floor a nurse/Floor Coordinator could be made accountable for checking if the documentation is complete in each file of the floor. She/he becomes point of contact for the MRD executives in case of any deficiencies in the medical records. In this way communication between the MRD and the wards could be streamlined and the system becomes even more efficient.

## REFERENCE


- Eric s Holmboe, MD**: Practice Audit, Medical Record Review, and Chart-Stimulated Recall, 2007.**

- Dr. Allister Farell**: An Approach to Records Management Audit.**

- Ehrenberg A, Ehnfors M, Smedby B**: Auditing Nurse Content in Patient Records,** Department of Public Health and Caring Sciences, Sweden.

- Sample Size calculation from; http://www.surveysystem.com

**ANNEXURE**

## MRD ASSESSMENT CHECKLIST (Annexure 1)

| Date of Admission | Area | IP NO | Improper /Incomplete Consent with details | Discharge Summary | Nursing admission assessment | Nutritional Screening/ Nutritional Therapy Plan | Care plan countersigned by Consultant within 24hrs | Nursing Care Plan | Missing Records |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

**REMINDER SLIP** **(ANNERXURE 2)**

| | |
|---|---|
| Date | |
| Incomplete Documents | |
| Missing Content | |
| Responsibility | |