Internship Training at B.L.Kapoor Hospital

BY

Dr. Nitika Chahal

PGDHM
2012-2014

International Institute of Health Management Research

Internship Training

At

B.L.Kapoor Hospital

Study on adherence of medical record documentation as per NABH Standards in BLK Super Specialty Hospital, Pusa Road

By

Dr Nitika Chahal

Under the guidance of

Ms. Anupma Sharma

Post Graduate Diploma in Hospital and Health Management
2012-2014
International Institute of Health Management Research
New Delhi

BLK
Super Speciality Hospital

Radiant Life Care
Private Limited

Ref: - BLK/HR/2014/APR/ 353

Dated: 30.04.2014

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr. Nitika has completed her Internship w.e.f . 15th Feb. 2014 to 30th Apr., 2014 in the department of **Quality.**

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

We wish her all the best for her future.

For Dr. B.L. Kapur Memorial Hospital

Rupinder

Rupinder Kaur
Head-Learning & Development

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TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Nitika Chahal** 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 **B.L.Kapoor Hospital** from **15th February,2014** to **30th April,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.

12/5/14

Dean, Academics and Student Affairs

IIHMR, New Delhi

Ms. Anupama Sharma

Name of mentor

IIHMR, New Delhi

Certificate Of Approval

The following dissertation titled **"TITLE OF YOUR PROJECT"** at **"YOUR ORGANIZATION** 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. S. R. CHAUHAN	8.5.14
Dr A. K. KHOKHAR	
Dr. B. S. Singh.	

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Nitika Chahal,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled "**Study on adherence of medical record documentation as per NABH standards in B.L.K. Super Specialty Hospital**" 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.

Ms Anupama Sharma

Assistant professor,

IIHMR, New Delhi

Dr. Ajay Singh

Assistant Manager (Quality)

B.L.K. Super Specialty Hospital

CERTIFICATE OF APPROVAL

The following dissertation report titled "**Study on Adherence of Medical Records documentation in accordance with the NABH standards in BLK Super Specialty Hospital,, Pusa Road**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory. It is understood by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation project report only for the purpose it is submitted.

Sign:

Ms. Anupama Sharma

(Mentor)

Submitted by:

Dr. Nitika Chahal

DATE: 6/5/14

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation title **"Study on Adherence of Medical Records documentation in accordance with the NABH standards in BLK Super Specialty Hospital,, Pusa Road"** and submitted by **Dr. Nitika Chahal** Enrollment No.**PG/12/057** under the supervision of **Ms. Anupma Sharma** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from **15th February, 2014** to **30th April , 2014** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Signature

5

FEEDBACK FORM

Name of the Student: Dr. Nitika Chahal

Dissertation Organisation: BLK Super Speciality Hospital

Area of Dissertation:
Continuous Quality improvement.

Attendance: 88%.

Objectives achieved:
- Completion of assigned work on daily basis.
- Submission of compiled & analysed report on dissertation within defined time frame.

Deliverables:
- Audit tool kit for the medical records
- Analysis of pt. feedback data & its presentation.
- Continuous follow up of any untoward incident for RCA & CAPA

Strengths:
- Target oriented.
- learner

Suggestions for Improvement:
- A little more concentration and time devotion towards basic components of task assigned.

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

Date: 30/4/14.
Place: BLK Hospital, Pusa Road.

ORDER OF CONTENTS

ABSTRACT

Background: 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 become 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.

Objective: "To identify the Gaps/compliance in medical record documentation of patients at BLK Super Specialty Hospital".

Method: The Retrospective audit of 200 patient files was conducted in the medical record department of BLK Super Specialty Hospital from 1st March 2014 to 31st March 2014. The sample was randomly selected and subjected to audit. The parameters were marked as FC (Fully complete), PC (Partial complete), NC (Not complete), NA (Not Applicable) according to the documents completeness and analyzed after the completion of audit.

Result: The study at hospital showed that there was 58% of parameters were fully complete in the surgery records sheet , anaesthesia record sheet, nursing records, consent forms etc. having almost met the standards set by NABH. There was deficiency noted in general consent form(12%), valuable form(22%), nutritional assessment(93%), Nurses notes(16%), drug char(77%)t, estimate of expense sheet(34%) and Signature of doctor's and consultant in initial assessment sheet, emergency sheet, doctors progress notes and drug charts.

Conclusion: 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 and decreasing deficiencies in documentation, thereby improving quality of care.

ACKNOWLEDGEMENT

It is my esteemed pleasure to present the dissertation report on "**Study on Adherence of Medical Records in accordance with the NABH standards**" in the organization. I would like to extend my sincere thanks to all of them in the organization who helped me out with this project.

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

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

I would also like to express my gratitude towards **Ms. Anupma Sharma (Mentor, IIHMR)** for her kind co-operation and encouragement at each step, which helped me in completion of this project.

List of Figures

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List of Symbol And Abbreviations

ABBREVIATIONS	FULL FORM
BAER	Burn Area Emergency Rehabilitation
BERA	Brain stem evoked response audiometery
BMT	Bone marrow transplant
BMW	Bio medical waste
CAPA	Corrective and preventive action
CT	Computer tomography
CTVS	Cardio thoracic vascular surgery
ECG	Electrocardiogram
ECP	External counter pulsation
EEG	Electroencephalogram
EMG	Electromyogram
EM	Emergency medicine
F&B	Food & beverage
FC	Fully complete
HIS	Hospital information system
HR	Human resources
ICU	Intensive care unit
ICCU	Intensive coronary care unit
IT	Information technology
IVF	In vitro fertilization
IPD	In patient department

JCI	Joint commission international
LAMA	Leave against medical advice
MRD	Medical record department
MRI	Magnetic resonance imaging
MICU	Medical intensive care unit
NABH	Nation accreditation board of hospital
NCS	Nerve conduction studies
NCV	Nerve conduction velocity test
NC	Not complete
NA	Not applicable
NCB	Needle core biopsy
OPD	Outpatient department
PC	Partial complete
PFT	Pulmonary function test
RMST	Rehabilitation medicine scientist testing
RCA	Root cause analysis
SSEP	Somatosensory evoked potential
TMT	Treadmill test

INTERNSHIP REPORT

ORGANIZATION PROFILE

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

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

VISION

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

MISSION

• Achieve professional excellence in delivering quality care

• Push frontiers of care through research and education

• Adhere to national and global standards in healthcare

• Ensure care with integrity and ethics

• Provide quality healthcare to all sections of society

LOGO

A passion for healing…

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

LEGACY

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

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

HOSPITAL MANAGEMENT

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

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

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

INFRASTRUCTURE

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

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

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

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

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

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

AS PER OBSERVATION:

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

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

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

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

OPD 2: Ophthalmology

First floor –

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

OPD 4: Plastic Surgery, Reconstructive & Craniofacial Surgery

OPD5: Surgical Gastroenterology, Gastroenterology & Hepatology

OPD 6: Nephrology & Dialysis

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

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

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

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

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

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

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

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

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

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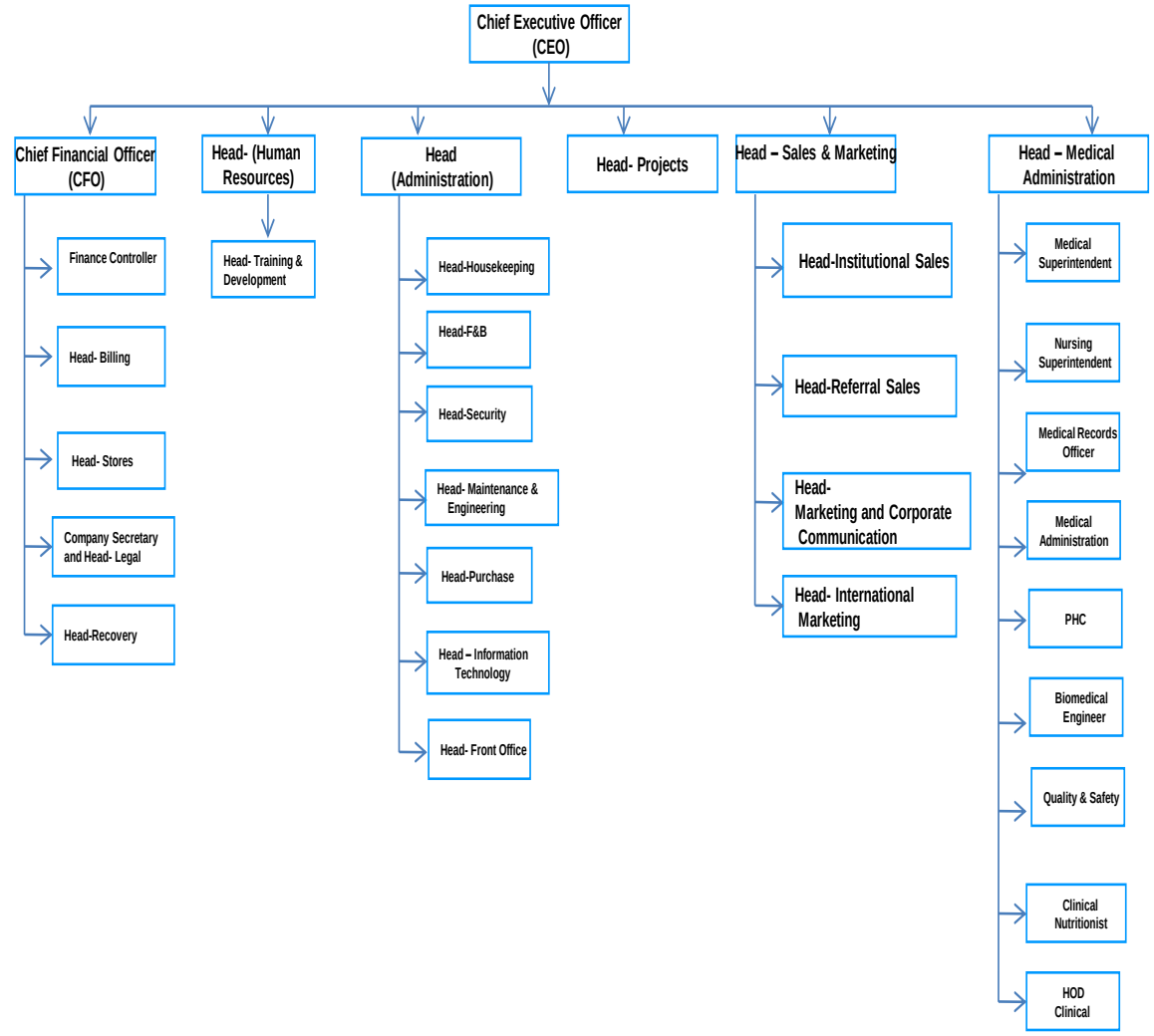
ORGANOGRAM
LANDSCAPE



SCOPE OF SERVICES

Centers of Excellence

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

Specialties

1. Anesthesiology
2. Ayurveda
3. Bariatric & Advanced Laparoscopic Surgery
4. Dental & Maxillofacial Surgery
5. Dermatology
6. Emergency & Acute Care Medicine
7. Endocrine & Breast Surgery
8. Endocrinology & Endocrine Surgery

9. ENT Surgery & Cochlear Implant
10. External Counter Pulsation
11. General & Minimal Access Surgery
12. Obstetrics & Gynecology
13. Internal Medicine
14. Interventional Radiology
15. Infertility & IVF Treatment
16. Neurology
17. Nuclear Medicine
18. Nutrition & Health
19. Ophthalmology
20. Pathology
21. Pediatric
22. Pediatric surgery
23. Physiotherapy & rehabilitation
24. Plastic & Cosmetic Surgery
25. Psychiatry
26. Respiratory Medicine, Allergy & Sleep Disorder
27. Rheumatology
28. Surgical Gastroenterology
29. Vascular & endovascular Surgery

JOB RESPONSIBILITIES

- Worked in Quality Department as an intern.
- To conduct concurrent and retrospective internal audit of patient files on routine basis as per requirements of NABH standards.
- To analyze the data collected from the audits at the end of the month.
- To assist Quality team Members in their routine work.
- To maintain the register of Incident form entry at appropriate interval and their follow up.
- To assist the peers in making reports.
- To prepare excel sheet of cases of bed sores and falls from September to March, 2014.

LEARNING POINTS

Being as an intern in Quality Department,

- I got an opportunity to learn the process of audit, how we should do it as per the standards of NABH
- What retrospective and concurrent audit means?
- Learned to apply standards of NABH in practical terms
- Learned how an incident form comes to the department and the procedure followed to get it completed.
- How to fill an incident form and what are the parameters which has to be filled as per the requirement of NABH (i.e. RCA, CAPA etc.)

DISSERTATION REPORT

INTRODUCTION

A Medical Record, Health Record or medical chart is a systematic documentation of patient's medical history and care OR the medical record is a clinical, scientific, administrative and legal document relating to patient care in which is recorded sufficient data written in sequence of events to justify the diagnosis and warrant the treatment and end results. The terms are used for both the physical folder that exists for each individual patient and for the body of information found therein.

Medical record is intensely personal document and there are many ethical and legal issues surrounding them such as third-party access and appropriate storage and disposal. The medical record includes a variety of types of "notes" entered over time by health care professionals, recording observations and administration of drugs and therapies, orders for the administration of drugs and therapies, test results, x-rays, reports, etc. The maintenance of complete and accurate medical records is a requirement of health care providers. The medical record serves as the central repository for planning patient care and documenting communication among patient and health care provider and professionals contributing to the patient's care. An increasing purpose of the medical record is to ensure documentation of compliance with institutional, professional or governmental regulation. In addition the individual medical record may serve as a document to educate medical students/resident physicians, to provide data for internal hospital auditing and quality assurance, and to provide data for medical research and development.

RATIONALE OF STUDY

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

REVIEW OF LITERATURE

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

Medical records form an essential part of a patient's present and future healthcare .As a written collection of information about a patient's health and treatment, they are used essentially for the present and continuing care of the patient[1]. In some studies it has also been shown that completeness of documents affects validity of audit.

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

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

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

A book on "Practical Guide to the evaluation of Clinical Competence" authored by Eric S. Holmboe, MD explained in chapter 5 (Practice Audit, Medical Record Review, and Chart-Stimulated Recall) about the different aspects of medical records audit and one of ehich is learning and evaluating by doing . means self assessment of audits[5.]

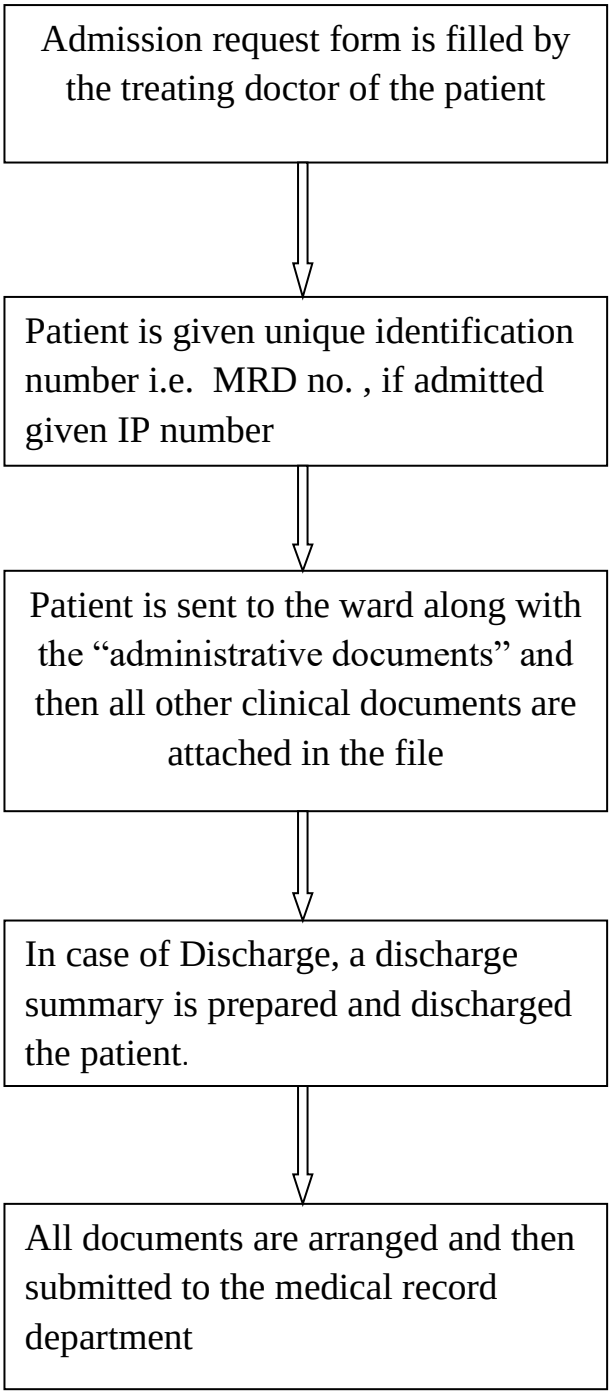
Mogli stated that evaluation of medical records is considered the essential process of quality assurance –the basis of those decisions, action and changes are made in order to guarantee superior performance in medical records department[6].

Input of current study is also taken from a journal "An approach to Records Management audit" written by Dr. Allister Farell. This journal explains about every details of recording audit like planning and preparing audit, role of an internal audit, compliance audit etc[7.]

A study was done by Ning Wang, David Hailey & Ping Yu on "Quality of nursing documentation and approaches to its evaluation: a mixed-method systematic review" which reports a review that identified and synthesized nursing documentation audit studies, with a focus on exploring audit approaches , identifying audit instruments and describing the quality status of nursing documenttion[8.]

FLOW OF MEDICAL RECORDS IN BLK HOSPITAL

Figure 1



Medical record file should have following documents:

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

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

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

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

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

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

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

g) **Operation Notes & surgery records** : Immediately after the surgery treating consultant shall write which consist of Preoperative diagnosis, description of Findings, procedure done and surgical check list, Postoperative plan with implant sticker in surgery records should be attached by nursing staff in file.

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

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

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

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

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

STEPS OF AUDIT

Stage 1: Identify the problem or issue

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

Stage 2: Define criteria & standards

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

Inclusion Criteria:

Inactive files only which will include

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

- Estimation of expenses

Exclusion Criteria

Active files were not included

Stage 3: Data collection

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

Stage 4: Compare performance with criteria and standards

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

Stage 5: Implementing change

Recommendation were suggested for the scope of improvement.

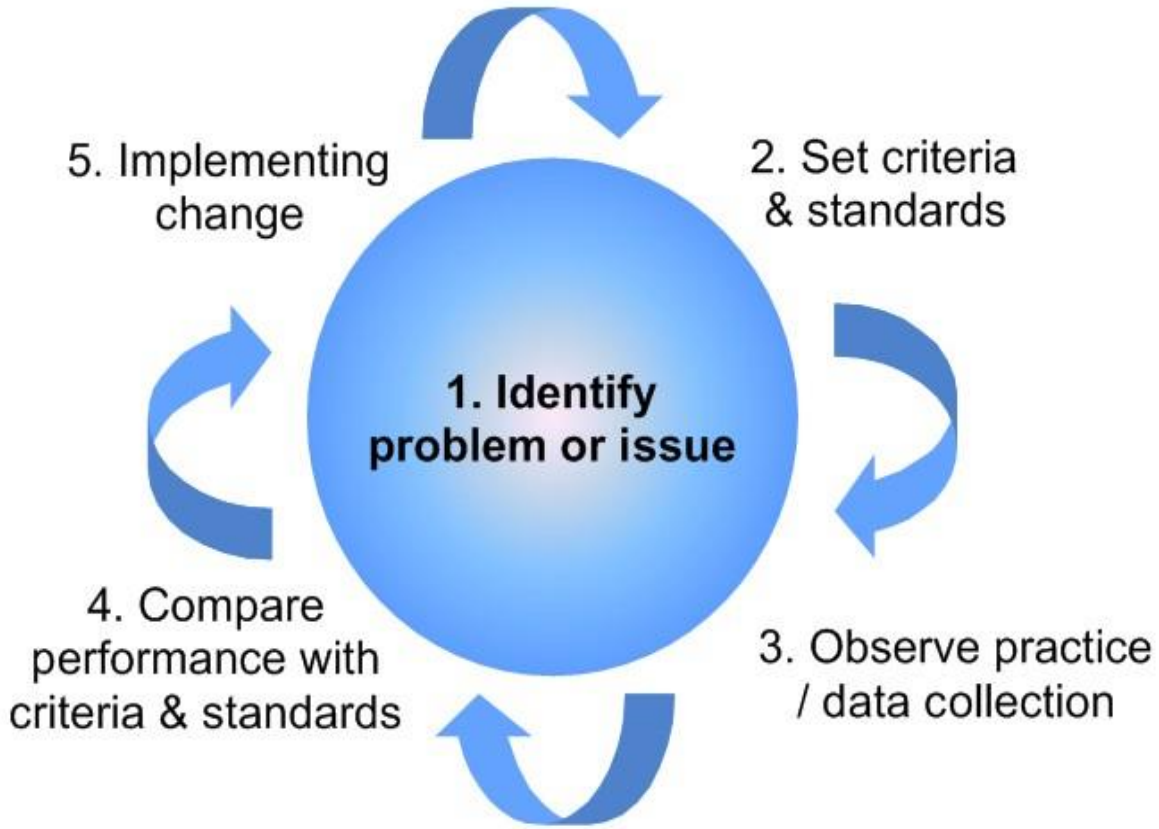


Figure 2

OBJECTIVE

General Objective

To identify the Gaps/compliance in medical record documentation of patients as per NABH standards in BLK Super Specialty Hospital".

Specific Objectives

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

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

2. To identify the problem areas in MRD files.
3. To provide recommendations for problem areas if required, thereby improving compliance of MRD files.

METHODOLOGY

- **Study design and area -** Study was conducted in BLK Super Speciality Hospital, Pusa Road. It was a descriptive cross sectional study in nature.
- **Sampling Method** – Simple random sampling method
- **Population size** - 417
- **Sample size** - 200 patients
- **Confidence lev**el – 95%
- **Confidence interval** – 5%
- **Time** - 1st March to 31st March 2014
- **Tool** - Checklist
- **Data source** – Primary Data
- **Technique** – Retrospective audit was conducted of MRD files with the help of a checklist. The data was collected and marked as FC (Fully complete) or PC (Partial complete) or NC (Not complete) or NA (Not applicable) in the checklist according to the completeness of parameters. Later the Data was analyzed for the percentage of compliance of MRD files as per the NABH standards and recommendations were given for the problem areas.

RESULT AND FINDINGS

Initial assessment: (Table – 1)

Initial Assessment /IPD case note	FC	PC	NC	NA
Chief complaints/Past history	191	2	7	0
Provisional diagnosis	162	0	38	0
Plan of care (with preventive, promotive curative and rehabilitative)	160	14	26	0
Date,time,sign & name of Doctor present	158	31	11	0
Consultant counter signed	153	12	34	0
Nutritional assessment	15	0	185	0
Nutritional, growth, psychosocial and immunization assessment (for paediatric pt.)	5	6	10	179

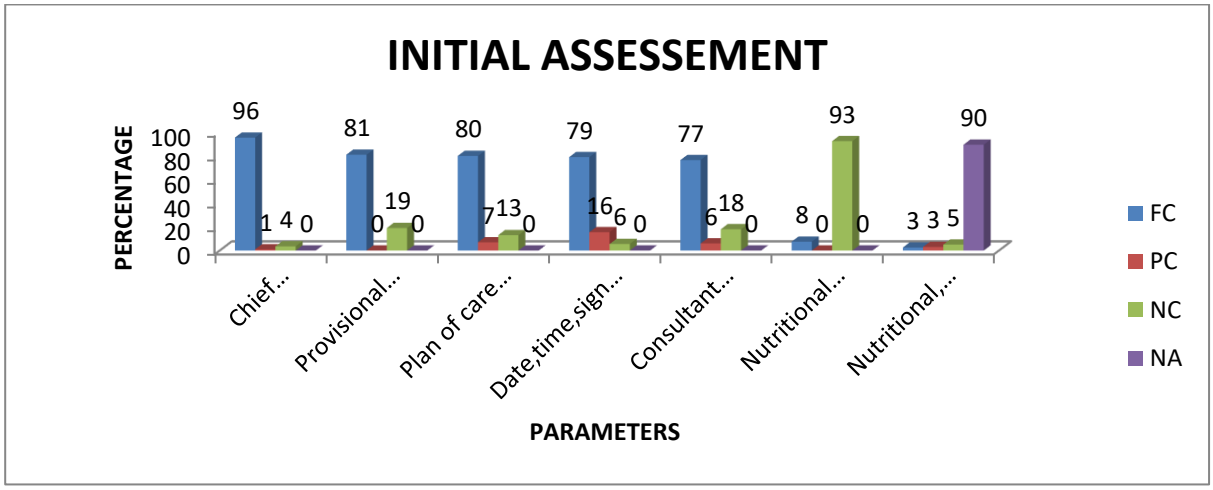


Figure 3

Interpretation:

- In initial assessment sheet, out of 200 files, 183 files didn't have nutritional assessment sheet, 34 files were not signed by consultants, 38 files didn't have provisional diagnosis in the sheet, and other documents were mostly completed. The percentage of compliance of each parameter is shown in Figure 3.

Emergency: (Table – 2)

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

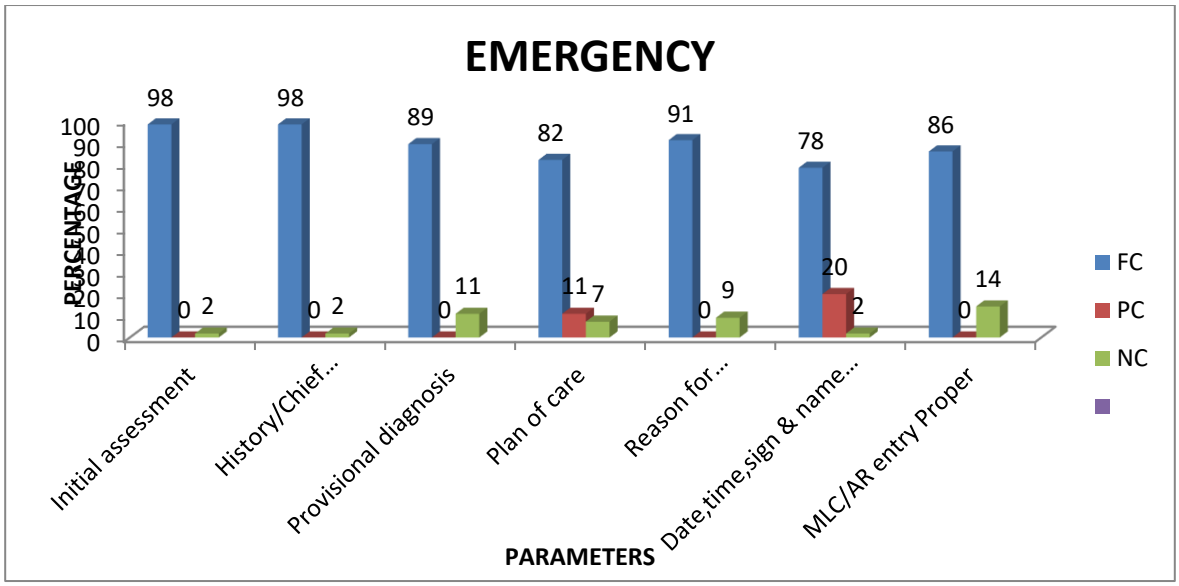


Figure - 4

Interpretation :

Out of 200 files only 55 files were of emergency and 7files of medico legal cases included in those 55. In emergency sheet, out of 55 files in 11 files the date, time and name of doctors were partially filled .In 6 files provisional diagnosis, 5 files specialty mentioned and in 4 files plan of care was not complete. The percentage of compliance is given Figure4 .

Doctor's Progress notes (Table – 3)

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

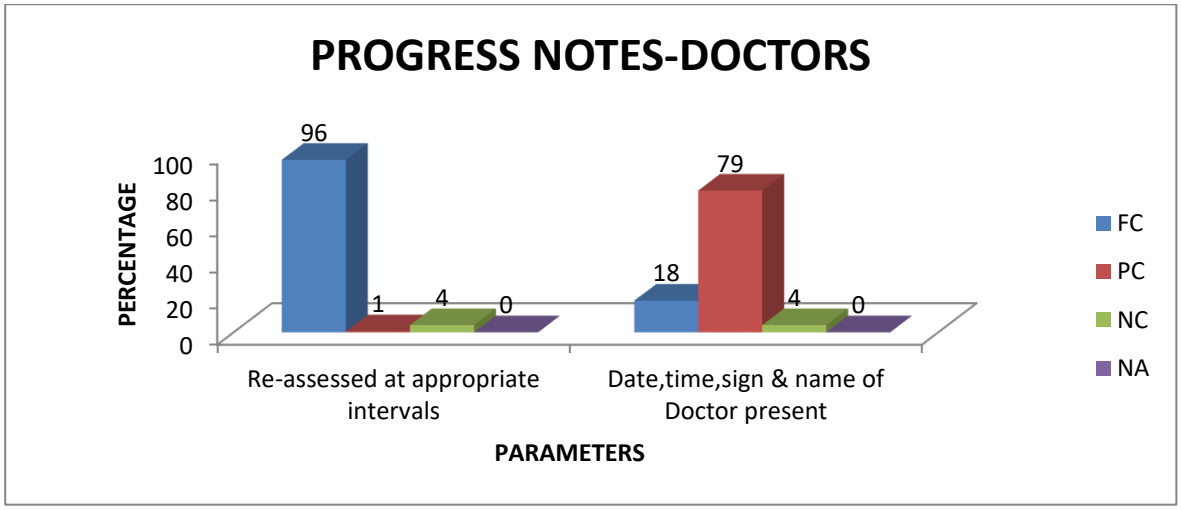


Figure - 5

Interpretation:

In doctor's progress notes sheet, out of 200 files, date, time, sign of doctor were partially completed in 155files but the reassessment were fully complete in 189 files. The percentage of compliance is shown in figure- 5.

Drug Chart (Table - -4)

Drug Chart	FC	PC	NC	NA
Medicine name in capital	41	154	5	0
Route, Dose and Frequency written	105	90	5	0
Abbreviations used	185	10	5	0
Signature with name, Date and Time	94	101	5	0

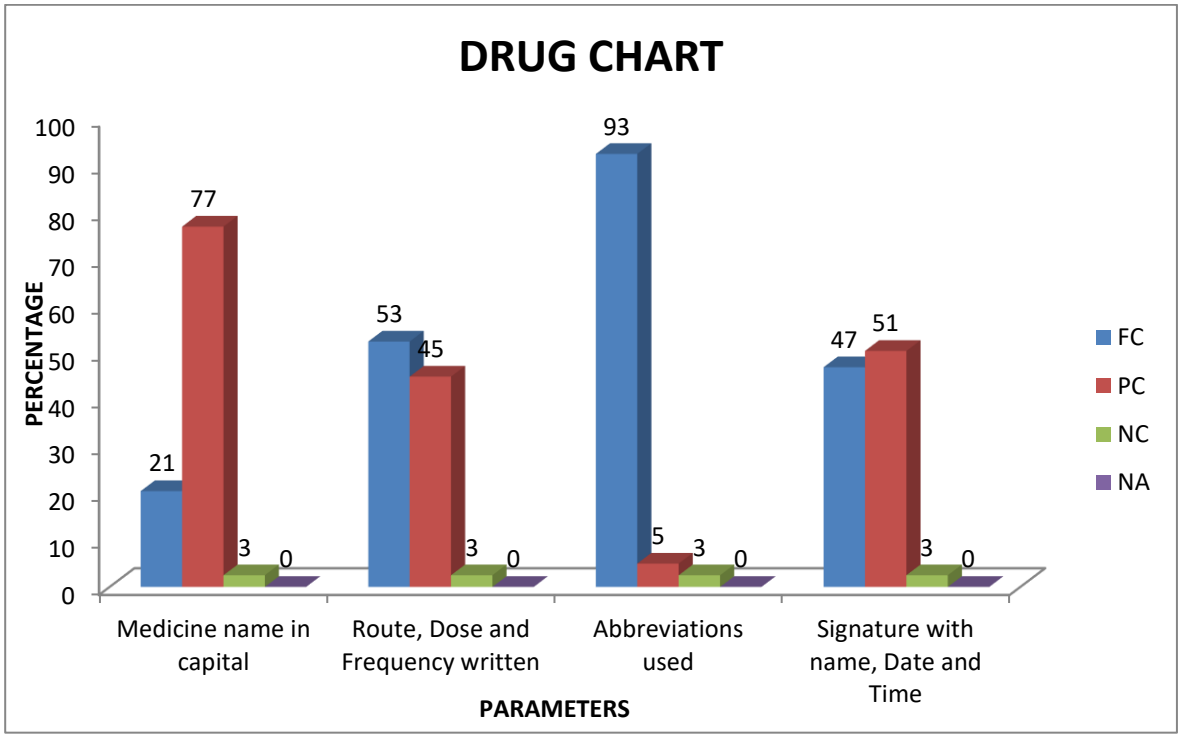


Figure - 6

Interpretation:

In drug chart sheet, out of 200 files, in 154 medicine name were not in capital and in 101 files the signature with name, date , time and route, dose, frequency parameters in 90 files were partially filled. The percentage of compliance of drug chart is given in figure – 6

Consents (Table – 5)

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

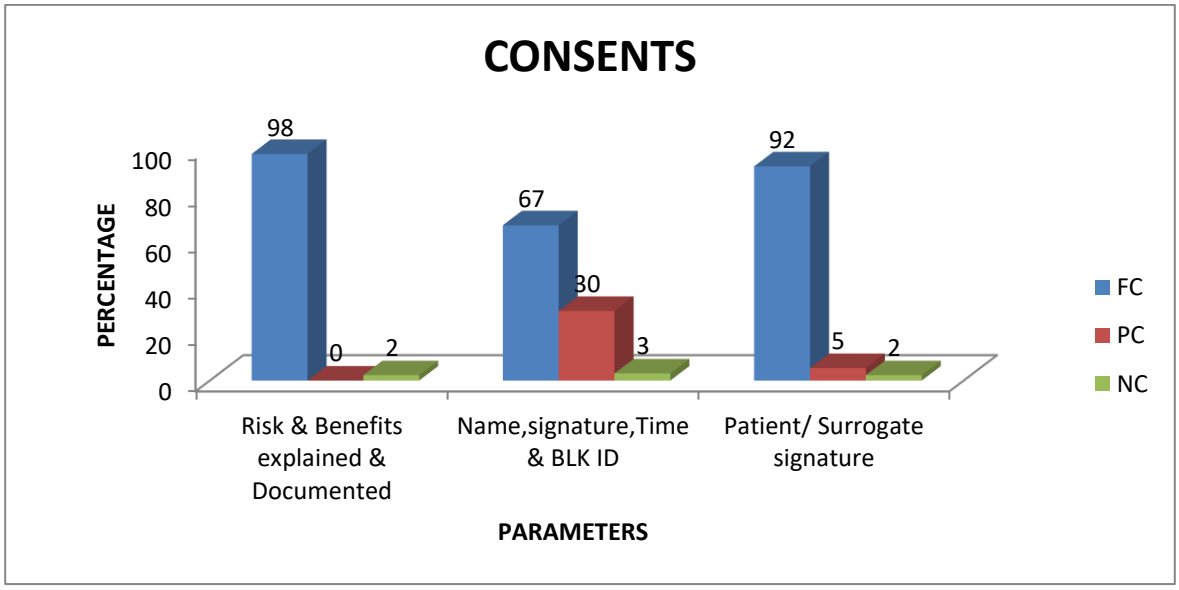


Figure - 7

Interpretation:

Consents forms were mostly complete except for the parameter Name, signature, time and BLK ID was partially filled 39 files out of 130 files for which consents were valid. The percentage of compliance is shown in figure – 7.

Anaesthesia Record Sheet (Table – 6)

Anesthesia record sheet:	FC	PC	NC
Pre-anaesthetic assessment done & plan documented	84	0	0
Pre-operative assessment done	83	0	1
Post operative monitoring done & documented	79	1	4

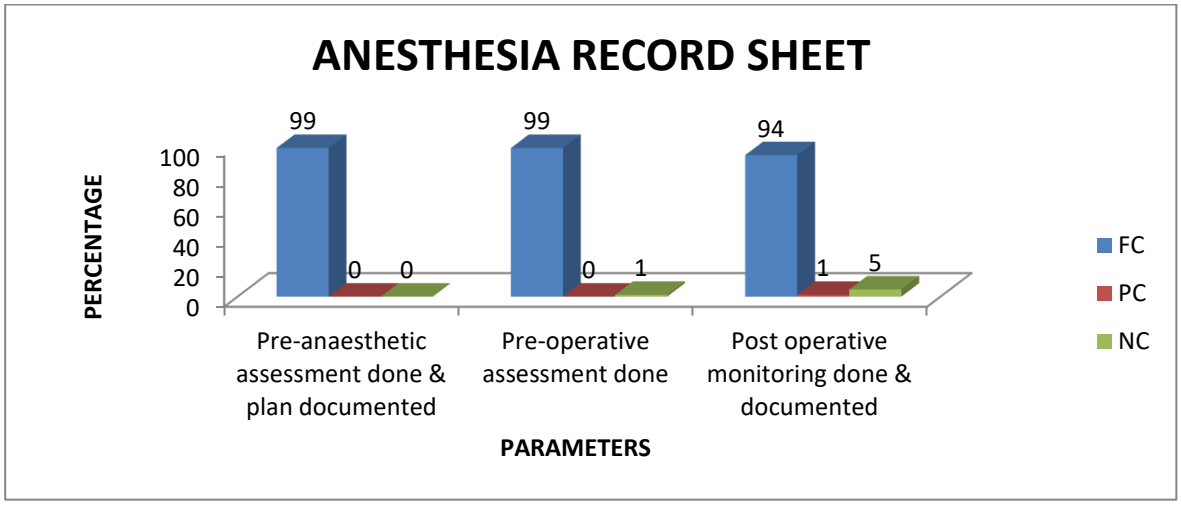


Figure - 8

Interpretation:

Out of 200 files , in 84 patients anesthetic or surgical procedures were done. All of the parameters of anesthesia record sheet were fully completed . The percentage of compliance is shown in figure – 8.

Surgery Records (Table – 7)

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

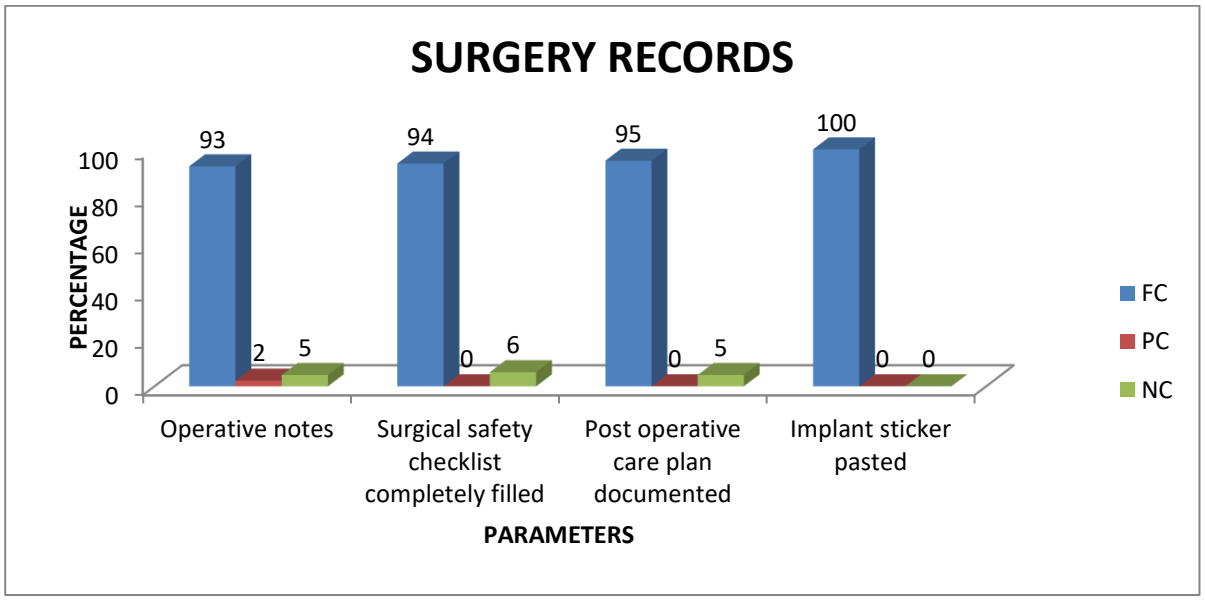


Figure - 9

Interpretation:

All parameters were mostly fully complete in surgery records sheet of 84 files. The percentage of compliance is shown in figure – 9.

Nursing (Table – 8)

Nursing:	FC	PC	NC	NA
Nursing initial assessment proper-All parameters (with plan of care)	191	0	9	0
Progress notes-Nurses	161	7	30	0
Re-assessment at appropriate intervals	180	13	5	0
Daily nursing Vital flow sheet	189	1	8	0
Fall risk assessment	188	0	10	0
Pain assessment (intensity, character, frequency, location, duration and referral and/or radiation)	190	0	8	0

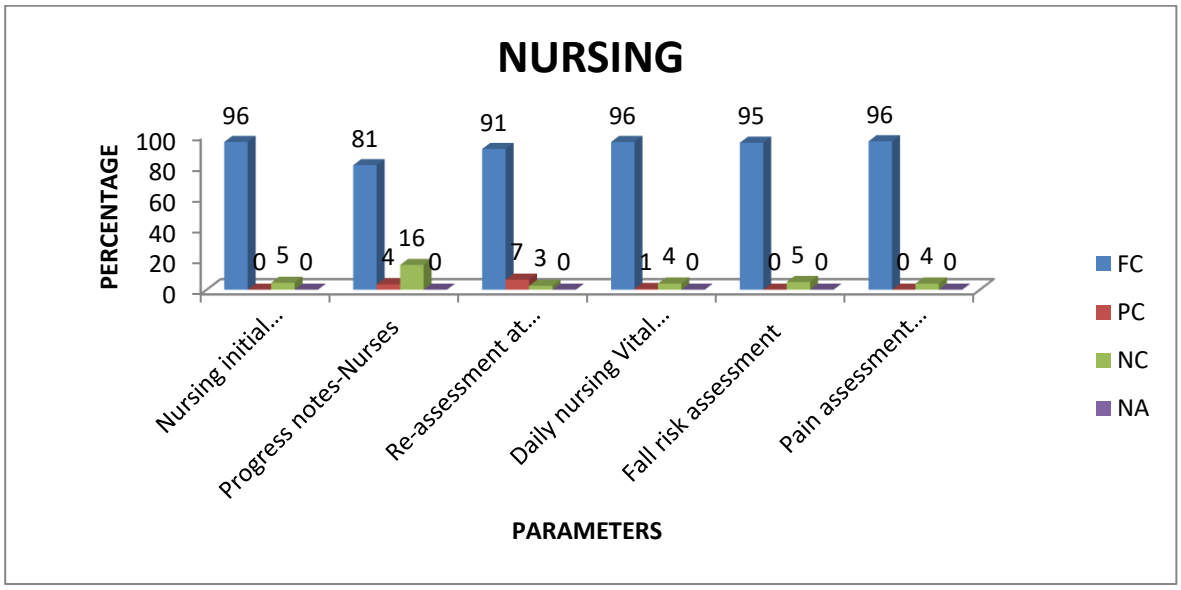


Figure - 10

Interpretation:

Out of 200 files, 30 files did not have nurses progress notes, 10 files didn't have fall risk assessment otherwise most of the parameters were fully complete. The percentage of compliance is shown in figure – 10.

Discharge (Table – 9)

Discharge	FC	PC	NC	NA
Discharge Summary	195	2	0	0
Diagnosis, findings and reason of admission	196	2	0	0
Investigations, procedure notes and medication documented	198	2	0	0
Follow up advice, medication	198	2	0	0

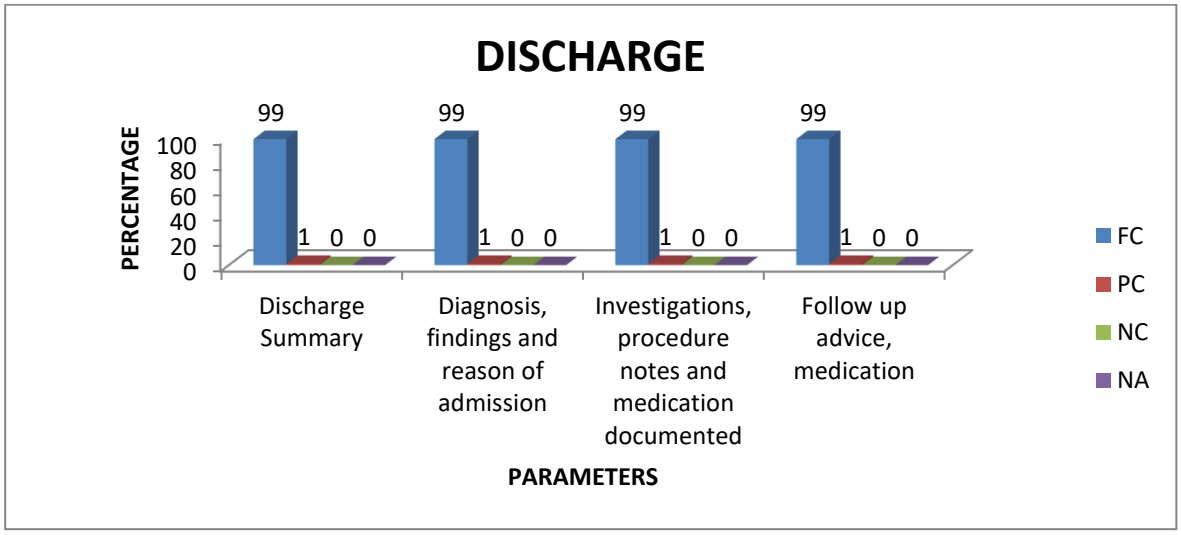


Figure - 11

Interpretation:

Discharge summary parameters were fully completed in the discharge summary sheet. The percentage of compliance is shown in figure 11.

Others (Table – 10)

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

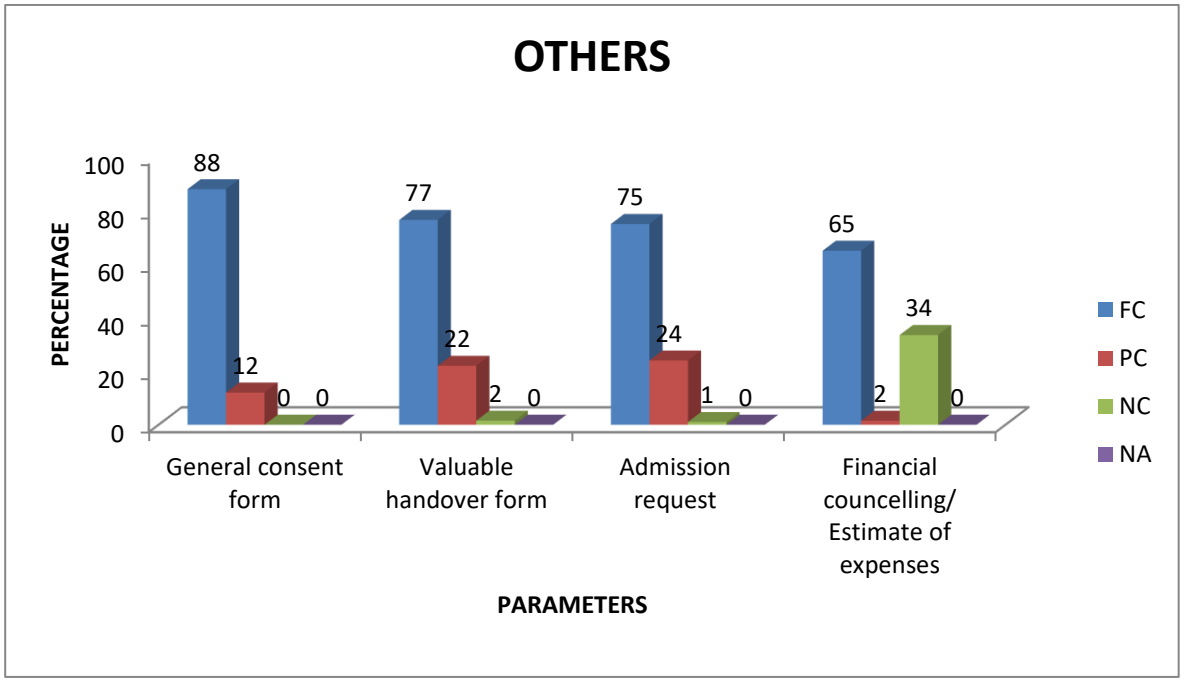


Figure - 12

Interpretation:

Out of 200 files, 67 files did not have estimate of expense sheet, and general consent form, valuable handover form, admission request were partially completed. The percentage of compliance is shown in figure 12.

OVERALL % OF PARAMETERS

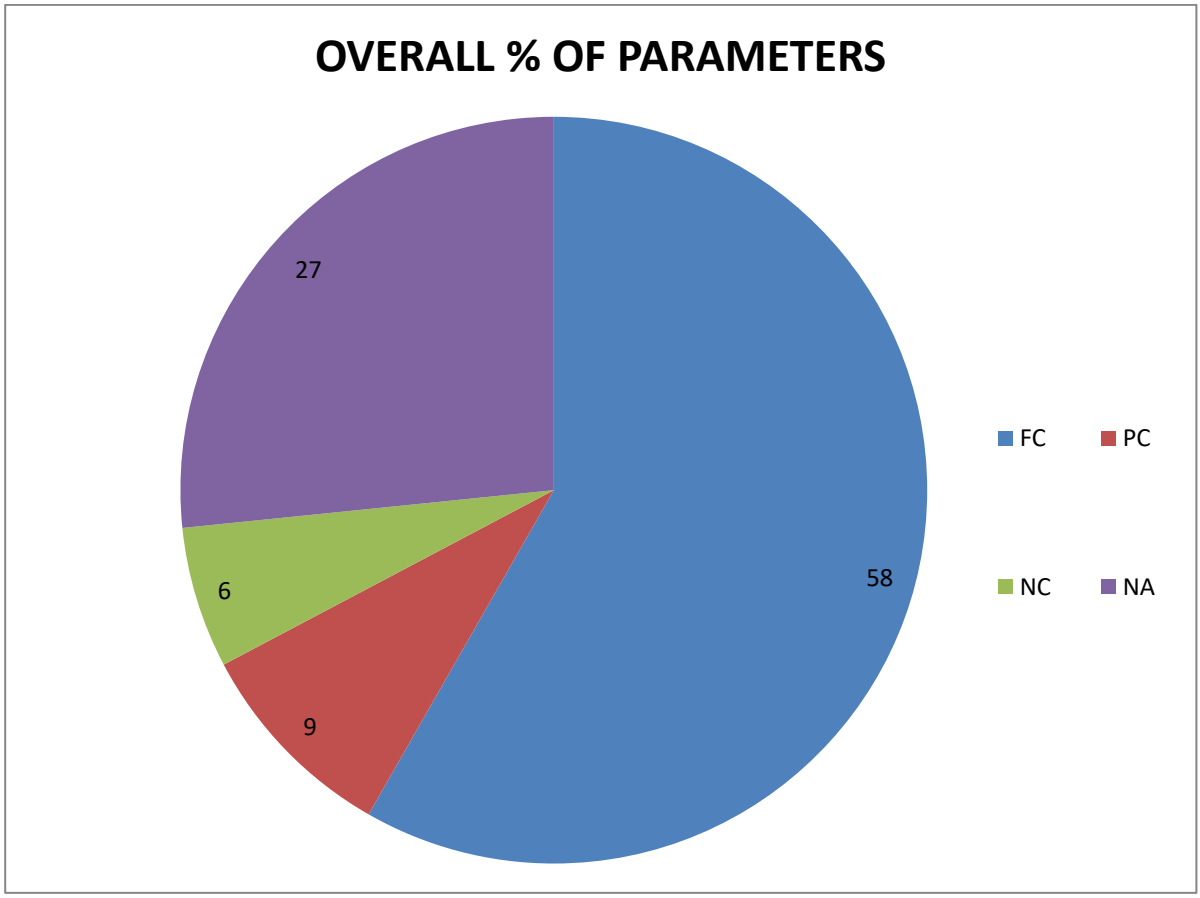


Figure - 13

Interpretation:

58% of the parameters were fully complete, 9% were partially complete , 6% were not complete and 27% of the parameters were not applicable . the percentage of compliance is shown in figure 15.

DISCUSSION

- 58% of the parameters were fully complete as per the Given NABH standards.
- In initial assessment sheet, 93% of nutritional assessment was not present. 19% of provisional diagnosis, 18% of consultant counter sign and 13% of plan of care were also not completed in the sheet.
- In emergency sheet, 14% of MLC entry and 11% of provisional diagnosis were not complete whereas 11% of plan of care and 20% of sign with date, time and name parameters were only partially complete.
- 79% of doctor's progress notes were partially complete as the time was not mentioned in most of the sheet.
- In drug chart, 77% of medicine name were not in capital letters, 45% of sheet didn't have route, dose and frequency written and 51% of the drug chart didn't have doctor sign and time.
- 16% of Nurses progress notes were not complete.
- General consent forms (12%), Valuable handover form (22%) and admission request forms were partially complete.
- 34% of the files did not have estimate of expense sheet.

RECOMMENDATION

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

CONCLUSION

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

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

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

LIMITATION

- Time constraints.
- Sample size was small.
- Not allowed to talk to the doctors or nursing staff and other staffs to inquire about the deficiencies.

REFERENCE

1. Medical Records Manual: A guide for developing countries, World Health Organisation, Western Pacific Region,2006;01

   http://www.wpro.who.int/publications/docs/Medical Records manual

2. Khalis Mahmood, Shahid Shakkel, Hyas Saeedi, Zia Ud Din on "Audit of medical record documentation of patients admitted to a medical unit in a teaching hospital NWFP Pakistan"
   http://www.jpmi.org.pk/index.php/jpmi/article/view/8/1209

3. Letaief M, Mitraoui A, Mandhouj O, Ben Salem, Soltani,Bchir. Evaluation of the quality of medical records in the Monastir Regional Hospital-Tunisia, Tunis med ,2003,may:81(5);33-7

   http://www.ncbi.nim.nih.gov/pubmed/12934450

4. Sinha R K, Saha.D, R.N.Prathibha, Assessment of Medical Documentation As per Joint Commission International, Journal of the Academy of hospital administration. 2009;21(1-2);5-10
   http://ahaindia.org/admin/uploaded_docs/@@assessment_of_medical_documentation_as_per_joint_commission_internation.pdf

5. Eric S. Holmboe, MD, "Practical Guide to the evaluation of Clinical Competence"2008
   http://mededconnect.com/samplechapters/9780323047098/Sample%20Chapter.Pdf

6. Mogli G.D ,Medical Records Organisation And Management, New Delhi, Jaypee Brothers Medical Publishers private limited, 2006;403

7. Dr. Allister Farell “An approach to Records Management audit”,2007,may
http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/records/it04a.pdf
1. WANG N., HAILEY D. & YU P. (2011) WANG N., HAILEY D. & YU P. (2011) Quality of nursing documentation and approaches to its evaluation: a mixed-method systematic review. Journal of Advanced Nursing 00(0), 000–000. doi: 10.1111/j.1365-2648.2011.05634.x
http://www.ncbi.nlm.nih.gov/pubmed/21466578

ANNEXURE

Month:

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

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

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

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

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