Study on Assessment of Compliances in Medical Records Department in Accordance with NABH Standards at The Mission Hospital, Durgapur

By

Bhagyashri Borkar

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2017-2019

The IIHMR University, Jaipur

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INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that Dr.Bhagyashri Borkar, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at The Mission Hospital, Durgapur from 4th February 2019 to 30th April 2019

The Candidate has successfully carried out the study assigned 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.

Dean, Academics and Student Affairs
The IIHMR University, Jaipur

Professor
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THE MISSION HOSPITAL DURGAPUR | FUTURISTIC TECHNOLOGY. BRILLIANT MINDS.

Ref: TMH/HRD/OG/April/19/91 **Date: 01/05/19**

TO WHOM IT MAY CONCERN

This is to certify that **Dr. Bhagyashri Borkar** has done three months dissertation on **A Study on Assessment of Compliances in Medical Records Department in accordance with NABH Standards at The Mission Hospital, Durgapur, West Bengal** from 04/02/2019 to 30/04/2019.

During the period of dissertation **Dr. Bhagyashri Borkar** has been found sincere, hard working & having an attitude to learn.

We wish her a successful future and brilliant professional career ahead.

For The Mission Hospital, Durgapur

Ramesh Lall
Sr. General Manager - HR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **A Study on Assessment of Compliances in Medical Records Department in Accordance with NABH Standards at The Mission Hospital, Durgapur**and submitted by **Dr.Bhagyashri Borkar** Enrollment No. **IIHMR-U/01/2017/-19/549** under the supervision of **Dr. Anoop Khanna** for award of MBA in Hospital and Health Management in Health and Hospitals of the University carried out during the period **from 4th feb 2019 to 30th April 2019**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

ACKNOWLEDGEMENT

I feel privileged in expressing my kindest gratitude to **Dr. Partho Pal Sir (C.M.S.), Dr. Debashish Ghosh sir (D.M.S)**and **Dr.Tarak Sir (A.M.S)**under whose able guidance and supervision this study was conducted. The keen interest he evinced throughout this period and the graciousness with which he gave his valuable advice was his exclusive acumen.

I express my gratitude to, **HR Department** most importantly and the respondents who took out time from their busy schedule and helped me to make this happen

I would like to grab this opportunity to thank the entire team of **Quality Department, IT Department, Medical Records Department and Infection Control Team** for supporting me whole heartedly in every phase of my study.

I also feel privileged in expressing my thanks to **Dr. ANOOP KHANNA** whose guidance and support was always there for me.

At the end I would like to thank all the fellows and colleagues who have directly indirectly helped me in making this project a success and my apologies to anyone whose name I would have unintentionally forgotten to mention here.

Dr. Bhagyashri Borkar

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ABBREVATIONS

- MRD – Medical Records Department
- ICD – International Classification Of Diseases
- GDA – General Duty Assistant
- E-MRD – Electronic Medical Records Department
- NABH – National Accreditation of Board of Hospitals

ORGANIZATION PROFILE

The Mission Hospital, Durgapura 350 bedded, state of the art super Speciality hospital, with cutting edge technology.

The Mission Hospital started on**02/APRIL/2008**.This is the first super Speciality corporate hospital in Eastern India outside Kolkata. The hospital has taken an initiative to integrate the best in healthcare at its best manpower and technology

Built in an area spanning of three acres , offers of24 hours Accident and Emergency Department, facilities digital flat panel cath lab, eight major operation theatres with laminar airflow and HEPA filters, 100 bedded critical care unit, dedicated mother and child care unit, , laboratory, blood bank and for the first time, a fully computerized pneumatic chute system.

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

ACCREDITATION

The quality and Patient safety teams provide guidance and resources to ensure that The Mission Hospital, Durgapur is continually compliant with the health quality and patient safety standards as set to be **for National Accreditation Board for Hospitals (NABH)**

AWARDS

The Mission Hospital, Durgapur also receives **The AHPI Award of '*Quality* beyond Accreditation' for its commitment to Quality Health Care**

MISSION

The Mission of The Mission Hospital, Durgapur is to decentralize Superspeciality healthcare, and deliver it to every doorstep in Eastern India, beyond the metropolis, and heal Patients with dedication, honesty & tender loving care

VISION

The Mission hospital Durgapur will be recognized as a premier healthcare institute that strives to provide outstanding patient experiences, better clinical outcomes, and improved quality of life for the patients in the context of fiscal and social responsibilities.

OBJECTIVES

- To Provide continuous and regular training for the employees to bring out the best in them to achieve quality improvement
- To understand the needs of the patients and uphold standards of professionalism to improve the level of patient satisfaction.
- To Provide quality service that is responsive, efficient, courteous and helpful

LEVEL PLAN

LEVEL	DEPARTMENTS
BASEMENT	Executive health checks up OPD Auditorium/conference room Library Quality Department Sample collection room PFT/EEG/NCV/EMG Physiotherapy Yoga
GROUND FLOOR	Accident and Emergency Department Reception and registration OPD chambers Pharmacy Radiology Department Insurance desk/corporate desk Cafeteria Dietician
FIRST LEVEL	OPD Central Laboratory Endoscopy Blood bank General ward (male & female) Echo /ECG/TMT
SECOND LEVEL	MICU Cath lab

	CCU
THIRD LEVEL	OPERATION THEATRE CTVS ITU/CSSD
FOURTH LEVEL	Cardiac ward Administration department o HR Department o BOD Office o Finance Department o Marketing Department IP Pharmacy
FIFTH LEVEL	Labor room & Minor OT Dialysis unit,ESWL Room , Telemedicine NICU and Pediatric ward
SIXTH LEVEL	Semi-private patient Room Surgical ICU CTVS-HDU/Inpatient Billing
SEVENTH LEVEL	Semi-private patient room General ward – Pediatric Cardiology
EIGHT LEVEL	Super Deluxe Rooms Board Room

SPECIALITY SERVICES

- Outreach clinics
- Ambulances services
- Free health camps
- Master's in emergency medicine courses
- Telemedicine
- OPD Outreach clinics
- Pain Clinic
- Radiology services
- Online Appointments service

THE MISSION HOSPITAL,DURGAPUR

PROJECT REPORT

ON

A Study on Assessment of Compliances in Medical Records Department in Accordance with NABH Standards at The Mission Hospital, Durgapur

AT

THE MISSION HOSPITAL, DURGAPUR

PROJECT GUIDE

Dr. Anoop Khanna

IIHMR UNIVERSITY

MEDICAL RECORDS DEPARTMENT

Medical records department plays very important and silent role in the back office of hospital.

It also maintained medical records which is a legal document is gives information about patient history at the time of hospital stay. Physician, nurse practitioner and other health care practitioners may take entries in the record

It also contains types of each and every information including recording consultant's observation, drug therapies, lab reports,dietician notes, nursing department assessment, radiological reports etc

LOCATION

Medical Records Department is at the besides the Main building at Ground floor

TIMINGS OF DEPARTMENT

- 6 Days in a week
- 9 AM TO 6:30 PM

STUDY TIMINGS

- 6 Days in a week
- 9:00am to 5:15 pm

PURPOSE

- To maintain retained the excellent quality of all documents
- To give Information of the patient or patients relatives as per their need as soon as possible
- To maintain the confidentiality of the patient information

SCOPE

- Diagnosis and procedure coding utilizing ICD 10 (version 2016)
- Storage and retrieval system, including record tracking
- Store and retrieve the data from hospital information system

RESEARCH QUESTION

Is Medical Records Department compliance as per the NABH Standards?

OBJECTIVES

- To review the workflow of medical record department and to find the GAPS and identify areas which require improvement
- To assess the compliance of medical records department according to the NABH Standards
- To make a request proposal for E-MRD and do a Market Research

REVIEW OF LITREATURE

The study has been conducted at the hospital to find out Assessment of Adherence of Protocol in Documentation as per NABH standards [1] The main objective was, to audit were manually done according to the NABH standards and to recommend implementable solutions [2] Out of the 340 in patients records 160 were taken for this study [3]

It isobserved that many medical records were not sufficiently documented as well as unable togive evidence of quality care [4] It was found that in the various parameters assigned Admission request form, Doctors initial evaluation form, condition at the discharge time mentioned and birth certification matter comes into the poor segment, and patients' daily progress comes into the excellent parameters. [5]

Medical Records contents for discharged patients should be arranged prior to filing. [6] Qualitative analysis of Medical Records contents should be done on regular basis to monitor complete information. [7] It is recommended that entries will be recorded as closely as possible at the time of the encounter [8]

RESEARCH METHODOLOGY

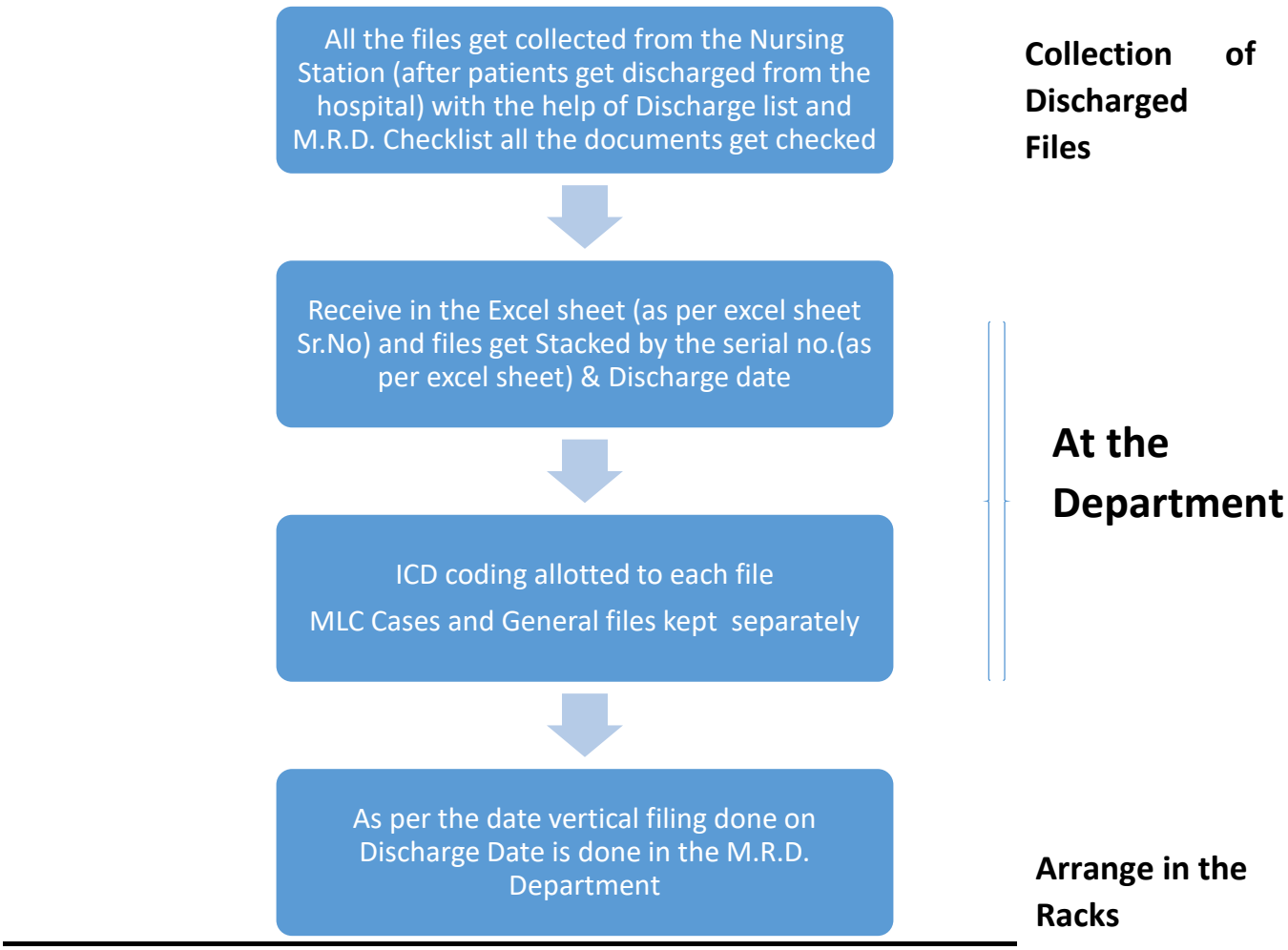
- **Study Area** – THE MISSION HOSPITAL, DURGAPUR
- **Study Duration** – 4th February to 3rd May 2019
- **Sampling Technique** – Convenience Sampling
- **Sample size - 315 IP Files**
    - Inclusion criteria – General Files and MLC Files
    - Exclusion criteria – Day Care Files

- **Type of Study -** Observational study
- **Study content -** The data was extracted from MRD file
- **STUDY DESIGN**- Descriptive study
- **SECONDARY DATA –**The data has been collected by observing the practices followed in The Mission Hospital, Durgapur

SR.NO	HEAD	PARAMETER	STATUS	RECOMMENDATIONS
1.	Regulatory	1.Birth Reporting 2.Death Reporting 3.MLC Intimation 4.Notifiable Disease Reporting	1.Maintained 2.Maintained 3. Maintained 4. Maintained	
2.	Arrangements	1.MRD File 2.Labelling 3.Tracer Card	1.Maintaining 2.labelling is not done 3.Maintaing	2.There should be Proper filling According file type 3.information on some Tracer card is missing sometimes
3.	Documentation	1.Closed file auditing 2.Quality Indicators 3.Medical Audit Committee Meeting 4.Death Review Committee Meeting	1.Close file audit done on monthly basis(on random basis done) 2. 3.Once in a three month 4.once in a three month	1.Close file audit of previous month should be done in the next month's first week
4.	Staff Awareness	1. vision, mission & values 2. PRE 3. CODES	1.no information 2. 3.Code information	1.vision ,mission and values should be displayed at the department

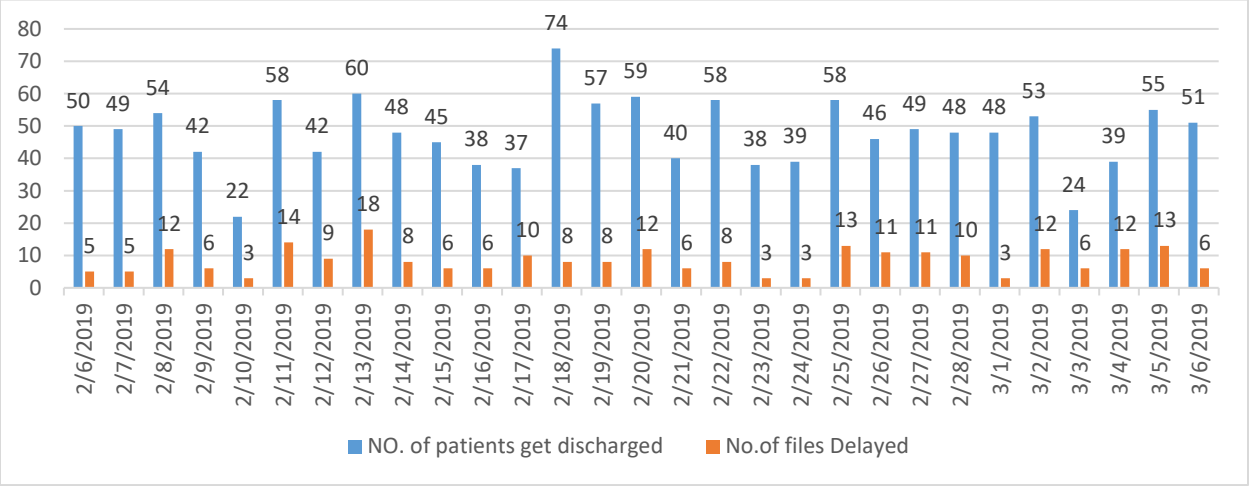
		4. Employees Rights & Responsibilities 5. Fire Safety 6. Hand Hygiene 7. Staff should read information board ,employee handbook & concerned policies	displayed 6.Usage of hand rub only 7.There is not a such a dedicated noticed board	3&5 Mock drills should be taken once in a six month and also medical switch should be placed 7.regarding departmental information notice board and employee handbook and concerned policies are missing
5.	Miscellaneous	1. ICD coding 2. Access to current & past medical record 3. Retention Record 4. Destruction of Records 5. File documents arranged in Chronological order	1. Following as per the ICD 10 (version 2016) 2. Yes 3. All the Documents are retained 4. Have not done yet 5. File documentation not arranged as per order	1.At the time of stacking the files ICD code should get be written on files 4.Should be done for general (IPD) cases after 10 years as per the norms 5.File documents should be kept in chronological records

QUALITY PARAMETERS



WORKFLOW OF THE MEDICAL RECORDS DEPARTMENT

PROBLEMS WERE IDENTIFIED



GRAPH – 1.1

Daily 10 files are getting late on an Average

Following are the files are delayed and piled up on the nursing station –

SR.NO	FLOOR	NO.OF INCOMPLETE FILES	Required Documents
1.	8th Floor	8	Billing card
2.	7th Floor	40	Billing card
3.	6th Floor	14	Billing card
4.	5th floor	1	Billing card
5.	4th floor	4	Billing card
6.	2nd floor	13	Billing card
7.	1st floor	84	Billing Card

TABLE – 1.2

For completion of the file -

- Missing Billing Card were identified as Major problem in the workflow
- On Date 1st April 2019 on every floor list was made as per the Sr.No., IP.No., Pt. Name, Date of Discharge and Required documents
- The list hand over to the floor in-charge/floor Co-coordinator person to complete the files with the required documents as soon as possible
- On dated 25th April 2019 all the files were completed with the Billing Card and required documents such as (Lab Reports, M.R.D. Checklist, and History sheet etc.)

FOR DOCUMENT RETRIEVAL PROCEDURE

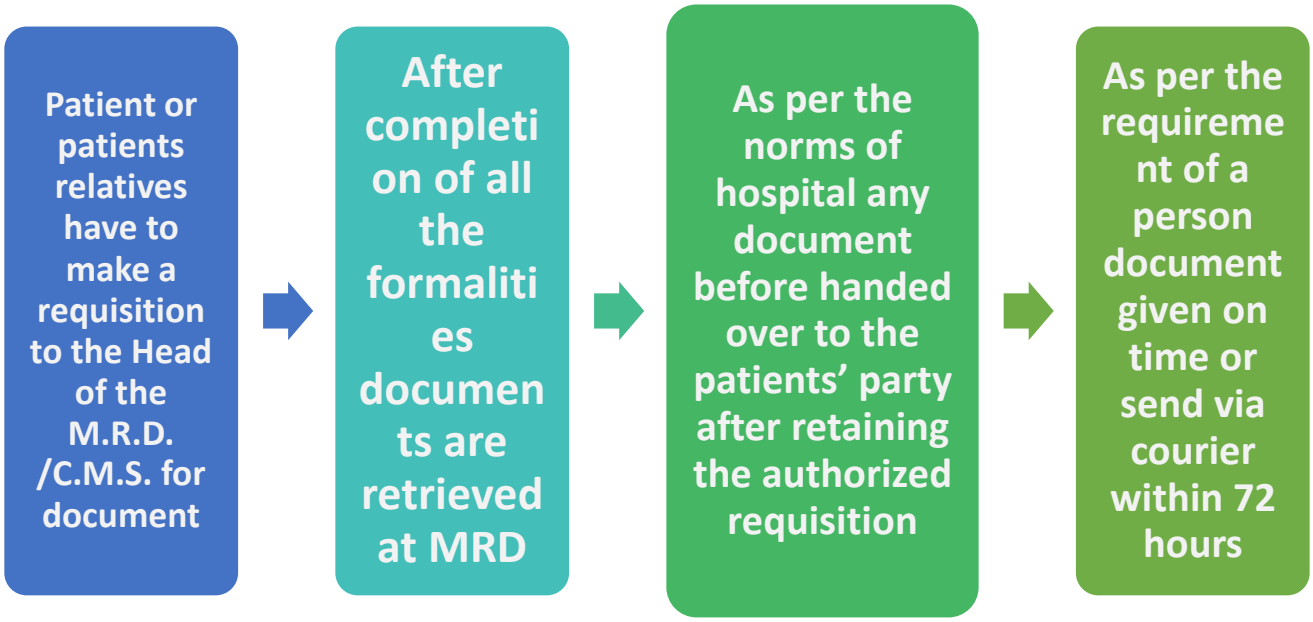


FIGURE – 1.2

NABH STANDARDS ACC. TO MEDICAL RECORDS DEPARTMENT -

- 11 STANDARDS
- 40 OBJECTIVE ELEMENTS

SR. NO	NABH STANDARDS	OBJECTIVE ELEMENTS	C/PC/NC	RECOMMENDATIONS
1.	AAC.4.I	1.The care plan is countersigned by the clinician in-charge of the patient within 24 hours	1.Compliance	
2.	AAC 13 b,c,d	1. Medico legal case documentation 2. LAMA case file has discharge summary and risk explained	1.Compliance 2.Compliance	
3	AAC 14 b,c,d,e,f,g	1. Discharge summary (pt. name, UHID no., DOA, DOD etc.) 2. Cause of death in case of death summary 3. Discharge summary acknowledge by patient/family 4. Check for completeness of consent documents i. Procedure ii. Blood transfusion iii. Moderate sedation	1.Compliance 2. Compliance 3. Non - Compliance 4. Partial - Compliance 5. Partial- Compliance 6.Non- Compliance	2.Cause of Death should be written as per PHYSICIAN MANUAL ON MEDICATION CERTIFICATION of cause of death issued by office Registrar General, India 3. While explaining discharge summary by nurse signature in all copies should be taken from patient party

		iv. Anaesthesia v. Surgery vi. Research vii. MTP,HIV 5. General consent 6. Language consent		4. To take consents in proper format as per legal obligations 5.All the consents should get signed with date, time
4.	**COP.12.**	1.Patient assessment includes detailed nutritional, growth, developmental and immunization assessment 2. The children's family members are educated about nutrition, immunization and safe parenting and this is documented	1.Partial - Compliance 2.NonCompliance	1.Stict adherence to the policies 2.Nutritional advise and parenting should be given on the advice on safe parenting
5.	**COP.15. d.f.g.**	1. Surgical safety checklist ,operating notes, recovery criteria, post-operative plan of care	1.Compliance	
6.	HIC 3	1. In cases of notifiable diseases, information (in	1.Compliance	

		relevant format) is sent to appropriate authorities		
7.	**FMS 6.A**	1. The organization has plans for fire and non-fire emergencies within the facilities	1.Non - Compliance Currently Department have fire extinguisher only	• Mock drills should be done once in a six months • No provision for emergency exit • As per the standards fire proof cabin should be there • Trolley and segregation of the documents should be done as soon as possible
8.	**IMS.3.A-H**	1. Every medical record has a unique identifier 2. Organization policy identifies those authorized to make entries in medical record 3. Entry in the medical record is named, signed,	1.Non - Compliance 2.Compliance 3.Partial – Compliance 4.Partial- Compliance 5.Compliance 6.Partial -	1.There should be a unique identifier for each document 3,4&5.To ensure the completeness of all files before collection 6.Only medicines ordering

		dated and timed 4. The author of the entry can be identified 5. The contents of medical record are identified and documented 6. The record provides the organization has a documented policy for usage of abbreviations and develops a list based on accepted practices 7. a complete, up-to-date and chronological account of patient Care 8. Provision is made for 24-hour availability of the patient‘s record to healthcare providers to ensure continuity of care	Compliance 7.Partial - Compliance 8.Non - Compliance	abbreviations are updated 8.MRD should be in operations for 24 hour
9.	**IMS 4 A-H**	1. The medical record contains information regarding reasons	1.Partial - Compliance 2.Complian ce	5.Each and every copy of the discharge summary should

		for admission, diagnosis and care plan 2. The medical record contains the results of tests carried out and the care provided 3. Operative and other procedures performed are incorporated in the medical record 4. When patient is transferred to another hospital, the medical record contains the date of transfer, the reason for the transfer and the name of the receiving hospital 5. The medical record contains a copy of the discharge summary duly signed by appropriate and qualified personnel 6. In case of death,	3.Compliance 4. Compliance 5.Partial Compliance 6.Compliance 7.Compliance	be signed by appropriate and qualified personnel

		the medical record contains a copy of the cause of death certificate 7. Whenever a clinical autopsy is carried out, the medical record contains a copy of the report of the same 8. Care providers have access to current and past medical record		
10	IMS 5 A-G	1. Documented policies and procedures exist for maintaining confidentiality, security and integrity of records, data and information 2. safeguarding of data/record against loss, destruction and tampering 3. technology for improving confidentiality, integrity and	1.Compliance 2.Compliance 3.Non – Compliance 4.Compliance 5.Compliance	3.E-MRD Proposal is on request process

		security 4. Privileged health information is used for the purposes identified or as required by law and not disclosed without the patient‘s authorization 5. A documented procedure exists on how to respond to patients/physicians and other public agencies requests for access to information in the medical record in accordance with the local and national law.		
11	**IMS.6.**	1. Documented policies and procedures are in place on retaining the patient‘s clinical records, data and information 2. Maintainace of confidentiality	1.Compliance 2.Compliance 3.Non - Compliance	

		and security at all stages 3. Method of destruction of medical records, data and information		
12	**IMS.7.**	1. Medical Record Audit – Frequency ,sample size, person authorised,timelin ess,legibility and completeness ,active and discharged patient record	1.Non-Compliance	
13	**ROM 2**	1. Communication of notifiable diseases to concerned authorities	1.Complian ce	

FINDINGS

As per the NABH Standards for medical records department are –

- Standards – 13
- Objective elements – 40

Sr.No.	No.of compliances	No.of Partial-Compliance	No.of Non-Compliance
1.	29	09	01

TABLE 1.5

RESULT

It is observed while the study that M.R. Department is Compliant 51% which include most of the Regulation of Documented Policies and Medical records Documentation (includes Completion of the documentation etc.)

26% of Partial Compliance is observed and most of those are in progress (for ex. The children ‘s family members are educated about nutrition, immunization and safe parenting and this is documented etc.)

When it is come to the Technology for improving confidentiality, integrity and security organization is looking forward for accepting E-MRD as soon as possible and shows 23% Non-Compliance

RECOMMENDATIONS

- **MANPOWER**

As per the workflow of the Department two more people should be recruit as soon as possible

- **INFRASTRUCTURE**
  - Blue Code switch should be allotted as soon as possible
  - Provision for Emergency exit should be there
  - Stores should be in hospital premises
  - For Document Safety fire proof Cabin should be there

- **TECHNOLOGY**
  - Implementation of E-MRD

- **AUDITS**
  - Open File Audit should be follow before collection of files
  - Close file audit should be done monthly
  - Mortality Audit Should be done monthly

- **MISCLLENEOUS**
  - Mock Drills – Mock Drills should be taken regularly

E-MRD REQUEST FOR PROPOSAL

THE WEST BENGAL CLINICAL ESTABLISHMENT

Chapter II.—Registration and Standards—Section 7

(n) That every clinical establishment shall immediately after coming into force of this Act, implement e-Prescription, maintain Electronic Medical Records and provide a set of all medical records and treatment details along with the discharge summary at the time of discharge of the service recipient

Electronic Medical Record – It is a digital version of a patient's paper chart. EMR is real time, patient-centered records that make information available instantly and securely to the authorized user

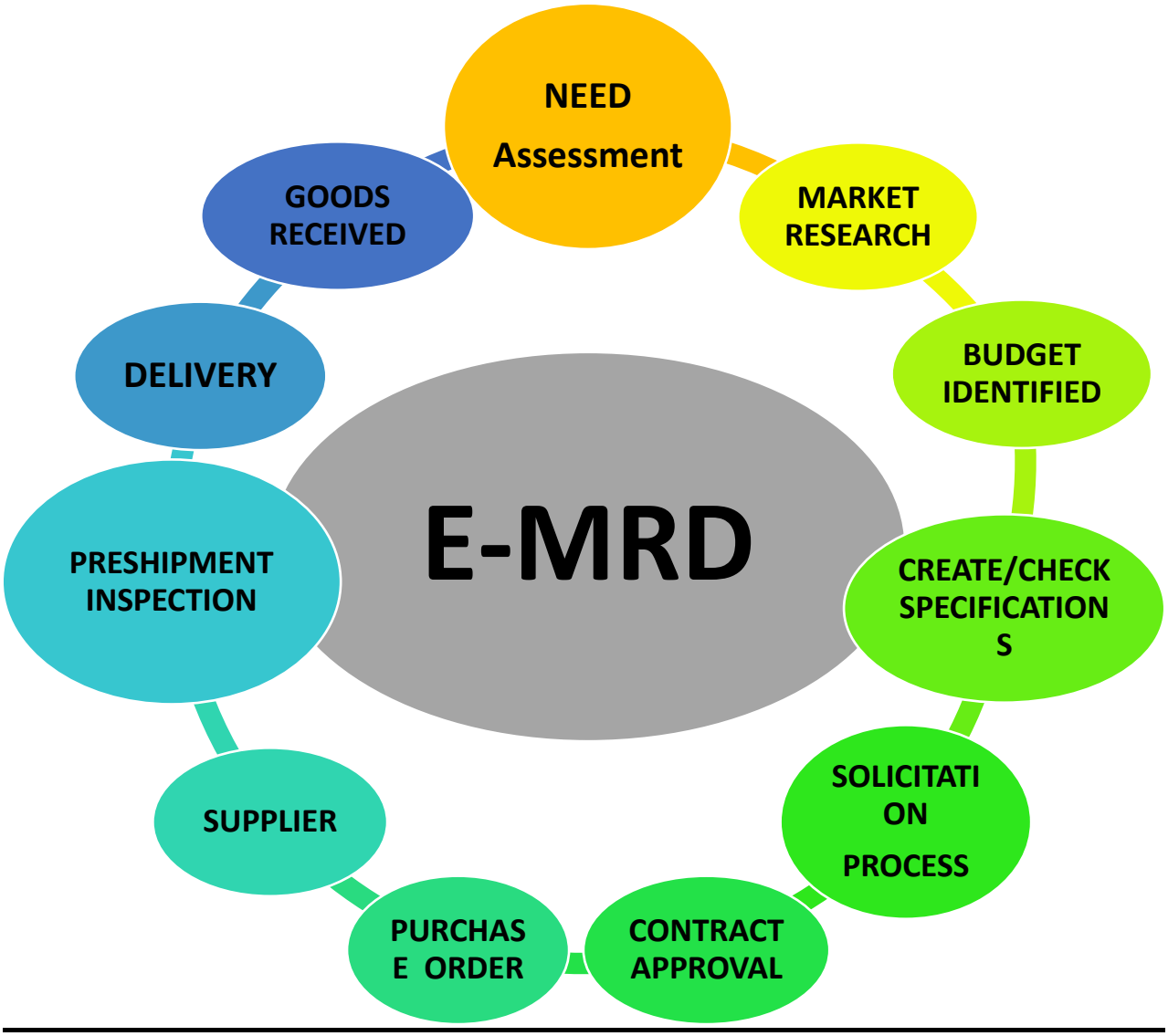

NEED
Assessment
MARKET
RESEARCH
BUDGET
IDENTIFIED
CREATE/CHECK
SPECIFICATION
S
SOLICITATI
ON
PROCESS
CONTRACT
APPROVAL
PURCHAS
E ORDER
SUPPLIER
PRESHIPMENT
INSPECTION
DELIVERY
GOODS
RECEIVED
E-MRD

FIGURE –1.3

NEED ASSESSMENT -

- A needs assessment is a systematic process for determining and addressing needs, or "gaps" between current conditions and desired conditions or "wants". The discrepancy between the current condition and wanted condition must be measured to appropriately identify the need
- Document retention procedure will be easy and service to the patient as soon as possible

MARKET RESEARCH –

Sr.No	OUTSOURCED Vendors	PRICE	NOTES
1.	CBSL Group	• Scanning – 300 dpi/Grey Scale/Simplex – INR – 0.42 /per image	• All rates are exclusive of GST charges • All Charges are applicable only for the ONE YEAR after which an escalation of 10% will be applicable • 5% payment must be in advanced • 150GB space is provided FREE to customer. After Every 1TB is charged at

			INR 3000 per month
2.	Crown Records Management	• Scanning services - 0.40/image • Indexing Charges – 0.10/per file • For offsite scanning, transportation to and fro charges for setup - 2000	Currently working with • Fortis Hospital • Medica Hospital • Neotia Hospital • AMRI Hospital • Apollo Hospital • Genesis Hospital
3.	SoftAge Information Technology Limited	Document Scanning for A4 and A5 size page – 0.55/per image Document Scanning for A3 size page – 0.60/per image	

TABLE 1.6

Sr.No	OUTSOURCED Vendors	PRICE	Scanning rates	Scanning storage
1.	CBSL Group	• Scanning – 300 dpi/Grey Scale/Simplex – INR – 0.42 /per image	• Back File – 134090 • Avg. page per file – 60 • Scan Estimate 4559060*0.38 =1,732,442.8/-	Back File – 134090
2.	Crown Records Management	• Scanning services - 0.40/image • Indexing Charges – 0.10/per file • For offsite scanning, transportation to and fro charges for setup – 2000	• Scan Estimate – 4559060*0.40 = 1,823,624/-	• 60 files/carton (134090/60)= 2235carton*13.50=30173 • 30173*12=3,62,070 • For initial intake 60/-per carton =2235*60=1,34,100 • TOTAL EXPENDITURE = 4,96,170/-

3.	SoftAge Information Technology Limited	Document Scanning for A4 and A5 size page – 0.55/per image Document Scanning for A3 size page – 0.60/per image	Scan Estimate – 4559060*0.50 = 22,79,530/-	• 34/Per File/carton (134090/34)=3994 • 3994carton *17=67,898/- • TOTAL EXPENDITURE =67,898*12 = 8,14,776/-

TABLE – 1.7

Currently Investment for Medical Records Storage

- Bill Payment Per Month - For 2 MRD Store – 39,490/-
- For a Year – 4,73,880/-

REFERENCES

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