Documentation Compliance of In-Patient Files in Hospital

By

Mohd Aihatram Khan

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2017-2019

The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Sanganer, Airport
Jaipur 302029, Rajasthan
Ph: 0141 3924700, Fax: 3924738
Website: **www.iihmr.edu.in**

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IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

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

The Candidate has successfully carried out the study designated to his 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.

Col. (Dr.) Ashok Kaushik
Dean, Academics and Student Affairs
The IIHMR University, Jaipur

Dr. Tanjul Saxena
Associate Professor
The IIHMR University, Jaipur

THE MISSION HOSPITAL DURGAPUR | FUTURISTIC TECHNOLOGY. BRILLIANT MINDS.

Ref: TMH/HRD/OG/April/19/81 **Date: 01/05/19**

TO WHOM IT MAY CONCERN

This is to certify that **Dr. Mohd. Aihatram Khan** has done three months dissertation on **Documentation Compliance of In Patient Files at The Mission Hospital, Durgapur, West Bengal** from 04/02/2019 to 30/04/2019.

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

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

For The Mission Hospital, Durgapur

THE MISSION HOSPITAL DURGAPUR

Ramesh Lall
Sr. General Manager - HR

The Mission Hospital, Durgapur | 219(P) Immon Kalyan Sarani, Sector-2C, Bidhan Nagar, Durgapur - 713212
P: 0343 2535555 | M: 9233355555 | F: 0343 2532550 | Email: hospital@themissionhospital.in | www.themissionhospital.com
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THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled '**Documentation Compliance of Inpatient files in the Hospital**' in The Mission Hospital, Durgapur submitted by Dr.Mohd Aihatram Khan Enrollment No. IIHMR-U/01/2017-19/0601 under the supervision of Dr. Tanjul Saxena for award of MBA in Hospital and Health Management in Health and Hospitals of the University carried out during the period from 04th 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.

Aihatram Khan

Signature

Abstract
Documentation Compliance of In-Patient Files in Hospital
Author: Dr. Aihatram Khan

Background

Audit to assess the compliance of inpatient files can be a time-consuming process, but the benefits far outweigh the inconvenience. In the simplest terms, audit of inpatient files is a chart review which is used to identify what is being done correctly and what needs improvement.
Documentation is a communication tool exchange of information stored between nurses and caregivers. Quality documentation promotes structured, consistent and effective communication between caregivers and facilitates continuity and individuality of care and safety of patients. This study aims to audit the inpatient file compliance & investigate the knowledge, attitude & practices regarding documentation.

Methodology

To check the compliance rate in inpatient files a standard checklist was used to find the gaps and for the KAP a cross sectional study was carried out using structured closed ended questionnaire from 4th February 2019 to 3rd May 2019. Data was analyzed using excel sheet.
60 Files were taken each from male, female, cardiac & ICU wards to audit the compliance of inpatient documentation. Among all wards 100% compliance rate was found in admission details with accident & emergency cases in ICU compared to non- compliance rate of 100% with patient identity card in all the wards.

Results

A total of 80 respondents participated in the study. The respondents were staff nurse. The age of respondents ranges from 18 - 45 years of age with a mean age of 26.5 years. Most of the respondents fall in the ranges of 18 - 25 years of age group (57.5%). All the respondents in the study had sufficient knowledge in the documentation

Conclusion

The study to audit the inpatient compliance of Inpatient documentation concluded that compliance rate is relatively very low in some departments and particularly in some specified categories**.** The nurses appeared to be familiar with the required documentation knowledge, but still there are certain areas which we need to work on like making the documentation immediately and the files to be FACT a requirement rather than formality

Key Words

Documentation, Compliance, Inpatient Files, Record Keeping

ACKNOWLEDGEMENT

It has been a privilege to receive my Dissertation at The Mission Hospital Durgapur, West Bengal. These three months of my dissertation has helped me in gaining extensive knowledge in various departments.

I would like to express my gratitude to the Chairman of The Mission Hospital, Durgapur
Dr. Satyajit Bose for providing to undergo our Dissertation in the esteemed organization

My Thanks and Regards to my Chief Guide Dr Partha Pal, Chief Medical Superintendent, The Mission Hospital, Durgapur (West Bengal) for his valuable support and guidance throughout this project.

I would like to thank my Project Co- Chief Guide: Dr Tanjul Saxena**,** Associate Professor IIHMR University, Jaipur. I feel extremely proud to be her student. Her guidance proved valuable during the research work and her consistent Encouragement was an inspiration to me throughout this project. I gratefully acknowledge the interest, Attention and valuable time she has so delectably bestowed upon her work.

I whole heartedly thank Honourable Col. (Dr) Ashok Kaushik, Dean, Academics, IIHMR University, Jaipur, Rajasthan for his Support, Guidance and Encouragement throughout this project.

Last but not the least; I would like to thank the Human Resource Department and Staff of The Mission Hospital, Durgapur (West Bengal) for cooperating at the maximum, my parents and my college mates for their support and help throughout the project.

CONTENT

ACRONYMS/ABBREVIATIONS

TMH	the Mission Hospital
ECHS	ex- Serviceman Contributory Health Scheme
CGHS	Central Government Health Scheme
NABH	National accreditation board for hospitals & healthcare providers
NABL	National accreditation board for Laboratories
OPD	Outpatient department
BLS	Basic life support
MRI	Magnetic resonance imaging
CT SCAN	Computed tomography
IGRT	Image guided radiation therapy
IVUS	Intravascular ultrasound
OCT	Optical coherence tomography
VATS	Video - assisted Thoracoscopic Surgery
NICU	Neonatal intensive care unit
PM	Pressure Monitoring
BMT	Bone Marrow Transplantation

TEE Trans Esophageal Echocardiography

KAP Knowledge Attitude Practice

INTRODUCTION

Audit of inpatient files represents the main information support used by hospital. The purpose of this paper is to examine whether patient perception of hospital care quality related to compliance with inpatient-record keeping.

Audit to assess the compliance of inpatient files can be a time-consuming process, but the benefits far outweigh the inconvenience. In the simplest terms, audit of inpatient files is a chart review which is used to identify what is being done correctly and what is in the need of improvement. Depending on the objective, audits can be performed by staff within an organization. Audits conducted by a third party are generally to review compliance, and internal audits are usually performed to evaluate current treatment processes and measure quality of care.

Documentation is a communication tool in which exchange of information is stored between nurses and caregivers. Quality documentation promotes structured, consistent and effective communication between caregivers and facilitates continuity and individuality of care and safety of patients.

The medical record is a document that tells the story of the patient and facilitates each encounter they have with hospital staff involved in their care. In addition to telling patients story, complete accurate medical record will meet all legal, regulatory and auditing requirements. Quality documentation promotes effective communication between caregivers, which facilitates continuity and individuality of care. Documentation quality, accuracy and development need can be monitored through auditing instruments. Audit is the process of collecting information from the patient's reports and other documented evidence about patient care and assessing the quality of care by the use of quality assurance program. It is a detailed review and evolution of the selected clinical records by the qualified professional personnel for evaluating quality of patient care.

Clinical record keeping is an integral component in good professional practice and the delivery of quality healthcare. Regardless of the form of the records, good clinical record keeping should enable continuity of care and should enhance communication between different healthcare professionals. Consequently, clinical records should be updated, where appropriate, by all members of the multidisciplinary team that are involved in a patient's care (physicians, surgeons, nurses, pharmacists, physiotherapists, occupational therapists, psychologists, chaplains, administrators or students). Should the need arise patients themselves should have access to their records to be able to see what has been done and what has been considered. Clinical records are also valuable documents to audit the quality of healthcare services offered and can also be used for investigating serious incidents, patient

complaints and compensation cases. In this issue of Breathe we will present the importance of keeping good clinical records, ways of facilitating this and an overview of legal aspects linked with clinical record keeping. There is also a list of suggested reading from several countries that may prove useful

Good clinical notes document the medical history of the patient. By documenting all relevant clinical information you are recording this information for future reference. Remember, if you did not write it down, it did not happen. This is of particular relevance in the case of a contested medical decision but most importantly it ensures continuity.

Continuity in clinical notes is of vital importance to patient care as, in the current medical environment, many different healthcare professionals are involved in the treatment of a single patient.

Making sure that clinical notes are up to date and completed accurately with sufficient information will ensure that the proper information is provided to all relevant healthcare workers and will aid them in potential future decisions. This, in turn, will benefit the patient through less time lost on repeating tests and by averting inaccurate diagnoses or the prescription of inappropriate treatments.

The purpose of complete and accurate patient record documentation is to foster quality and continuity of care. It creates a means of communication between providers and patient/ patient relatives about health status, preventive health services, treatment, planning, and delivery of care.

REVIEW OF LITERATURE-

Voutilainen P[1], Isola A, Muurinen S Scand J Caring Sci. 2004 Mar;18(1):72-81

- The documents studied were mainly nursing care plans and daily note sheets. Seventy-three per cent of the nursing home residents had an up-to-date nursing care plan at the time of data collection. The main results demonstrated that a written statement on the patient's mental ability was lacking in every fourth document although 75% of the patients suffer from at least moderate dementia in Finnish long-term care institutions. Development activities should also be targeted to the documentation of clear and concrete means by which patients' independent functioning is supported. Although a lot of in-service training has been focused on improving the documentation practices, there is still a need for development. The means by which knowledge is transferred to guide the practice should be carefully considered. Also forms should be developed to meet the special requirements for recording nursing care in long-term care settings.

Boulay F, Chevallier T, Gendreike Y, Joliot Y, Sambuc R. et al: can medical be used to audit the hospital health care

- This study done by (Boulay F , et al 1997) and analysis of the 467 forms returned by 39 hospital, showed the quality of medical files recording should be improved as a large amount of data or important documents were missing : reason for hospitalisation (recorded on 74.1% of files), operation report
  (Found in 83.2% of files) and discharge summary (found in 66.6% of files [14].and there is an another study which state that general practitioners, admission document, and delivery, anaesthesia and transfusion record were almost always present. Surgery reports were found in 65 to 89% of the files. Low compliance with three criteria were observed: authorisation to give health care to a minor (39 to 89% of the files), identification the physician who prescribed the drugs during hospitalisation (6 to 32 %) and discharge prescription (42 to 95%) [15]
  Clinical audit would be compromised in certain hospital by the use medical files [14]. Wide spread and systematic application of clinical audit may improve the quality of patient care and maintain the trust of the population. However, clinical audit should be effective and cost effective

RESEARCH QUESTION-

What is the documentation compliance rate of inpatient files and is it depended on KAP (Knowledge, Attitudes and Practices) of people responsible for documentation.

OBJECTIVES-

- To audit the compliance of Inpatient documentation and assess the gaps in documentation.
- To assess the Knowledge, Attitudes and Practices for staff responsible for documentation.
- To investigate if there is any association between documentation compliance and demographic characteristics like gender, age and qualification of people responsible for documentation

HYPOTHESIS-

- There is no association between demographic characteristics like (Gender, Age, and Qualification) with KAP about documentation compliance.

MATERIAL AND METHODS-

STUDY DESIGN- Descriptive and analytical study

SETTING- The Mission Hospital, Durgapur

STUDY POPULATION- For Objective 1st Inpatient files and for 2nd objective staff responsible for documentation in 4 different Department

- Inclusion criteria-The patients those treatments is going on.
- Exclusion criteria- Discharged patient files and medical record files were excluded from the study

DURATION OF STUDY- 3 Months

SAMPLE SIZE-

- Total 240 **(**60 Inpatient files in 4 different Department)
- All staff responsible for Documentation in 4 different Department (Total 80)

SAMPLING TECHNIQUE-

- For inpatient files: consecutive enumeration: All patients admitted on the day of data collection till the desired number of 60 in the department was achieved.
- For KAP study – Convenience Sampling: 20 Hospital staff in the each department under study responsible for compliance

COLLECTION TOOLS- Checklist for Inpatient files, KAP (Knowledge, Attitudes and Practices) Questionnaire for KAP study

DATA ANALYSIS -

1- GAP analysis by comparing documented live files with standard documentation
2- Descriptive analysis for KAP
3- CHI square test for testing the Hypothesis

TOOLS OF ANALYSIS- Excel sheet

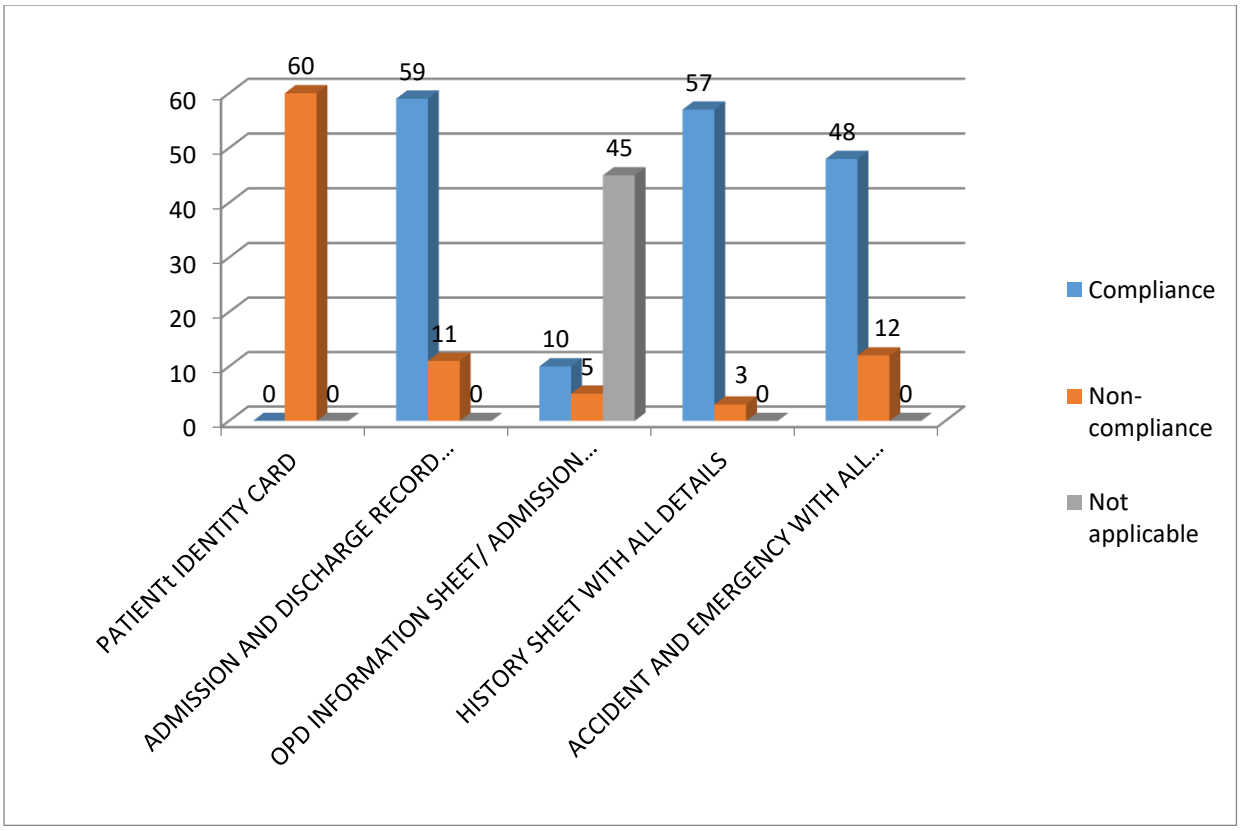
ETHICAL CONSIDERATIONS-

- Permission was obtained from the Head of the Quality Department & CMS of The Mission Hospital, Durgapur
- Appropriate measures should be stated to ensure data security, privacy, and confidentiality.

"DOCUMENTATION COMPLIANCE OF IN PATIENT FILES IN HOSPITAL"

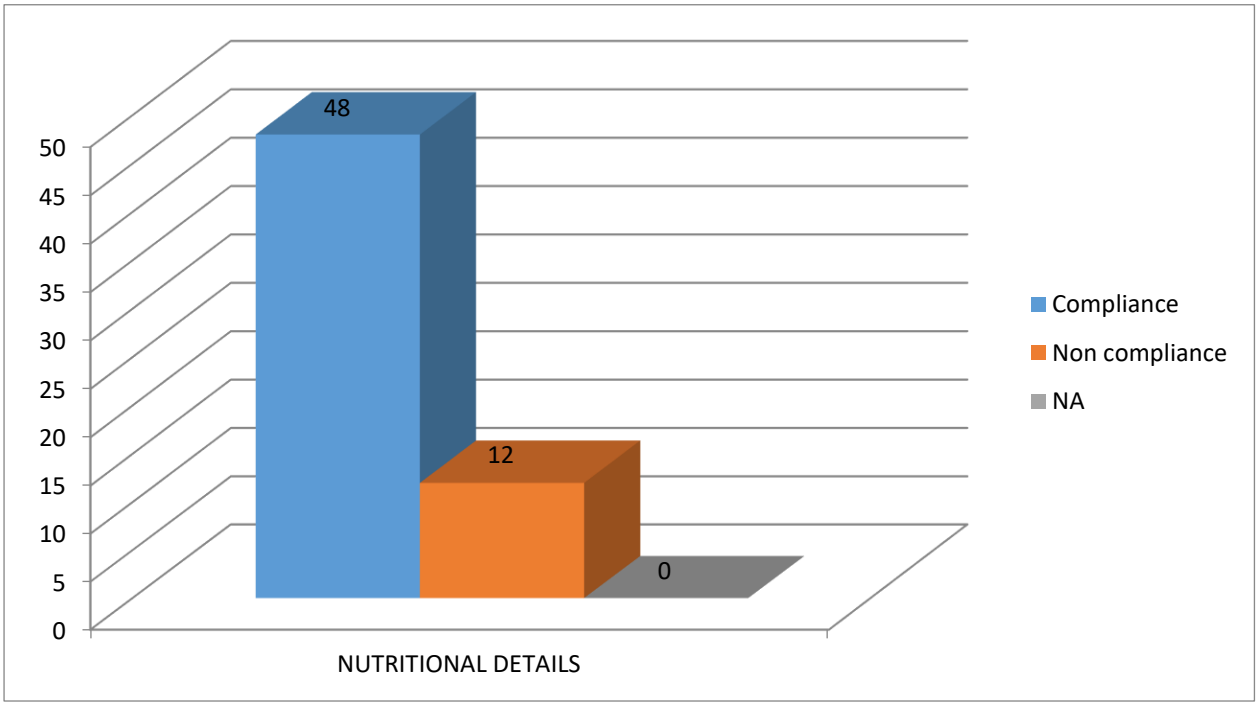
(DOCUMENTATION CHECKLIST OF FEMALE WARD

(A) ADMISSION DETAILS



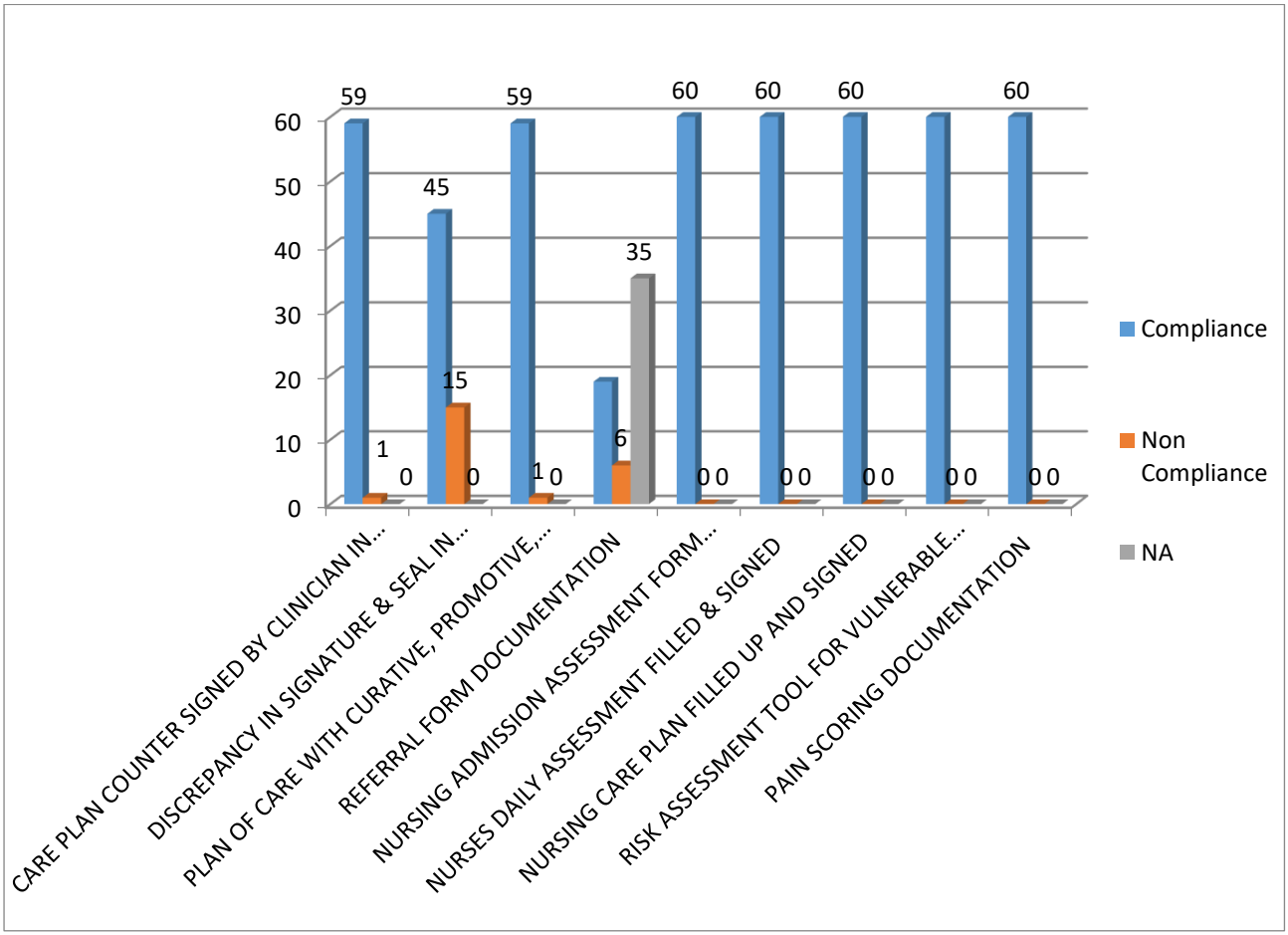
INTERPRETATION: Highest Compliance rate of 98.3% was found in Admission and discharge record with all details & lowest compliance rate is 0% in Patient Identity card, which signifies that patient identity card has highest non-compliance rate of 100% compared to lowest non-compliance rate of 20% found in Accident & Emergency with all details.

(B) NUTRITIONAL DETAILS



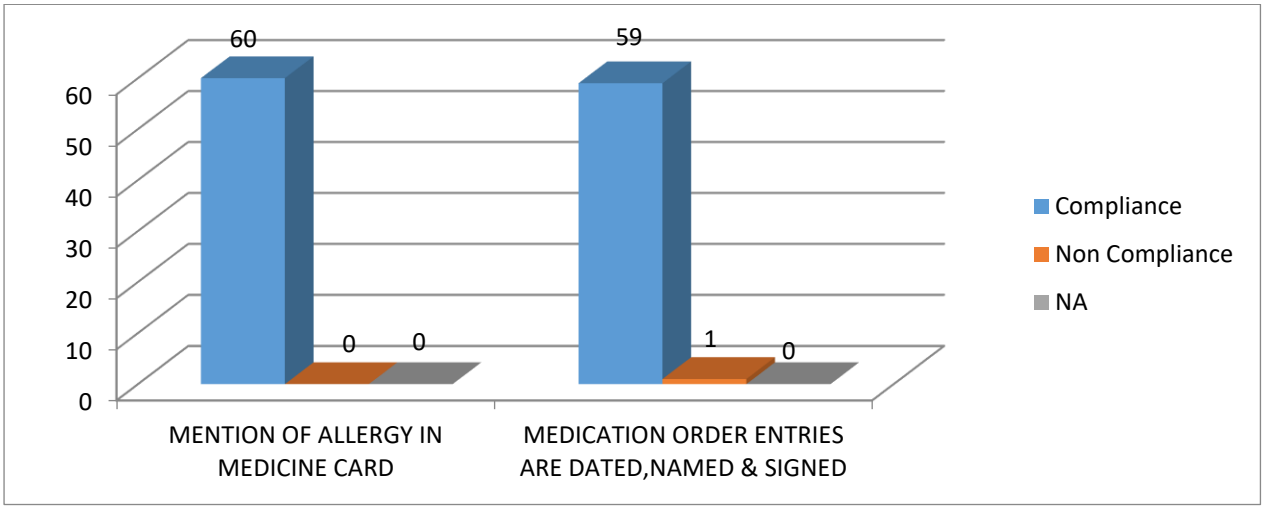
INTERPRETATION: 80% files were found to be compliant with nutritional details compared to 20% files which were non-compliance with nutritional details.

(C) DOCTOR AND NURSING DETAILS



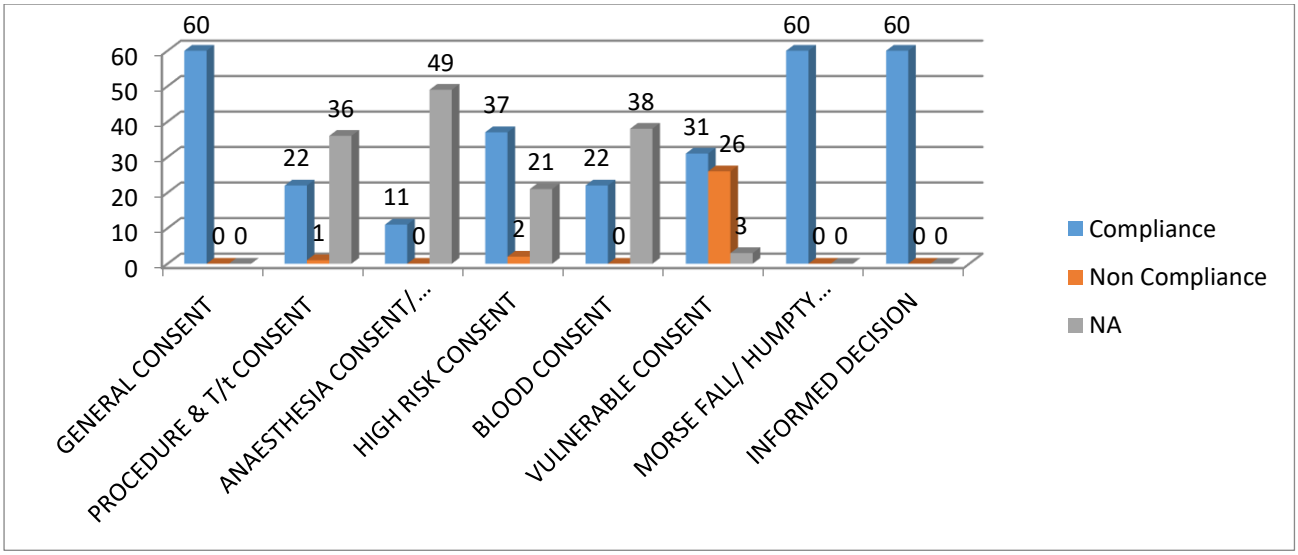
INTERPRETATION: 100% compliance rates were found in Nursing admission assessment form filled up & signed, Nurses daily assessment filled up and signed, Nursing care plan filled up and signed & in pain score documentation low compliance rate was found that is 31.6% in Referral form documentation. Highest non-compliance rate was in referral form documentation.

(D) MEDICINE CARD



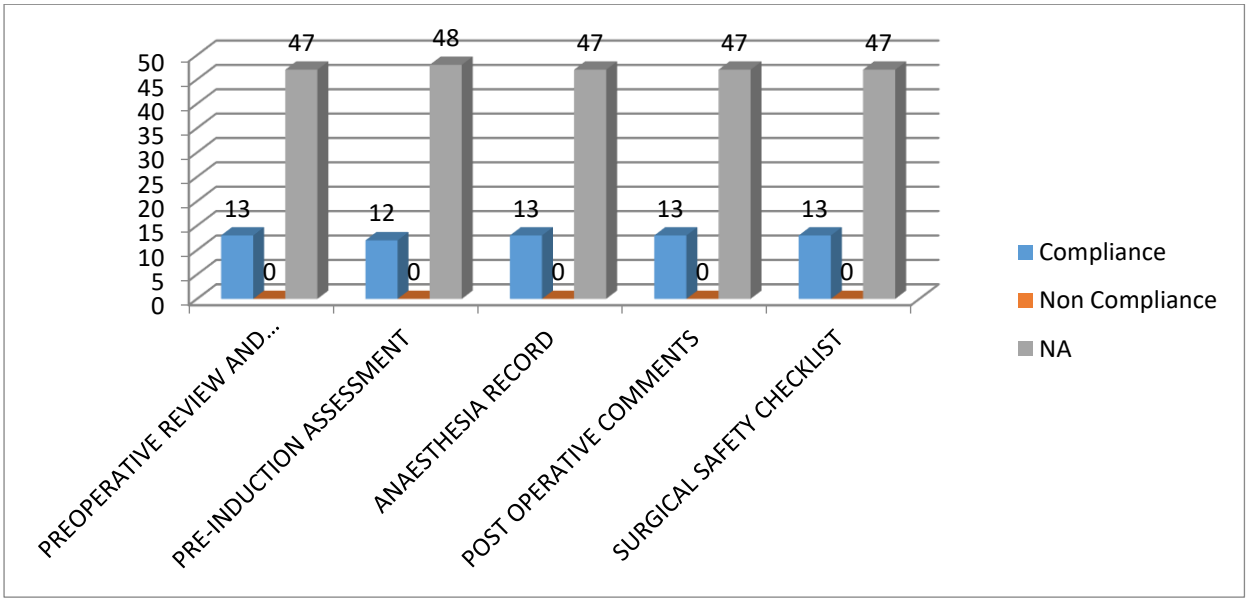
INTERPRETATION: There was 100% & 98% compliance with documentation of Mention of allergy in medicine card & medication order entries are dated, named & signed respectively.

(E) CONSENTS



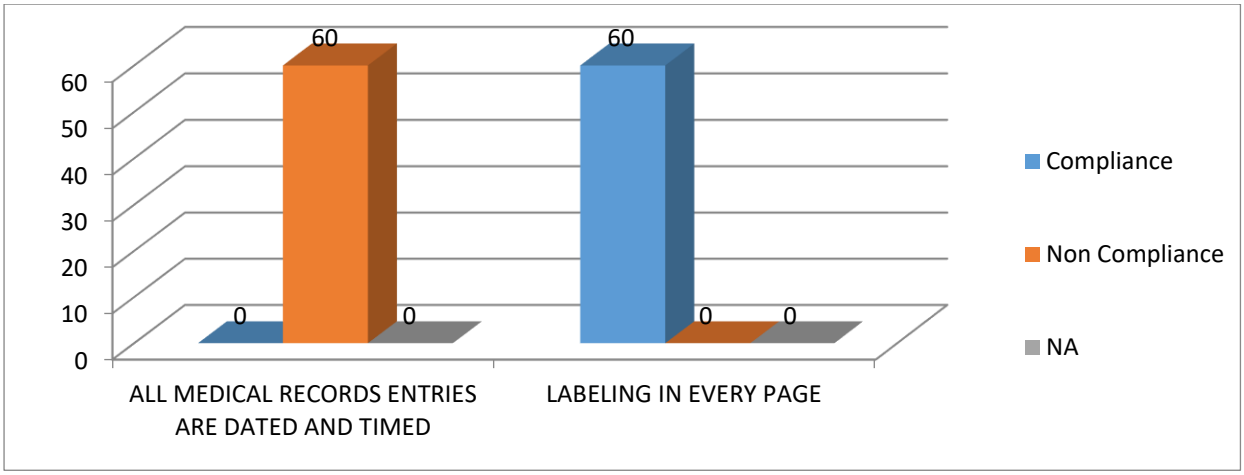
INTERPRETATION: Out of all the Consent forms 100% compliance was found in General consent, Morse fall/humpty dumpty scale & informed decision, lowest compliance 18.3% found in Anaesthesia Consent and type of anaesthesia. Highest non-compliance rate was found in vulnerable consent with 43.3% and High risk consent.

(F) PROCEDURE DOCUMENTATION



INTERPRETATION: There was 100% compliance found in files for procedure documentation.

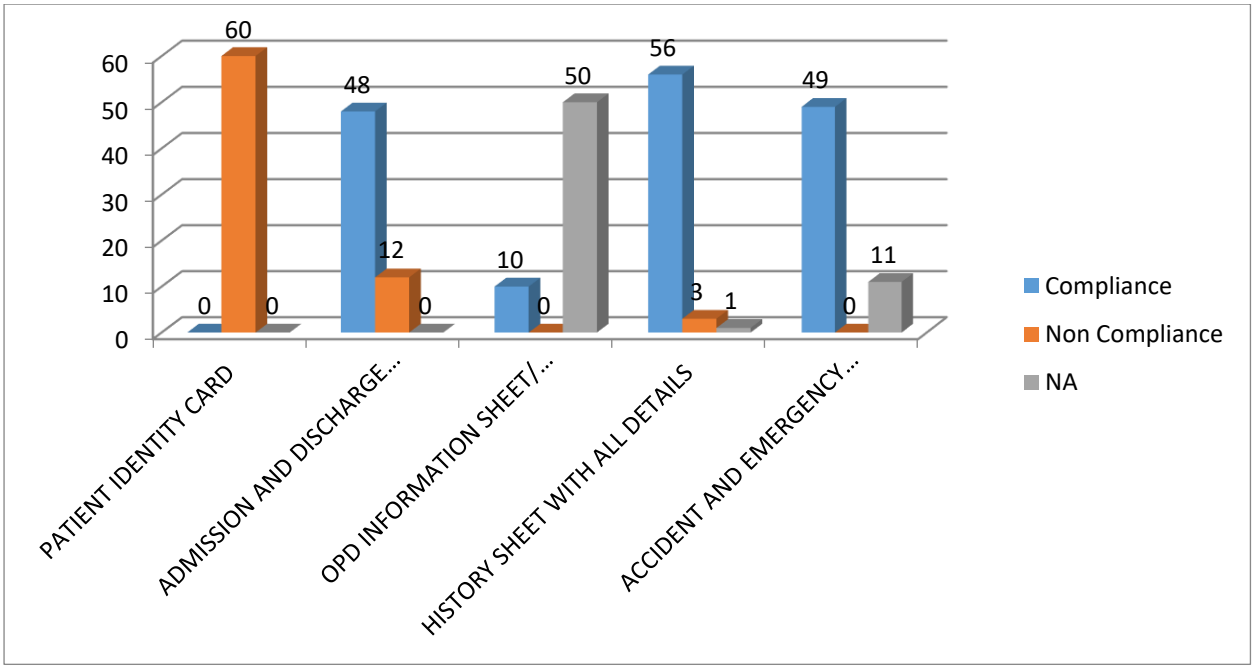
(G) OTHERS



INTERPRETATION: There was 100% compliance of files in labelling in every page compared to 100% non-compliance in files for medical records entries are dated & timed.

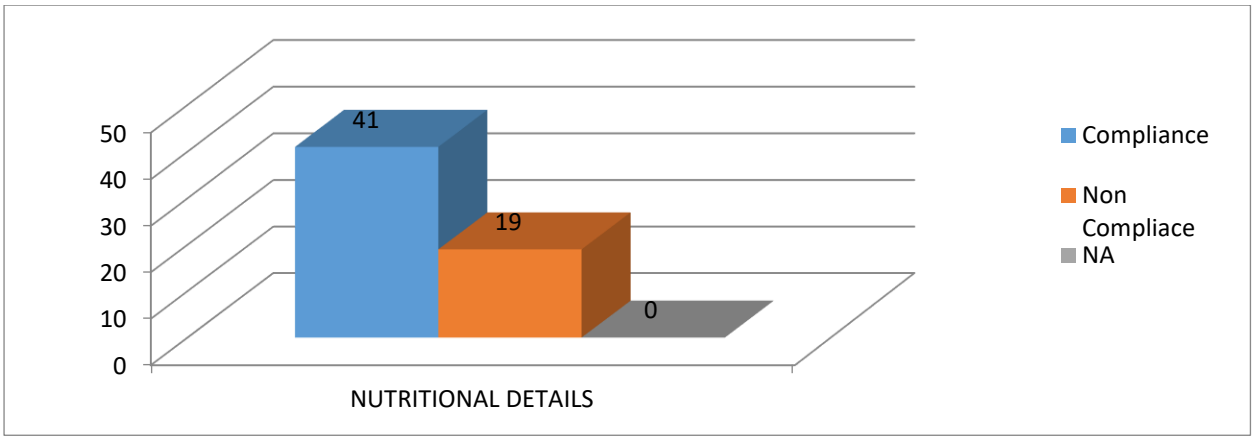
(DOCUMENTATION CHECKLIST OF MALE WARD)

(A) ADMISSION DETAILS



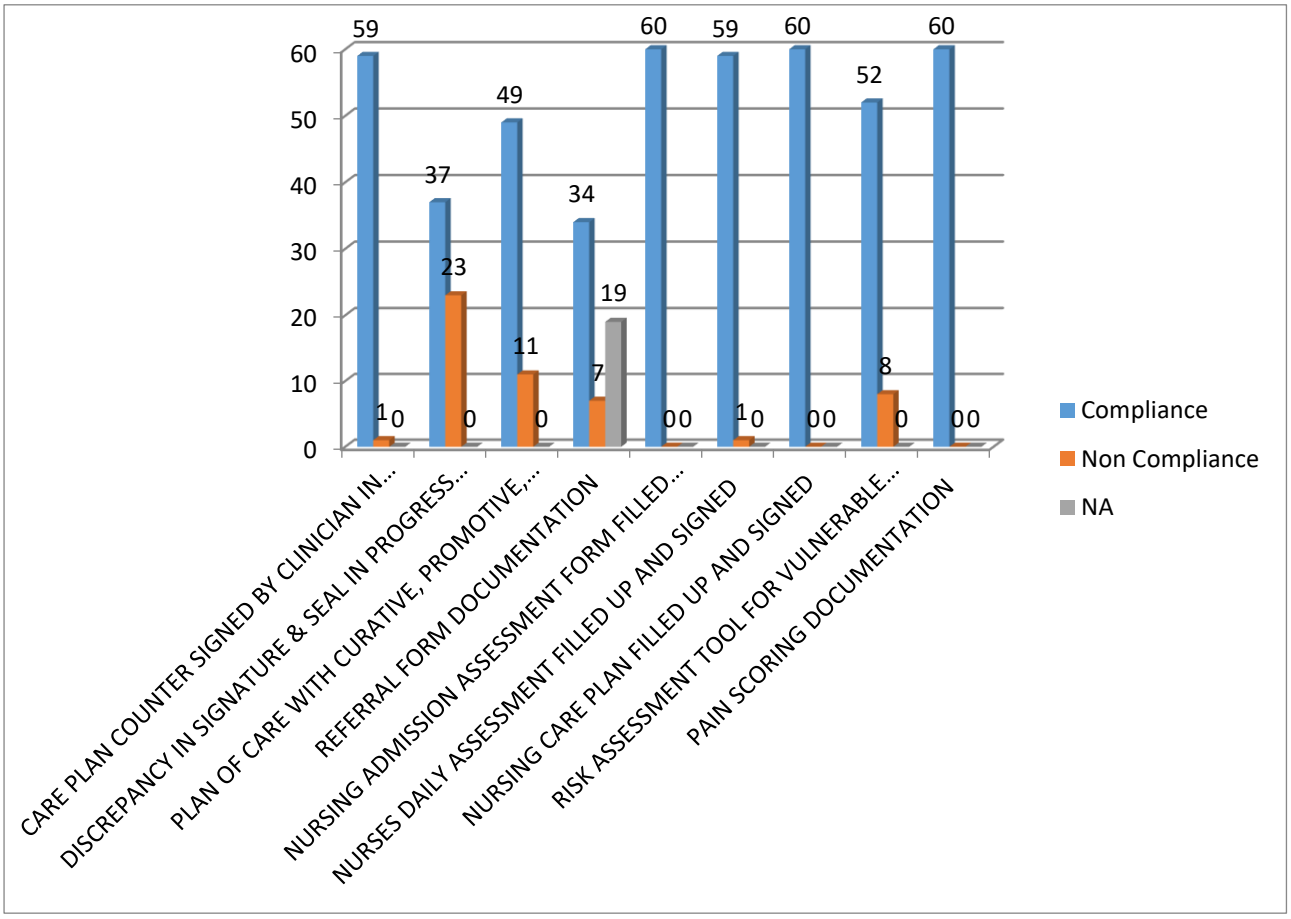
INTERPRETATION: Highest Compliance rate of 93.3% was found in History sheet with all details & lowest compliance rate is 0% in Patient Identity card, which signifies that patient identity card has highest non-compliance rate of 100% compared to lowest non-compliance rate of 0% found in Accident & Emergency with all details.

(B) NUTRITIONAL DETAILS



INTERPRETATION: 68.3% files were found to be compliance with nutritional details compared to 31.7% files which were non-compliance with nutritional details.

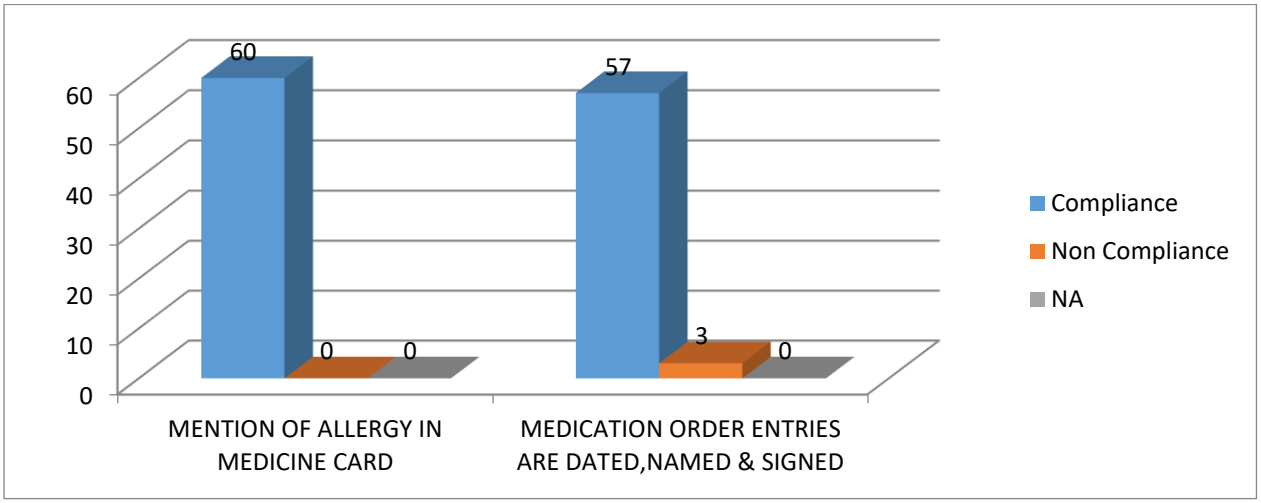
(C) DOCTOR AND NURSING DETAILS



INTERPRETATION: 100% compliance rates were found in Nursing admission assessment form filled up & signed, Nursing care plan filled up and signed & in pain score documentation compared to lowest compliance rate found in 56.6% in Referral form

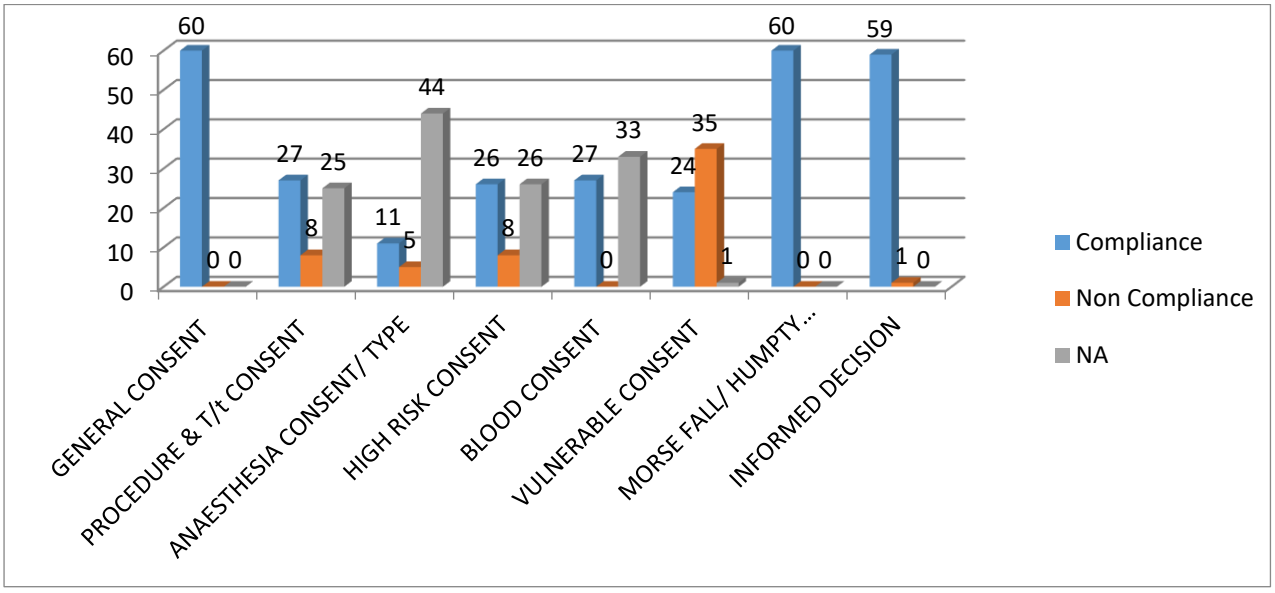
documentation. Highest non-compliance rate was in discrepancy in signature and seal in progress notes.

(D) MEDICINE CARD



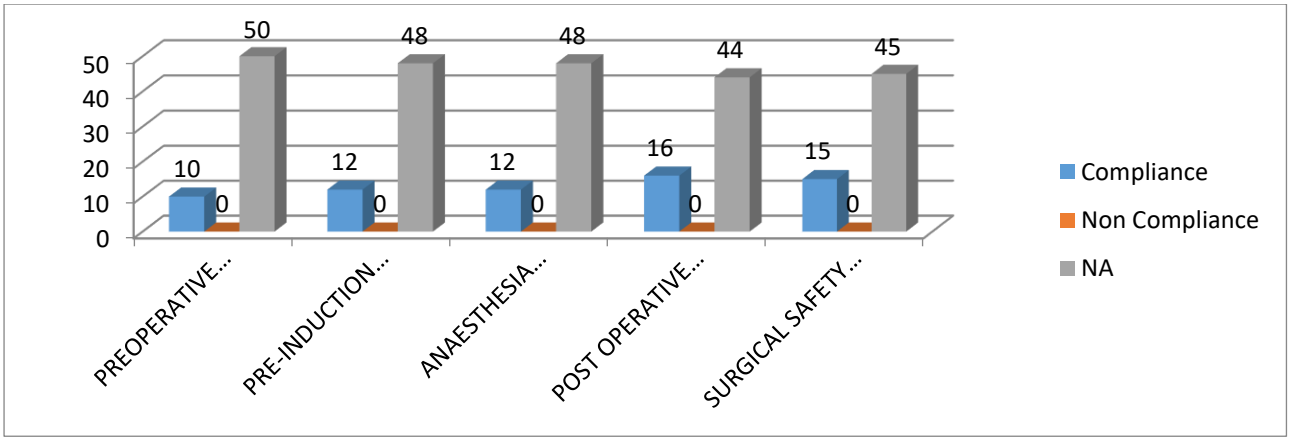
INTERPRETATION: There was 100% & 95% compliance with documentation of Mention of allergy in medicine card & medication order entries are dated, named & signed respectively.

(E) CONSENTS



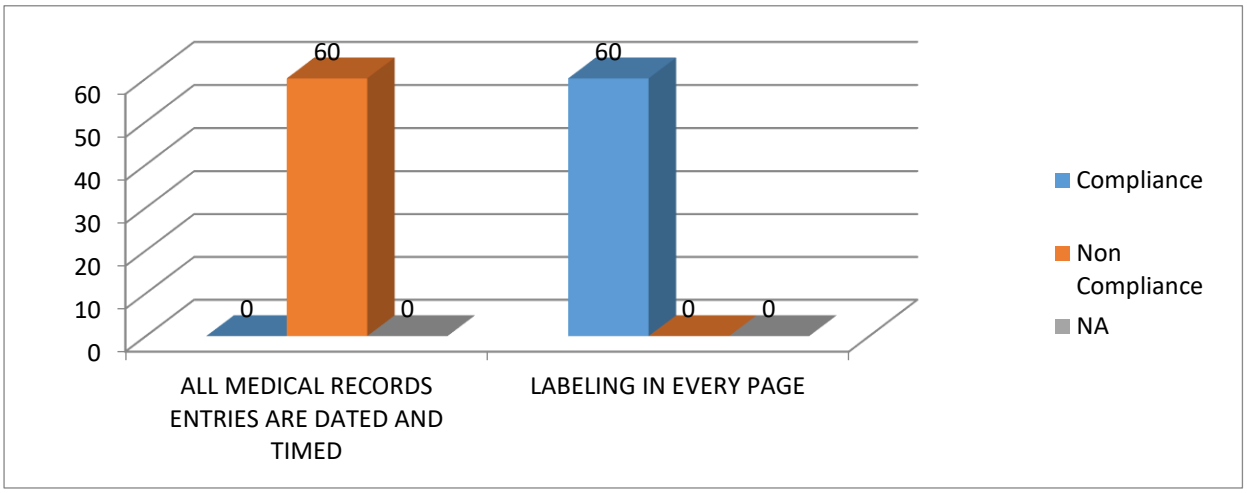
INTERPRETATION: Out of all the Consent forms 100% compliance was found in General consent & more fall/humpty dumpty scale as compared to lowest compliance rate of 18.3% found in Anaesthesia Consent and type. Highest non-compliance rate was found in vulnerable consent with 58.3%

(F) PROCEDURE DOCUMENTATION



INTERPRETATION: There was 100% compliance found in files for procedure documentation

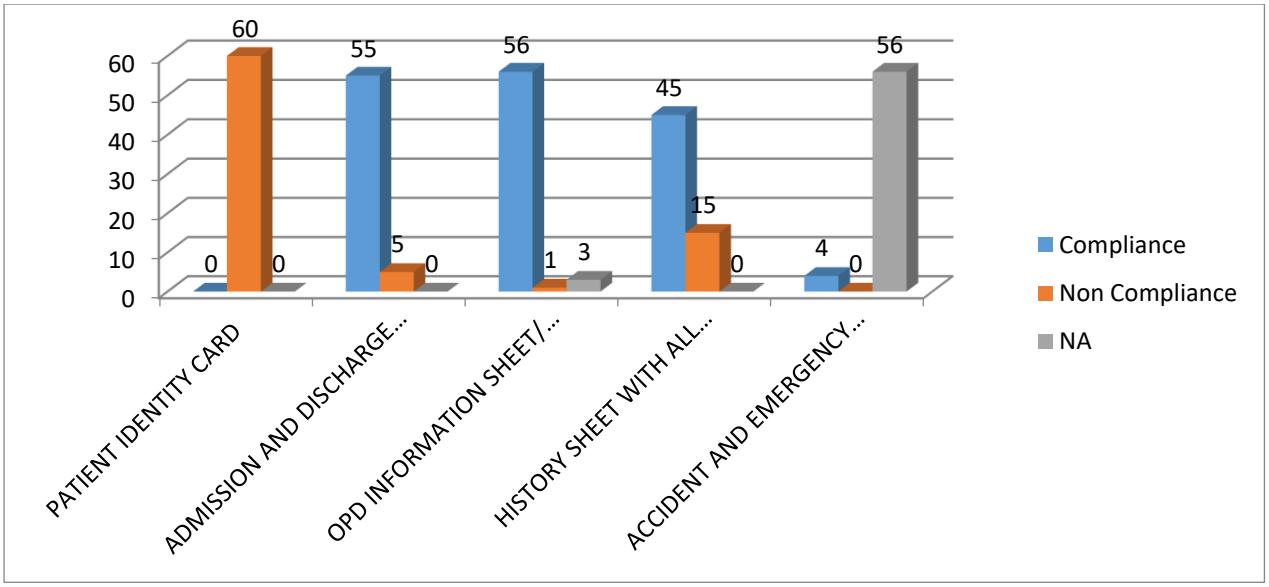
(G) OTHERS



INTERPRETATION: There was 100% compliance of files in labelling in every page compared to 100% non-compliance in files for medical records entries are dated & timed.

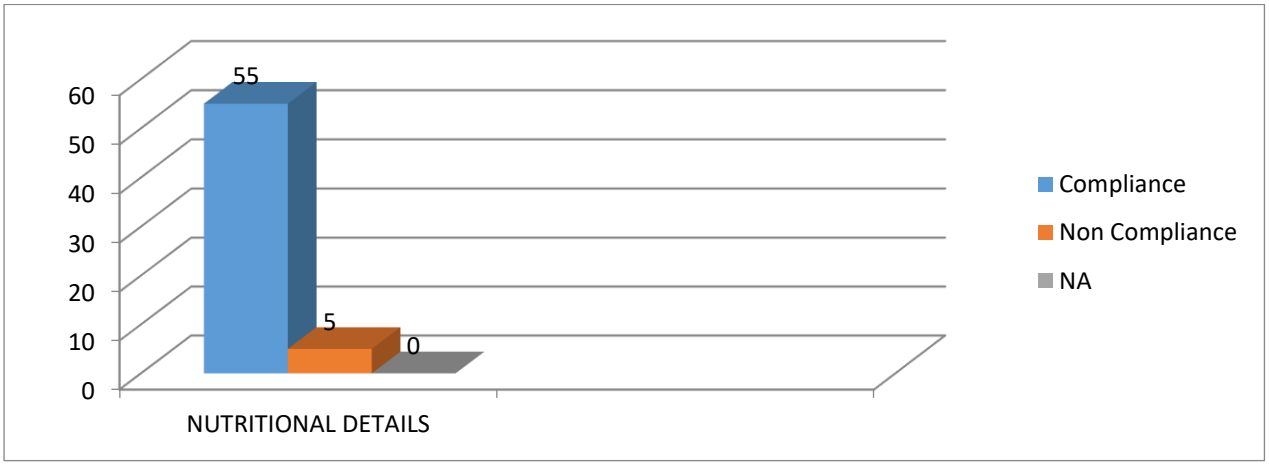
(DOCUMENTATION CHECKLIST OF CARDIAC WARD

(A) ADMISSION DETAILS



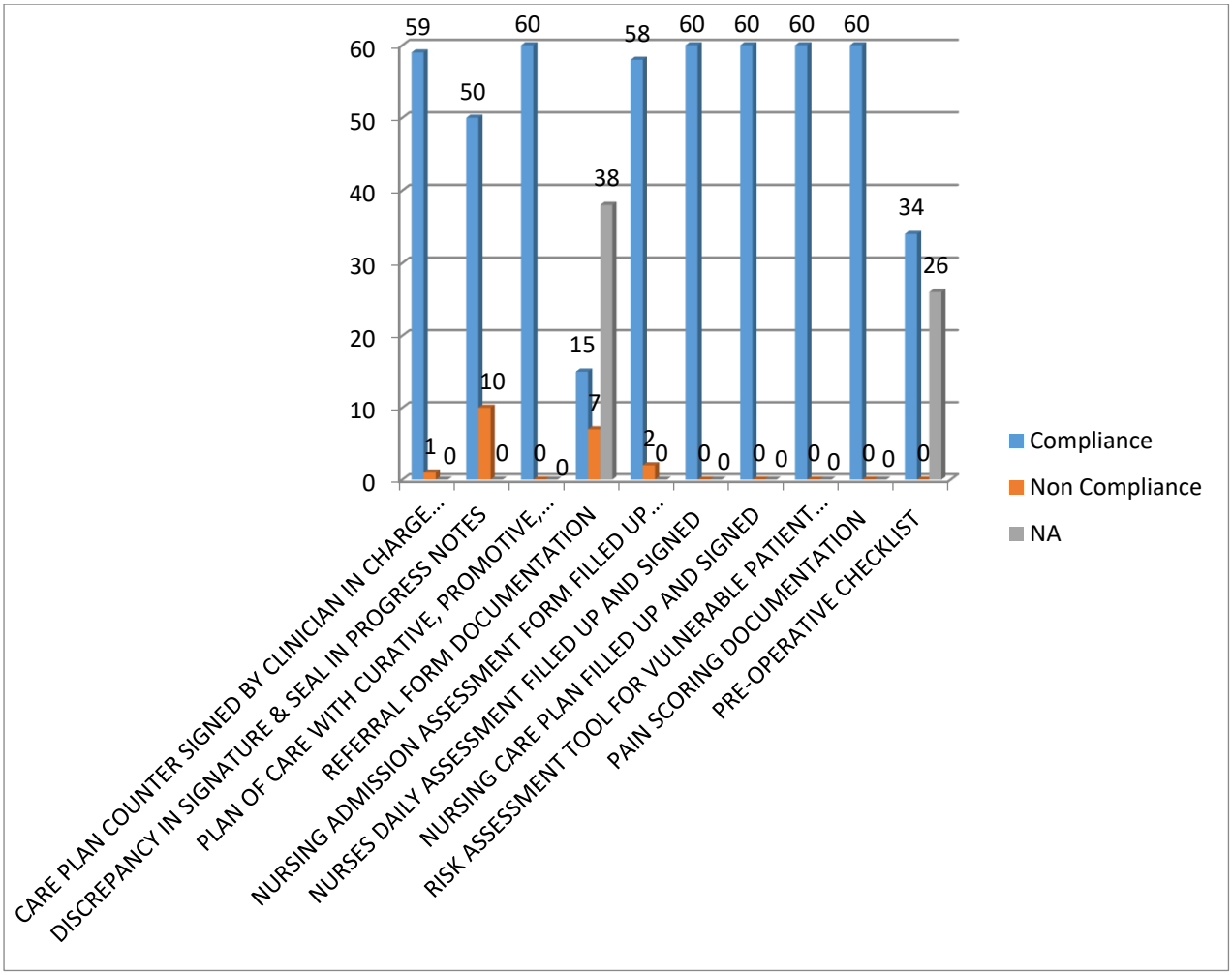
INTERPRETATION: Highest Compliance rate of 93.3% was found in OPD information sheet/Admission note sheet & lowest compliance rate is 0% in Patient Identity card, which signifies that patient identity card has highest non-compliance rate of 100% compared to lowest non-compliance rate of 0% found in Accident & Emergency with all details.

(B) NUTRITIONAL DETAILS



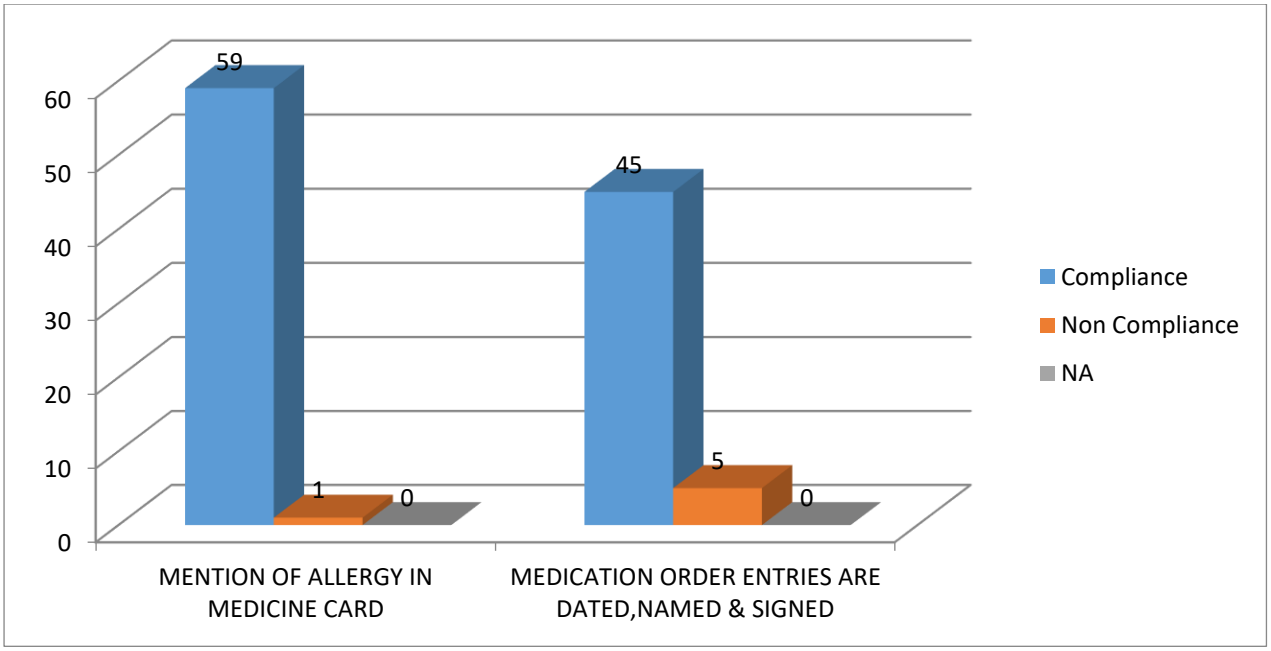
INTERPRETATION: 98.6% files were found to be compliance with nutritional details compared to 8.3% files which were non-compliance with nutritional details.

(B) DOCTOR AND NURSING DETAILS



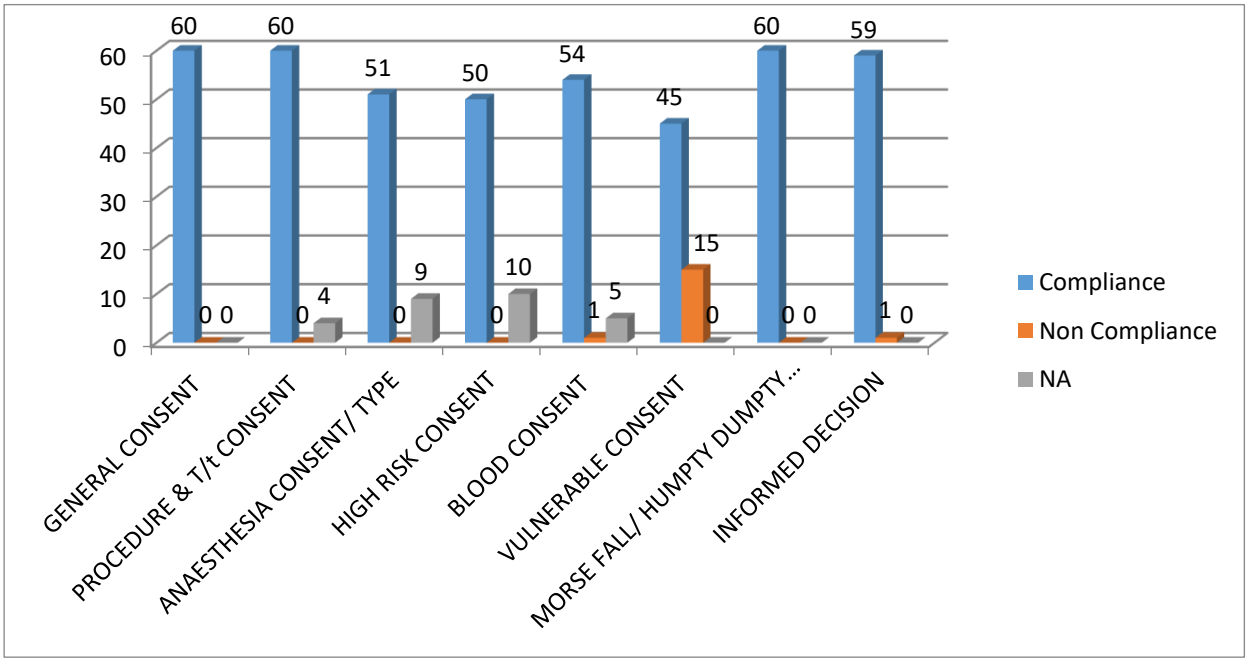
INTERPRETATION: 100% compliance rates were found in Plan of care with curative, promotive, preventive and rehabilitative aspects, Nurses daily assessment filled up and signed, Nursing care plan filled up and signed, Risk assessment tool for vulnerable patient with all details and signed, in pain score documentation, compared to lowest compliance rate found in 25% in Referral form documentation. Highest non-compliance rate of 16.6% was in discrepancy in signature and seal in progress notes.

(C) MEDICINE CARD



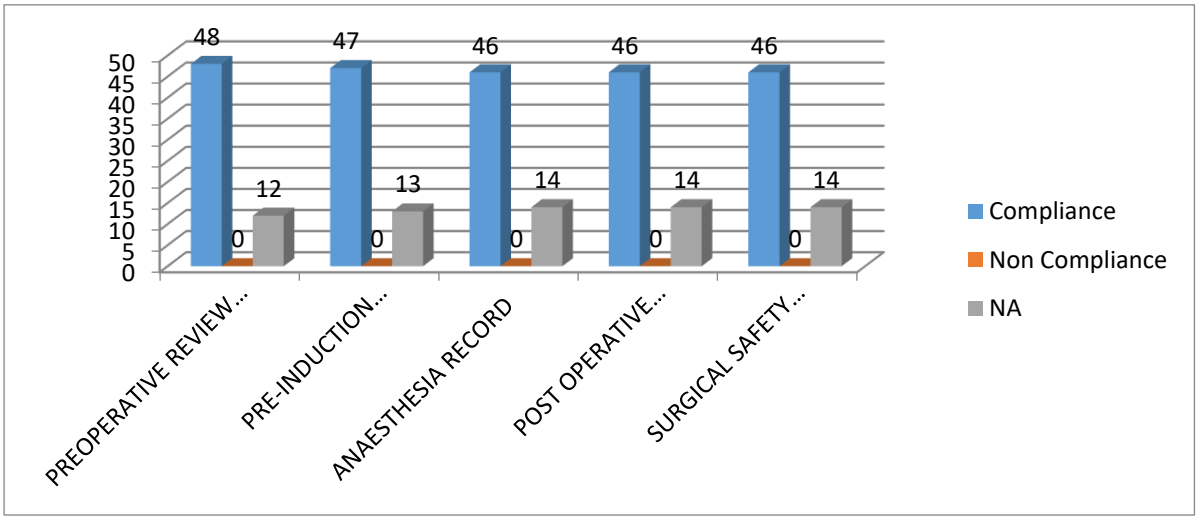
INTERPRETATION: There was 98.3% & 75% compliance with documentation of Mention of allergy in medicine card & medication order entries are dated, named & signed respectively.

(D) CONSENTS



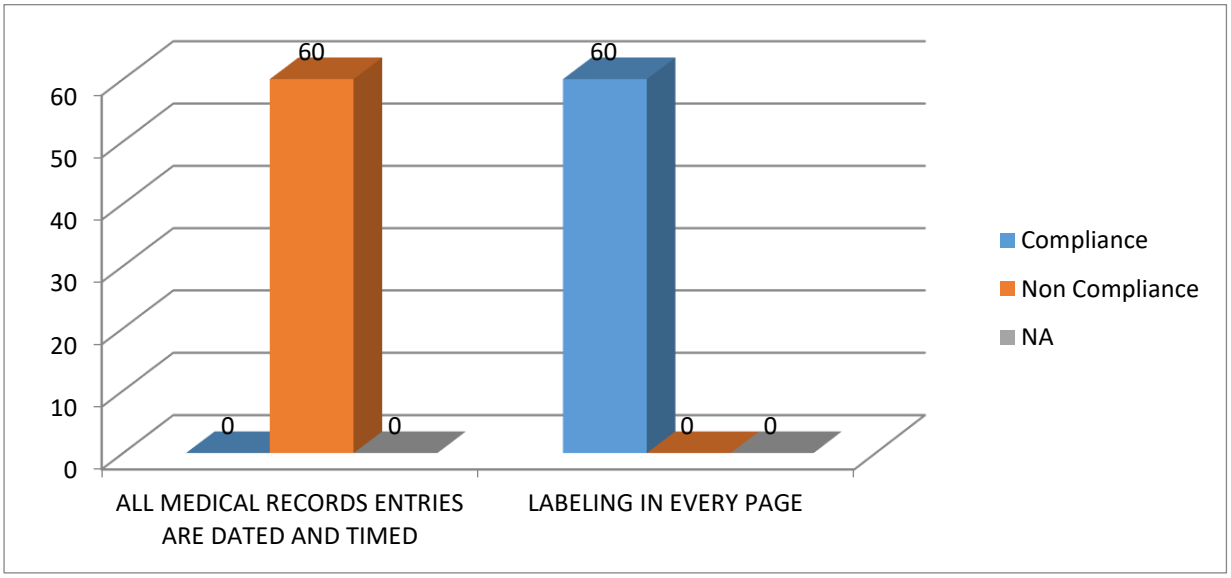
INTERPRETATION: Out of all the Consent forms 100% compliance was found in General consent, more fall/humpty dumpty scale and procedure and treatment consent, compared to lowest compliance and noncompliance rate of 75% respectively were found in Vulnerable Consent and type.

(E) PROCEDURE DOCUMENTATION



INTERPRETATION: There was 100% compliance found in files for procedure documentation.

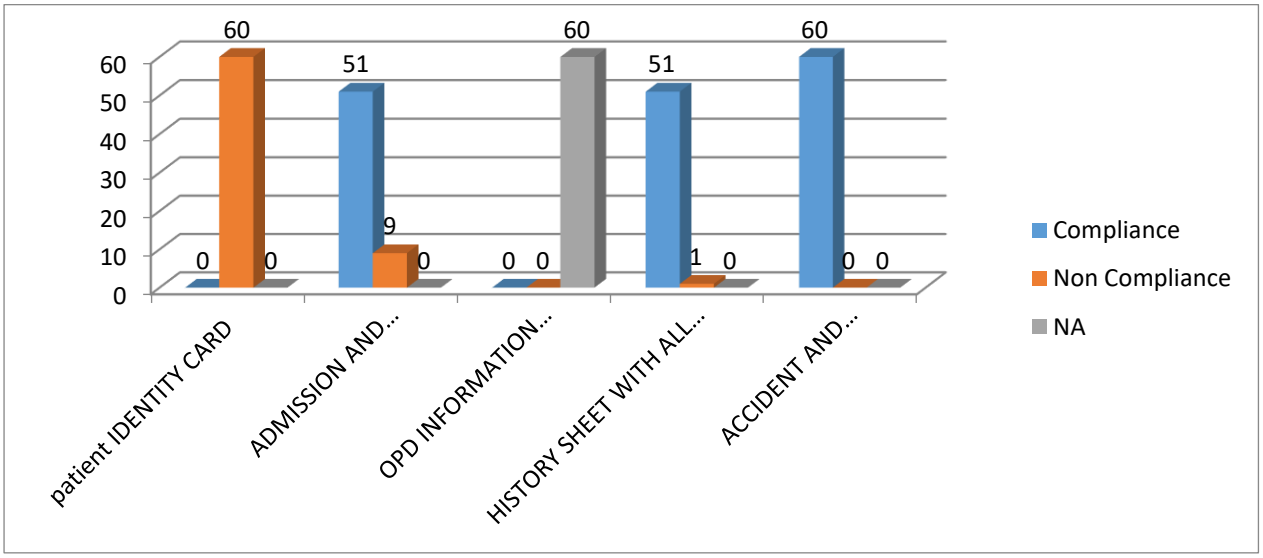
(F) OTHERS



INTERPRETATION: There was 100% compliance of files in labelling in every page compared to 100% non-compliance in files for medical records entries are dated & timed.

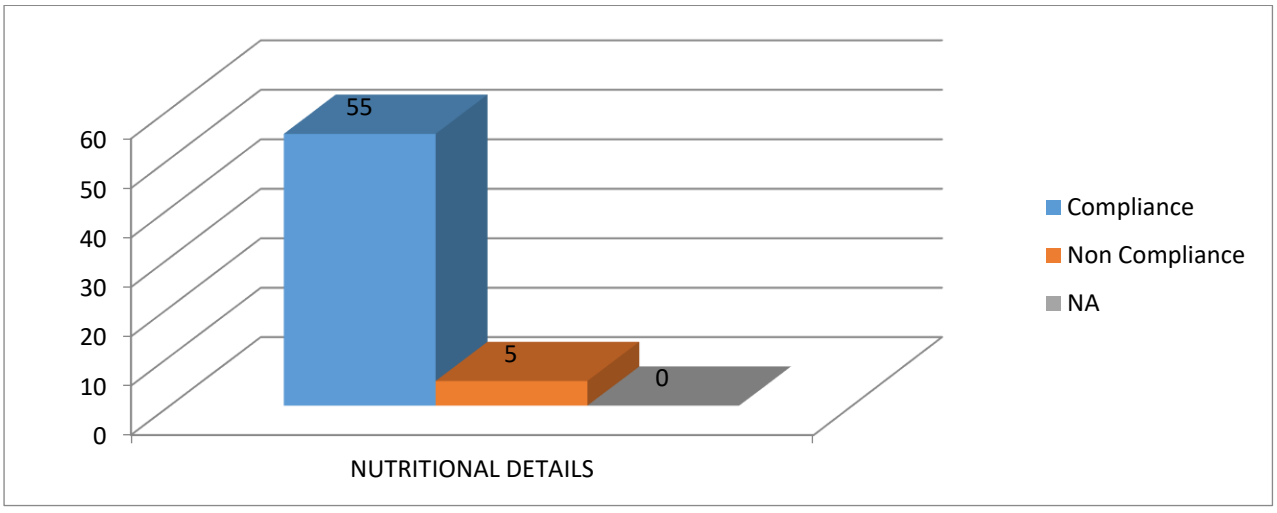
(DOCUMENTATION CHECKLIST OF ICU WARD

(A) ADMISSION DETAILS



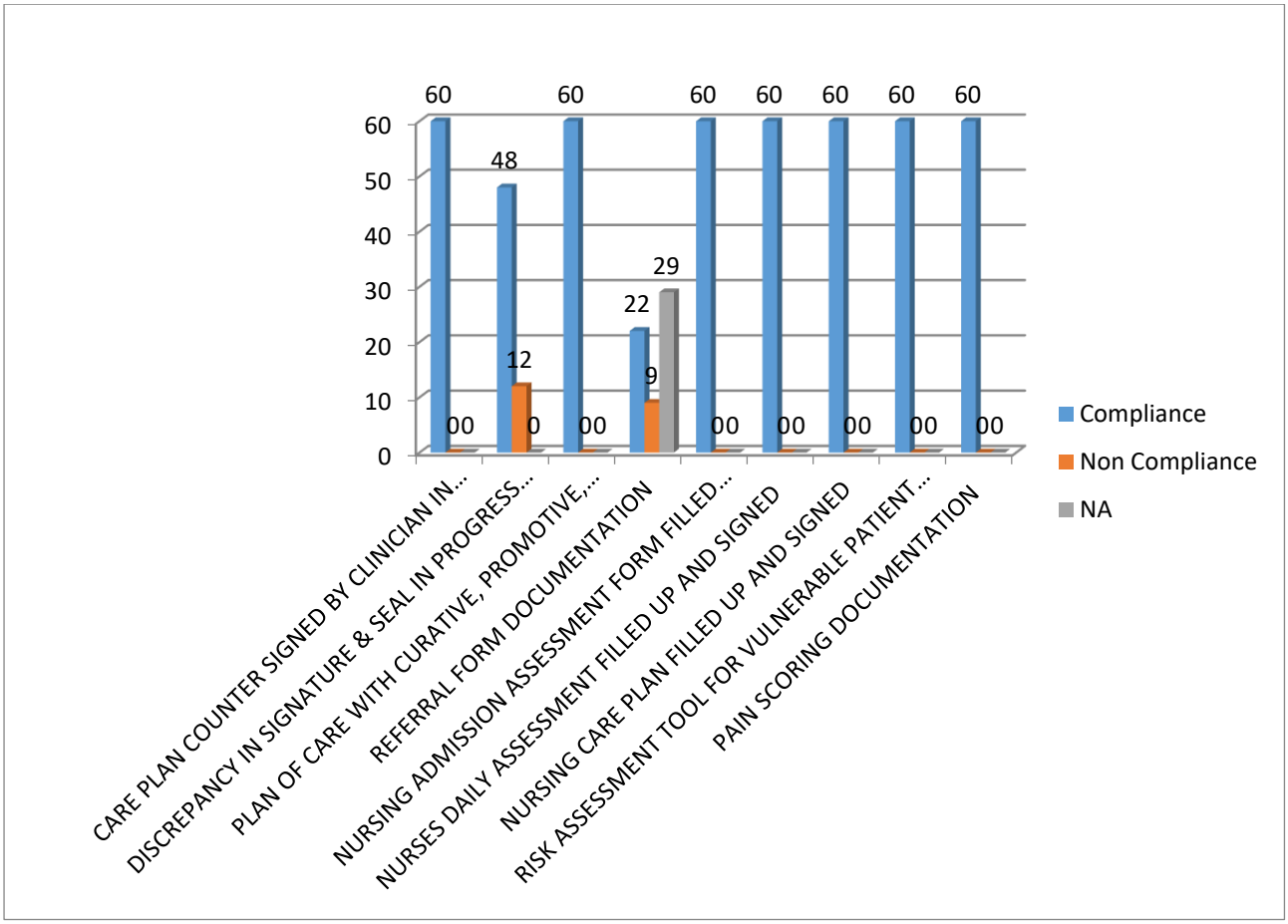
INTERPRETATION: Highest Compliance rate of 100% was found in in Accident & Emergency with all details compared to lowest compliance rate of 85% found in admission and discharge record with all details and history sheet with all details. Highest non-compliance rate of 100% was found in patient identity card compared to lowest non-compliance rate of 1.67 % found in History sheet with all details.

(B) NUTRITIONAL DETAILS



INTERPRETATION: 91.6% files were found to be compliance with nutritional details compared to 8.4% files which were non-compliance with nutritional details.

(C) DOCTOR AND NURSING DETAILS



INTERPRETATION: 100% compliance rates were found in all doctor and nursing details except discrepancy in signature & seal in progress notes and referral form documentation. Lowest non-compliance rate was found in referral form documentation with a rate of 15%

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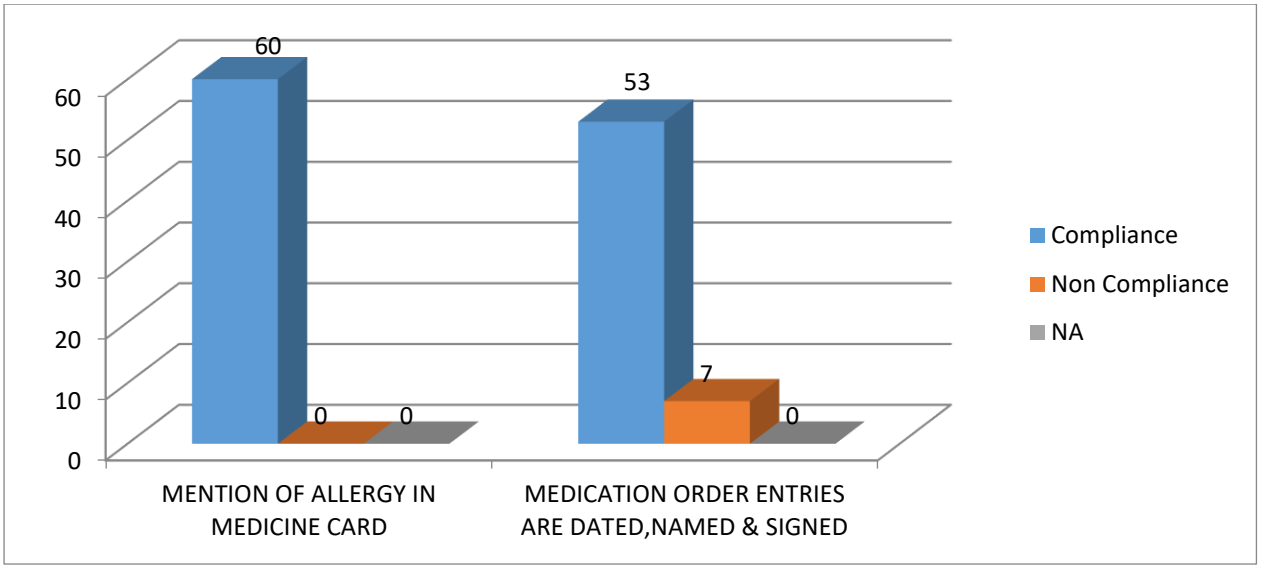
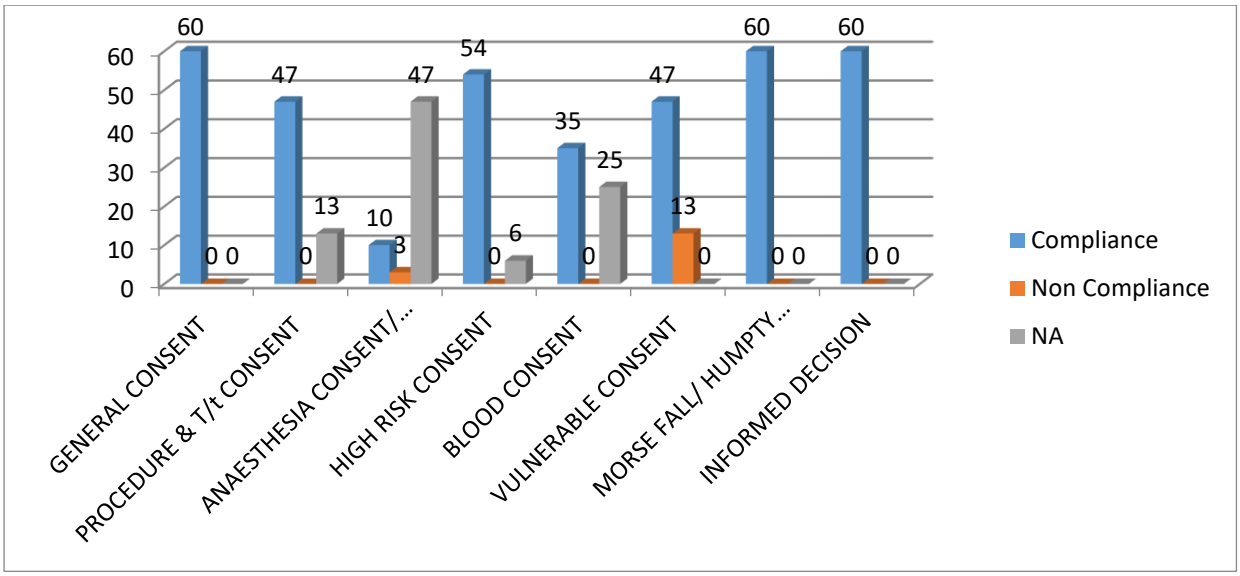
(D) MEDICINE CARD



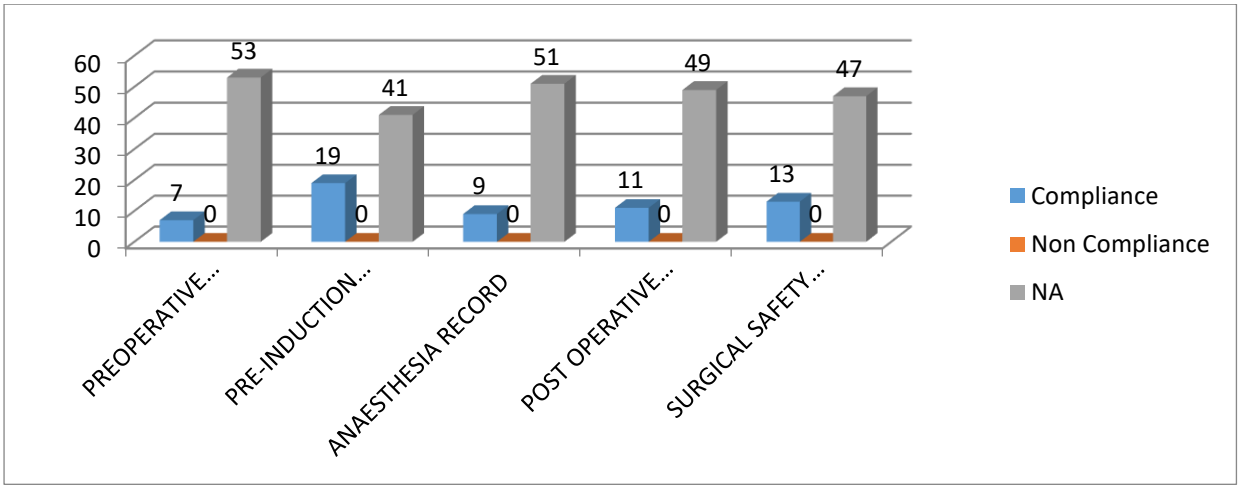
INTERPRETATION: There was 100% & 88.3% compliance with documentation of Mention of allergy in medicine card & medication order entries are dated, named & signed respectively.

(E) CONSENTS



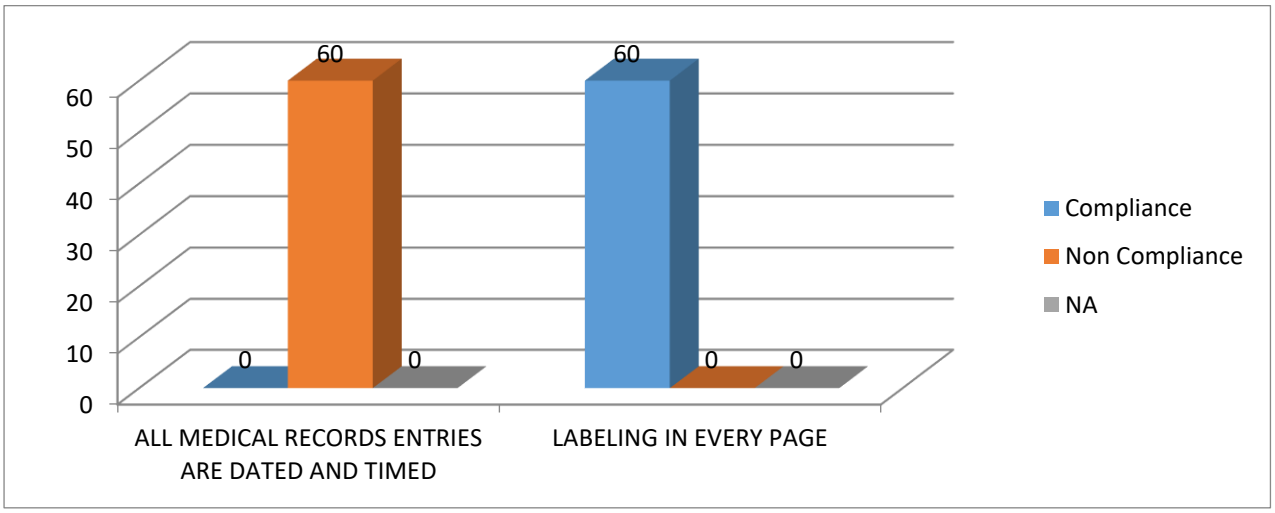
INTERPRETATION: Out of all the Consent forms 100% compliance was found in General consent, more fall/humpty dumpty scale and Informed decision consent compared to lowest compliance rate found in Anaesthesia consent and type. Highest non-compliance rate of 21.6% was found in vulnerable consent.

(F) PROCEDURE DOCUMENTATION



INTERPRETATION: There was 100% compliance rate in procedure documentation

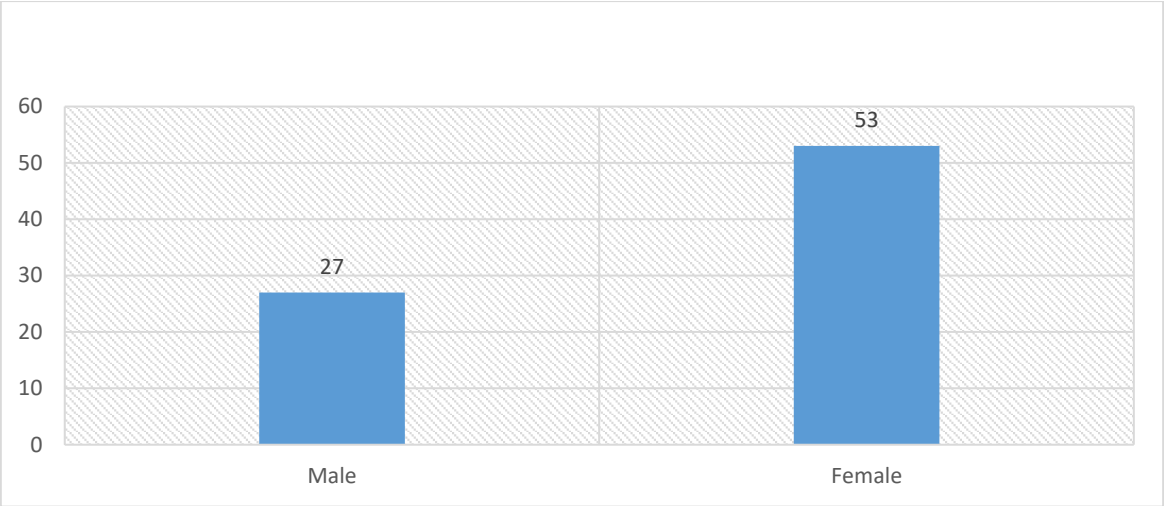
(G) OTHERS



INTERPRETATION: There was 100% compliance of files in labelling in every page compared to 100% non-compliance in files for medical records entries are dated & timed.

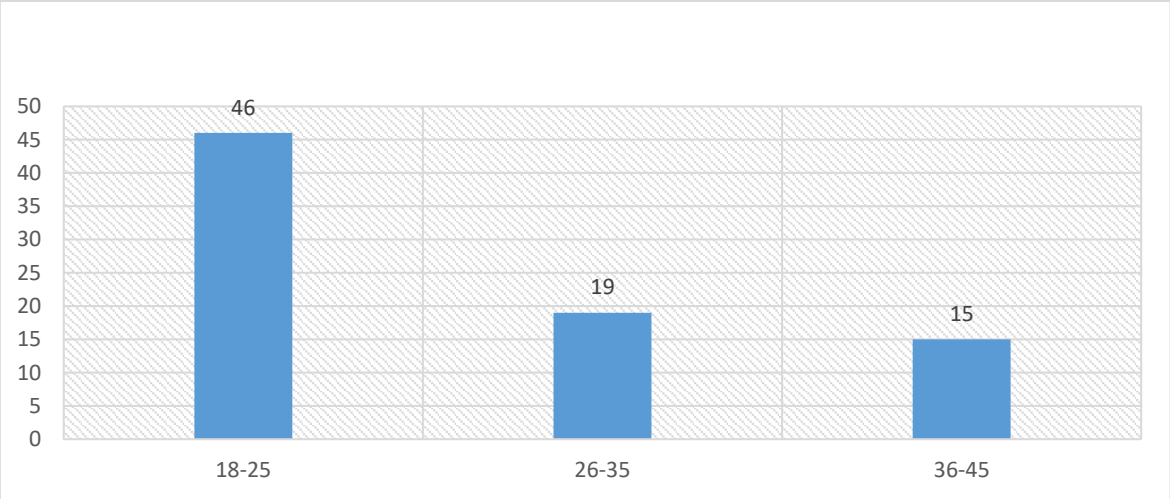
Assessment of Knowledge, Attitude & Practice for Staff Responsible for Documentation

1. Sex



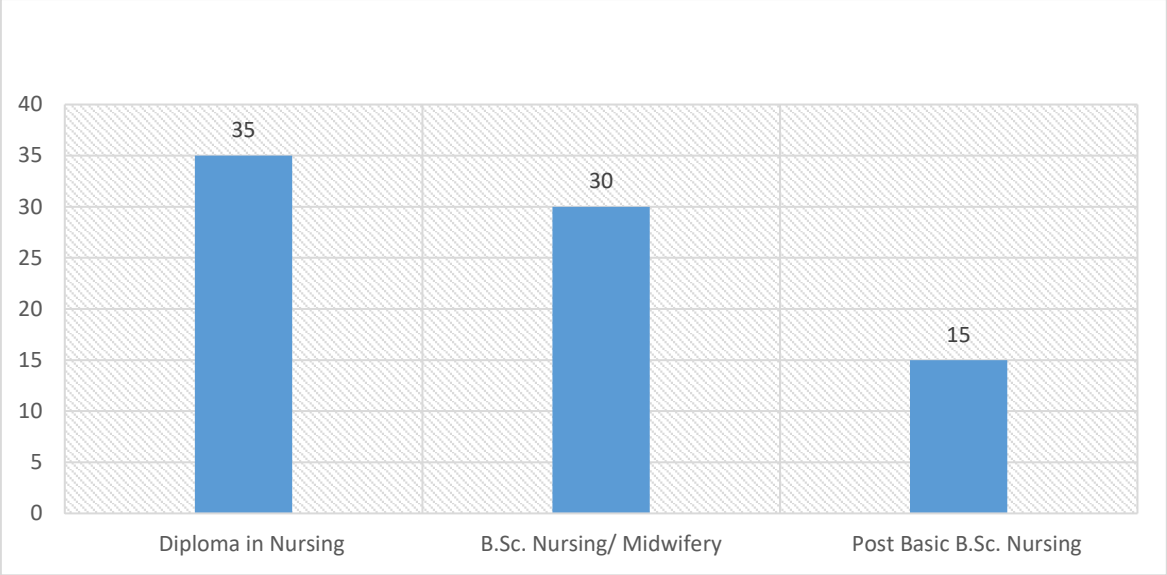
INTERPRETATION: 66.25% Respondents were female while 33.75% were male

2 Age



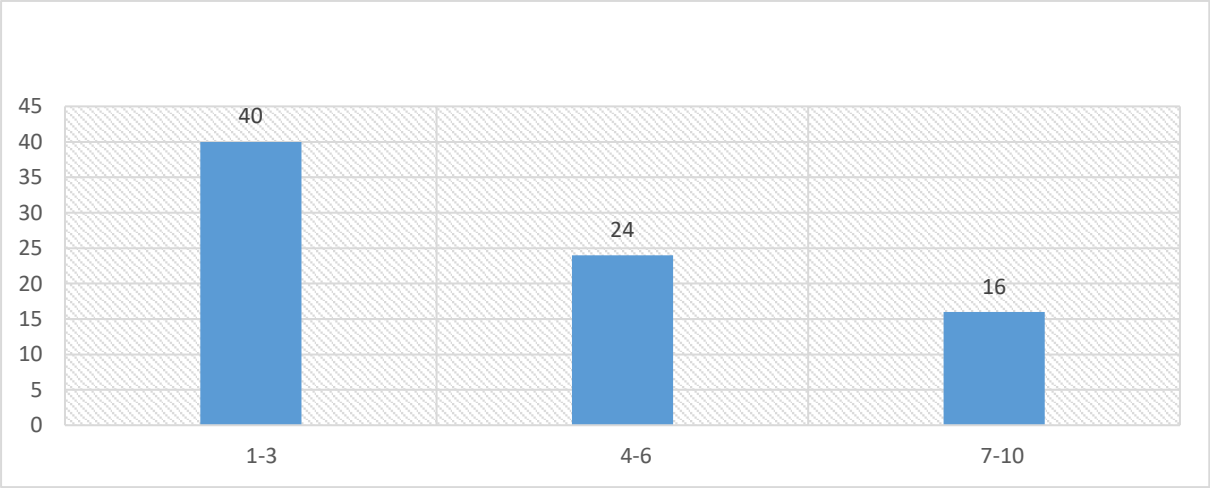
INTERPRETATION: Most of the Respondents were from age group of 18-25 Years of age

3 Educational Qualification



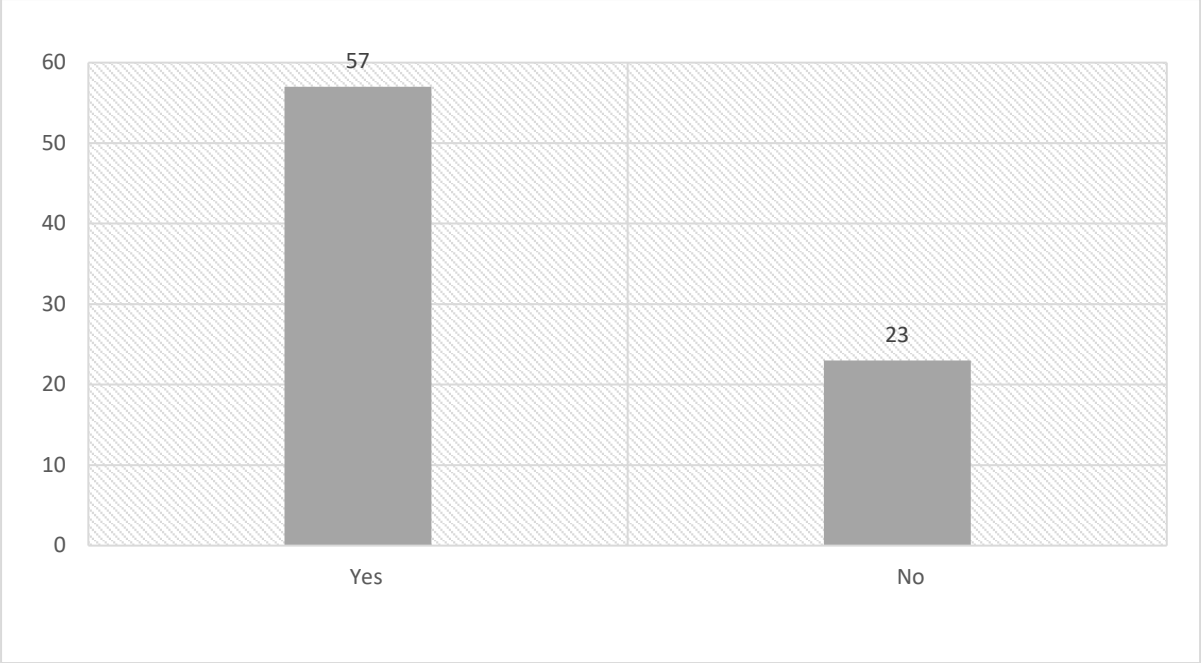
INTERPRETATION: 43.75% Respondents had Diploma in Nursing, 37.5% had bachelor's degree while 18.75% had Post Basic B.Sc. Nursing Degree

4 Years of Experience



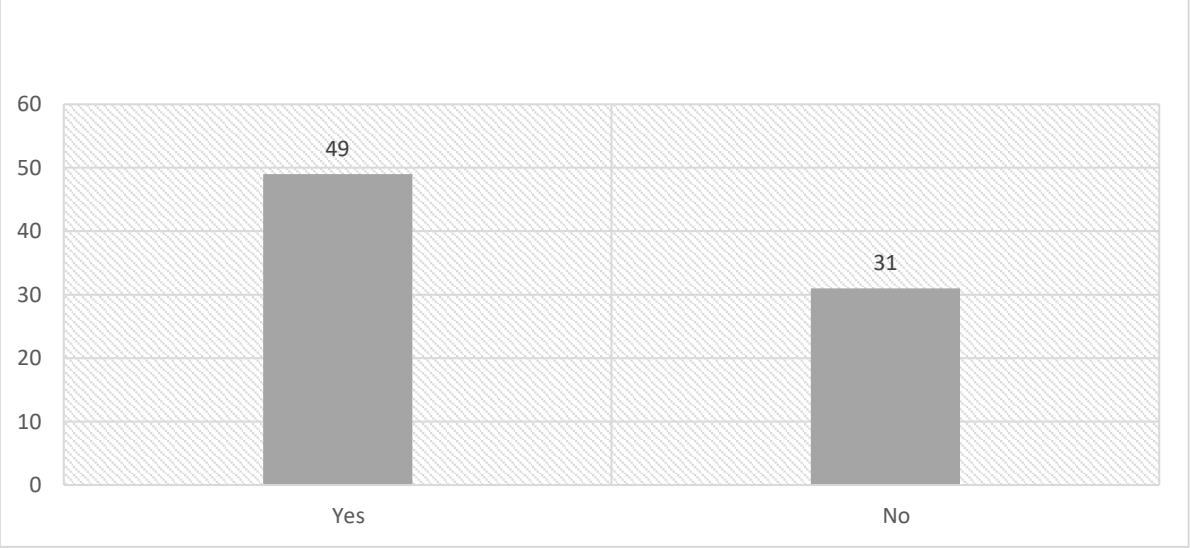
INTERPRETATION: 50% Respondents had experience of 1-3 years while 30% had experience of 4-6 years.

5 VARIABILITY IN FILE DOCUMENTATION & IMPACT PATIENT OUTCOME



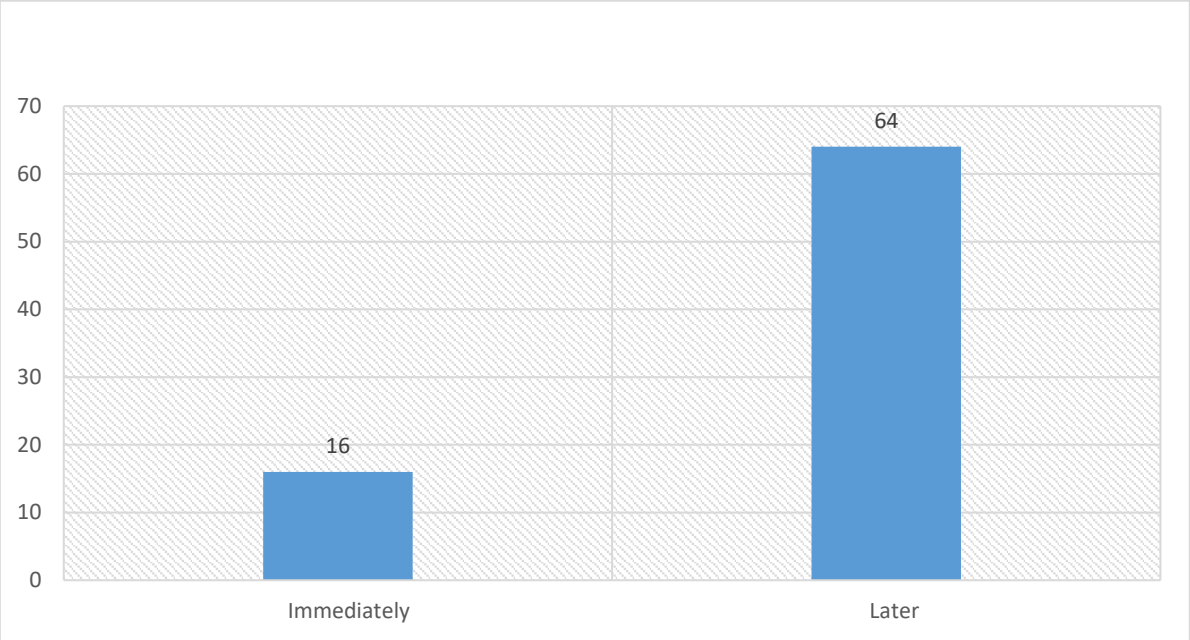
INTERPRETATION: 71.25% respondents agreed with the fact that variability in file documentation impacts patient outcome compared to 28.75% who didn't agree

6 DOCUMENTATION FOR ONE PATIENT BY ONE STAFF AT A SHIFT



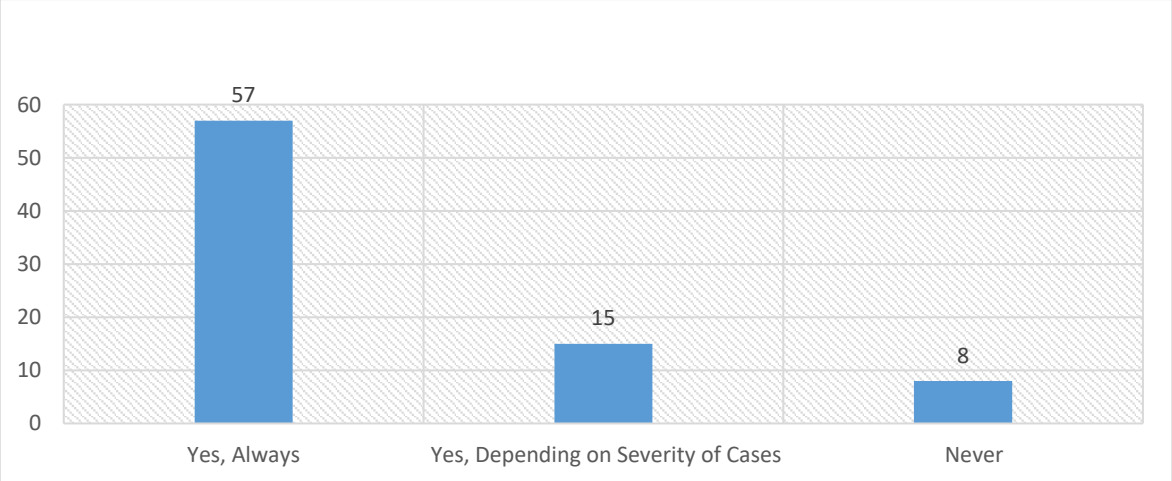
INTERPRETATION: 61.25% respondents agreed with the fact that documentation for a single patient should be done by one staff at a shift compared to 38.75% who didn't agree.

7 CONVENIENT TIME FOR DOCUMENTING FILES



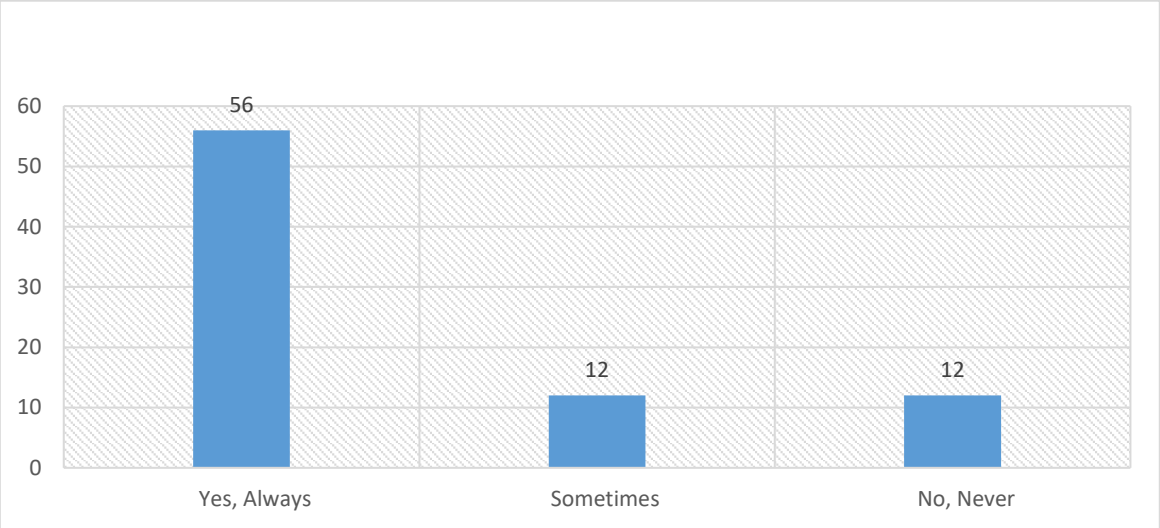
INTERPRETATION: 80% staffs were convenient with documenting files later while 20% respondents told that files should be documented immediately.

8 PLANNING OF NURSING CARE IMMEDIATELY WHEN PATIENT GETS ADMITTED



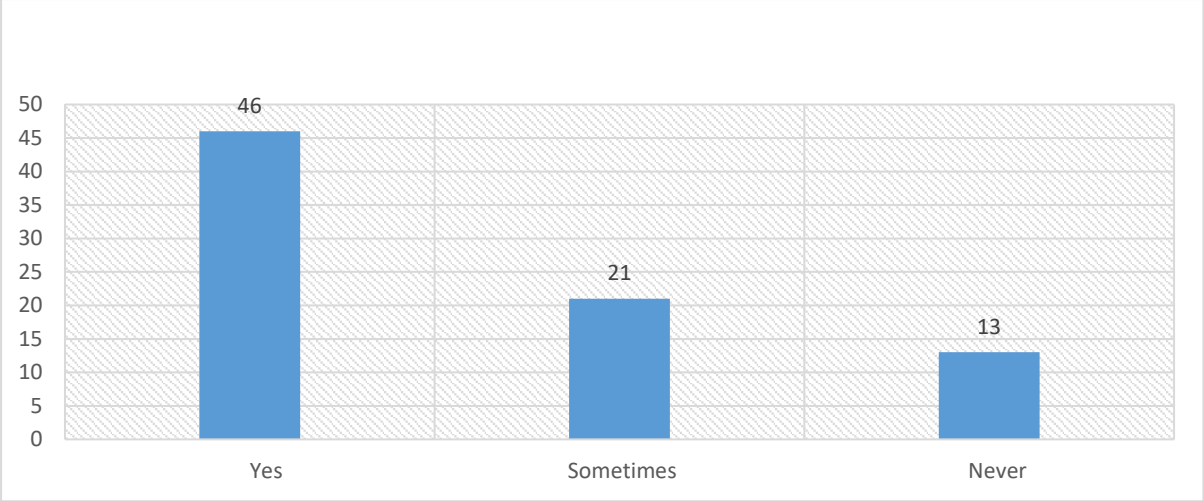
INTERPRETATION: 71.25% respondents start planning nursing care immediately while only 18.75% respondents plan it depending on severity of cases. 10% Staff never planned nursing care.

9 ABOUT FILE TO BE FACT (FACTUAL, ACCURATE, COMPLETE & TIMELY)



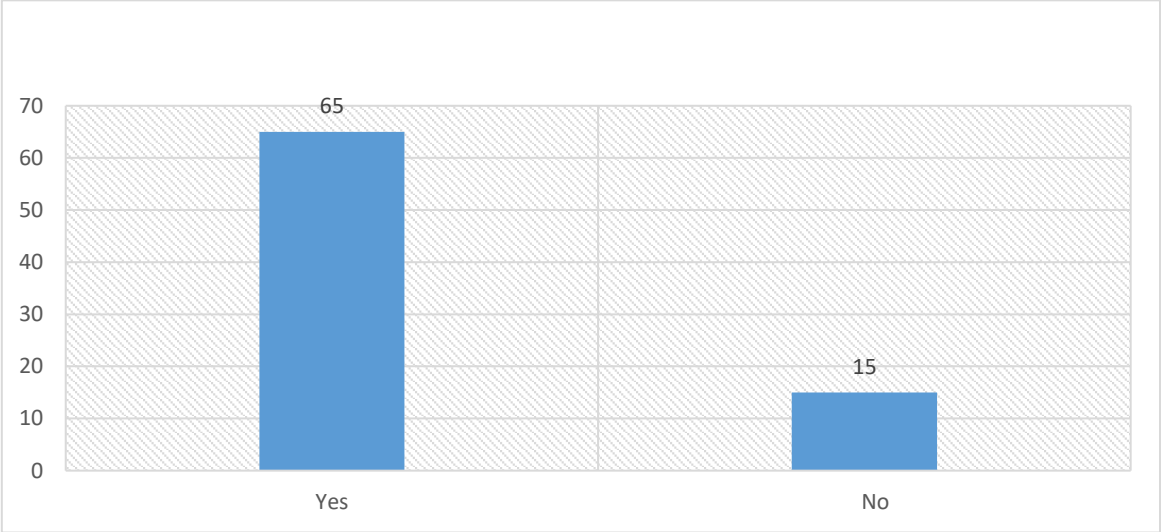
INTERPRETATION: 70% responded that Files should always be FACT, while 15% responded that files should be FACT sometimes compared to 15% who didn't agree that about the FACT.

10 DOCUMENTING BURDENS YOUR WORK THAN HOSPITAL WORK



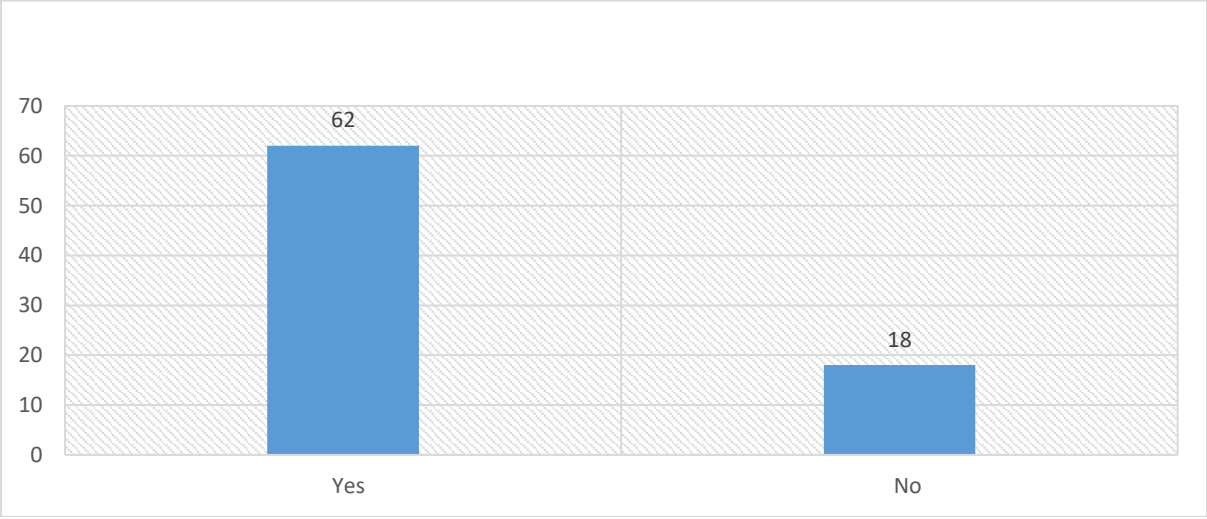
INTERPRETATION: 57.5% respondents agreed that documenting burdens their work compared to 16.25% respondents who didn't agree. 26.25% Respondents told sometimes documenting burdens work.

11 BELIEF THAT DOCUMENTATION ENHANCES TRANSPARENCY, QUALITY AND CONTINUITY OF CARE AND PATIENT SAFETY



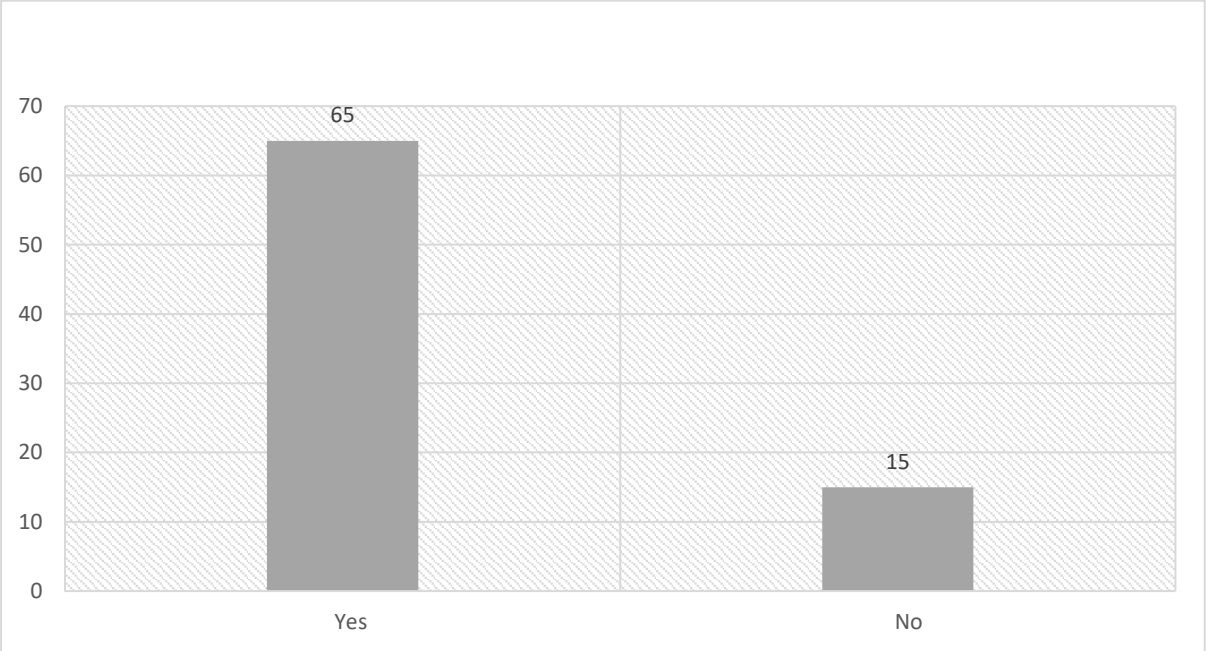
INTERPRETATION: 81.25% respondents agreed that documentation enhances transparency, quality & continuity of care and patient safety while 18.75% respondents didn't agree.

12 RECOMMENDING ELECTRONIC MEDICAL RECORDS SYSTEM



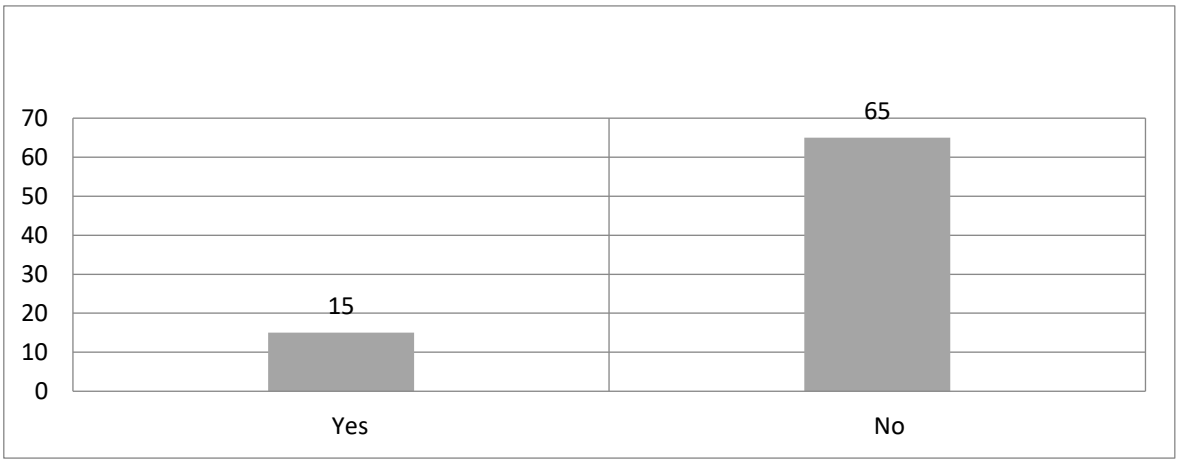
INTERPRETATION: 77.5% respondents felt the need of Electronic Medical Records System while 22.5% didn't felt the need.

13 SATISFACTION WITH DOCUMENTATION



INTERPRETATION: 81.25% respondents were satisfied with documentation they do compare to 18.75% who were not satisfied.

14 SATISFACTION WITH HOSPITAL WORK



INTERPRETATION: 81.25% respondents were satisfied with their work compared to 18.75% who were not satisfied.

DISCUSSION

60 Files were taken each from male, female, cardiac & ICU wards to audit the compliance of inpatient documentation. Among all the wards 100% compliance rate was found in admission details with accident & emergency cases in ICU compared to non- compliance rate of 100% with patient identity card in all the wards. Highest non-compliance rate in doctor & nursing details was found with referral form documentation (56.6%) and discrepancy in seal & signature (16.6%) in almost all the wards.

Highest compliance rate of nutritional details was found in cardiac ward with 98.6% compared to highest non-compliance rate of 31.7% in the male ward. Compliance rate was ranging from 75% to 100% in details with medicine card in all the wards and non-compliance rate was only 11.66% in medication entries with respect to date, time & signature in ICU ward.

Non-compliance rate was high in vulnerable type consents with an average of 37.05% in all the wards. Compliance was good and 100% with consents like general consent and more fall humpty/dumpty scale. Low -compliance rate of 11.6% & 21.6% was found in ICU and male & female ward respectively in procedure documentation. Highest compliance was found in cardiac ward with 78.3% for procedure documentation. There was 100% compliance in all the wards files labelling in every page. Also, there was 100% non-compliance in files of all the wards for medical records entries-date & time.

In the KAP a total of 80 respondents participated in the study. The respondents were staff nurse. The age of respondents ranges from 18 - 45 years of age with a mean age of 26.5 years. Most of the respondents fall in the ranges of 18 - 25 years of age group (57.5%). Females were most respondents (66.25%). Majority of the respondents had Diploma in Nursing as the highest degree (43.75%) & 37.5 % respondents were having bachelor's degree in nursing. There was no post graduate in the discipline among the respondents. All the respondents in the study have been in the profession for less than 10 years. Majority of the respondents were having experience between 1-3 years (50%).

All the respondents in the study had sufficient knowledge in the documentation. 71.25% of the respondents agreed that variability in file documentation impacts patient outcome. Majority of the respondents (80%) told that they were more convenient with documenting files later while the remaining 20% were convenient with documenting files immediately. Documenting the files immediately is a good practice since its possible to miss out some important events while documenting file later. 71.25% respondents start planning for nursing care when the patient gets admitted which is a good practice & 18.75% of the respondents plan nursing care depending on the severity of cases. 70% respondents think that the inpatient files should be FACT (Factual, Accurate, Complete & Timely) compared to 15% respondents who don't agree that the files should be FACT. 57.5% respondents agreed that documentation burdens their work, which is not a good attitude since documenting is an integral part of nursing care. 26.25% respondents told that only sometimes documenting becomes a burden.

All respondents (100%) think that documentation enhances transparency, quality, and continuity of care and patient safety which shows a genuine attitude of the respondents.

When the respondents were asked about Electronic Medical Records System (EMRS), 77.5% recommended it compared to 22.5% who didn't recommend because of the fact that EMRS is complicated to use and patient's information might get hacked. 81.25% respondents were satisfied with the level of documentation they do while 18.75% who were not satisfied with the documentation they follow. &81.25% respondents were satisfied with their work in contrast to 18.75% who were not satisfied with their work. Satisfaction plays an important role for any work to be properly done. If they are not satisfied with their work, it will lead to higher rate of non-compliance of anything in the hospital.

To test the hypothesis, we applied Chi-Squared test and found the P-Value to be as follow with various variables:

Demographic Variables	**KAP Variables**	**P-Value**	**Null Hypothesis H0**
	Knowledge		
Age	In-Patient Files to be FACT	0.020	Reject
	Is Signature of Responsible person Important	1	Accept
	Identification of Differences while handing over sheet	0.096	Accept
	Variability in File documentation impacts patient outcome	0.088	Accept
Gender	**Attitude**		
	Documentation burdens work than hospital work	0.243	Accept
	Enhancement of transparency, quality & continuity of care and patient safety	0.003	Reject
	Satisfaction with documentation	0.075	Accept
	Satisfaction with hospital work	0.075	Accept
Qualification	**Practice**		

	Planning of Nursing Care	0.517	Accept
	Documenting in Advance	0.057	Accept
	Most convenient time for documentation	0.096	Accept
	Recommendation of EMRS	0.190	Accept

Knowledge with Age

There is association between knowledge related age and in patient files to be FACT since the P value is 0.02 is less than the significance level of 0.05.

There is no association between knowledge related signatures of responsible person to be important, identification of differences while hand over sheet and variability among file documentation impacts patient outcome with age since the P value is more than the significance level.

Attitude with Gender

There is association between attitude related gender and enhancement of transparency, quality and continuity of care and patient safety since the P value is 0.03 is less than the significance level of 0.05.

There is no association between attitude related satisfaction with documentation, hospital work and documenting burdens hospital work with gender since the P value is more than the significance level.

Practice with Qualification

There is association between practice related qualifications and planning of nursing care, documentation in advance, convenient time for documentation and recommendation of EMRS since the P value is more than the significance level of 0.05.

CONCLUSION

The study to audit the inpatient file compliance of Inpatient documentation concluded that compliance rate is relatively very low in some departments and particularly in some specified categories. Patient Identity Card had 100% non-compliance. Proper patient identity card helps to reduce redundant patient records, improve accuracy for patient recognition and enhance organization's branding. Non-compliance in the files of wards for medical records entries-date & time also needs to be taken care of primarily since it plays a significant role in documentation.

Although efforts are being made to improve nursing documentation through clinical governance, these are not sufficient, and more attempts are needed. The nurses appeared to be familiar with the required documentation knowledge, but still there are certain areas which we need to work on like making the documentation immediately and the files to be FACT a requirement rather than formality.

RECOMMENDATIONS

- As my study result highest non-compliance rate in doctor & nursing details was found with referral form documentation (56.6%) and discrepancy in seal & signature (16.6%) in almost all the wards. Auditing of Inpatient files should be done frequently by the quality assurance cell to improve compliance rate of inpatient files in hospitals.
- Nursing Superintendent & other senior nursing officials should encourage the nursing staffs to follow the specified check lists of concerned departments to be followed for documentation.
- There should be Continued Nursing Education (CNE), focusing on the importance of documentation.
- Hospital Authorities should provide adequate documenting facilities and also employ more nurses in the hospital to improve nurses & patient ratio.
- Dissemination of information and research findings should be done online to improve its utilization and more research needs to be done in this area.

LIMITATIONS

- Area was limited
- Due to short period of time no. of respondents covered are limited

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- Scand J Caring Sci. 2004 Mar; 18(1):72-81. Voutilainen P[1], Isola A, Muurinen S Nursing documentation in nursing homes--state-of-the-art and implications for quality improvement.
- Boulay F, Chevallier T, Gendreike Y, Joliot Y, Sambuc R. et al: can medical be used to audit the hospital health care? Results of the regional audit of hospital file quality, 1997 Dec 20; 26(40): 1962-5.
- www.nhpco.org/regulatory
- Bello Hussainainat taiye,knowledge and practices of documentation among nurses in Ahmadu Bello university hospital 2015

ANNEXURE- 1

DATE:-	
PATIENT IP NO.	
CONSULTANT NAME	
A	**ADMISSION DETAILS**
2	ADMISSION AND DISCHARGE RECORD WITH ALL DETAILS
3	OPD INFORMATION SHEET/ ADMISSION NOTE
4	HISTORY SHEET WITH ALL DETAILS
5	ACCIDENT AND EMERGENCY WITH ALL DETAILS
B	**NUTRITIONAL DETAILS**
C	**DOCTOR AND NURSING DETAILS**
7	PERCENTAGE OF CASES WHEREIN THE PRE-DEFINED INITIAL NURSING ASSESSMENT (COMPLETED WITHIN 30 MINUTES)
8	CARE PLAN COUNTER SIGNED BY CLINICIAN IN CHARGE WITHIN 24 HRS
9	DISCREPANCY IN SIGNATURE & SEAL IN PROGRESS NOTES
10	PLAN OF CARE WITH CURATIVE, PROMOTIVE, PREVENTIVE AND REHABILITATIVE ASPECTS
11	REFERRAL FORM DOCUMENTATION
12	NURSING ADMISSION ASSESSMENT FORM FILLED UP AND SIGNED
13	NURSES DAILY ASSESSMENT FILLED UP AND SIGNED
14	NURSING CARE PLAN FILLED UP AND SIGNED
17	RISK ASSESSMENT TOOL FOR VULNERABLE PATIENT WITH ALL DETAILS AND SIGNED
18	PAIN SCORING DOCUMENTATION
19	PRE-OPERATIVE CHECKLIST
D	**MEDICINE CARD**

20	MENTION OF ALLERGY IN MEDICINE CARD
21	MEDICATION ORDER ENTRIES ARE DATED, NAMED & SIGNED
E	**CONSENTS**
21	GENERAL CONSENT
22	PROCEDURE & T/t CONSENT
23	ANAESTHESIA CONSENT/ TYPE
24	HIGH RISK CONSENT
25	BLOOD CONSENT
26	VULNERABLE CONSENT
27	MORSE FALL/ HUMPTY DUMPTY SCALE
28	INFORMED DECISION
F	**PROCEDURE DOCUMENTATION**
29	PREOPERATIVE REVIEW AND EXAMINATION
30	PRE-INDUCTION ASSESSMENT
31	ANAESTHESIA RECORD
32	POST OPERATIVE COMMENTS
33	SURGICAL SAFETY CHECKLIST
G	**OTHERS**
34	ALL MEDICAL RECORDS ENTRIES ARE DATED AND TIMED
35	LABELLING IN EVERY PAGE

ANNEXURE- 2

SEX –

Male
Female

Age

1. What is your Educational Qualification?
    a) Diploma in Nursing
    b) B.Sc. Nursing/ Midwifery
    c) Post Basic B.Sc. Nursing
    d) M.Sc. Nursing

2. Area of Specialization (If M.Sc.)
    a) Obestrics & Gynaecology
    b) Intensive Care
    c) Medical Surgical Nursing
    d) Psychiatric

3. Years of Experience
    a) 1-3
    b) 4-6
    c) 7-10
    d) More than 10 Years

4. Does Variability in File Documentation impact patient outcome?
    a) Yes
    b) No

5. Should Documentation for one patient done one staff at a shift?
    a) Yes
    b) No

6. Do you chart/ document in advance the files of patient?
    a) Yes
    b) No

7. What is the most convenient time for documenting files?
    a) Immediately
    b) Later

8. Do you plan nursing care when patient gets admitted in hospital?
    a) Yes, Always
    b) Yes, Depending on Severity of Cases
    c) Never

9. Do you think that the Inpatient File should be FACT (Factual, Accurate, Complete & timely)?
    a) Yes, Always
    b) Sometimes
    c) No, Never

10. Do you give orientation to new staff at joining about documentation of file according to protocol of your hospital?
    a) Yes
    b) No

11. Do you think documenting burdens your work than Hospital work?
    a) Yes
    b) Sometimes
    c) Never

12. While documentation do you think signature of responsible person important?
    a) Yes
    b) No

13. Do you believe that documentation enhances transparency, quality and continuity of care and patient safety?
    a) Yes
    b) No

14. Do you think it's necessary to identify the differences in practice of handover while shift change?
    a) Yes
    b) No

15. Do you recommend Electronic Medical records System?
    a) Yes
    b) No

16. Are you satisfied with documentation?

    A) Yes
    B) No

17. Are you satisfied with hospital work?

    A) Yes
    b) No