Assessment of Medical Records on Parameters of NABH: La Femme Fortis

By

Shruti Sharma

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2017-2019

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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 **Shruti Sharma** student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at **La Femme Fortis Hospital, Jaipur** from **14th February 2019 to 10th May 2019.**

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

The Internship is in fulfillment of the course requirements.

I wish her all success in all her future endeavors.

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

17 May 2019

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The certificate is awarded to

Dr. Shruti Sharma

In recognition of having successfully completed her
Internship in the department of

Medical Administration

And has successfully completed her Project on

A study to assess the patient medical records on the parameters as defined by national accreditation board for hospitals at Fortis La Femme hospital, Jaipur.

Date: May 10, 2019

Organization: Fortis La Femme

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

We wish her all the best for future endeavors.

Suman Kanwar

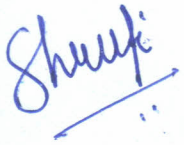
Centre Head

Monica Rathaur

Unit Head –Human resource

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"A study to assess the patient medical records on the parameters of NABH: Fortis La Femme, Jaipur"** and submitted by **Ms. Shruti Sharma** Enrollment No **IIHMR-U/01/2017-19/0672** under the supervision of **Dr. Sandesh Sharma** for award of MBA in Hospital and Health in The IIHMR University carried out during the period from February 2019 to May 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.



Shruti Sharma

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AKNOWLEDGEMENT

I would like to extend my heartfelt gratitude to the Facility Director, Fortis La Femme Hospital Shruti Saxena for providing us the opportunity to undergo my Dissertation in the esteemed organization.

I sincerely thank my mentor Dr. Jharna Bajpai the head of medical administration, for guiding me at each step and for providing me opportunities of judicious learning by allotting me project and giving me the opportunity to be a part of the NABH audit and always being open for constructive discussions.

The completion of this undertaking would not have been possible without the wholehearted support of all the staff at Fortis La Femme Hospital, Jaipur.

I would also like to extend a note of thanks to my mentor and guide at The IIHMR University, Dr. Sandesh Sharma for always being available whenever I needed his guidance.

I would also like to thank my family for supporting me during the dissertation period and providing their support whenever required.

FORTIS LA FEMME HOSPITAL

"Fortis Healthcare Limited (Fortis) launched La Femme, a comprehensive and distinctive boutique hospital for women offering a holistic range of medical services catering to all stages of a woman's life.

Fortis La Femme has been conceptualized keeping in mind contemporary women and the multiple roles they play. It aims to be their chosen healthcare partner by offering top notch clinical care, state of the art facilities and infrastructure and trained and experienced staff in a warm and nurturing environment. This facility is the second of its kind in the Fortis network; the first La Femme, in New Delhi, has earned a formidable reputation for itself over the last decade in providing personalized, tailor made, healthcare solutions for women.

Dedicating the facility to the service of women, **Mr. Bhavdeep Singh, Ex CEO, Fortis,** said, "Fortis La Femme, jaipur, extends the brand taking forward the legacy of its predecessor in New Delhi, which has earned a formidable reputation for itself in addressing every dimension of healthcare for women. This center clearly recognizes that a woman needs specialized medical care in a nurturing and comforting environment and we will go the extra mile to deliver that promise."

Focused on 'Making Strong Women Stronger,' La Femme gifts women medical care matching international standards through a pool of clinical specialists, superlative nursing care and efficient hospital staff who are equipped to manage all patient needs with empathy and warmth. The 28 bed women's health and wellness facility, located at Malviya Nagar in the heart of Jaipur, has a variety of rooms to suit all needs, including twin, single and deluxe rooms and presidential suites.

PROJECT

A study to assess the patient medical records on the parameters as defined by national accreditation board for hospitals at Fortis La Femme hospital, Jaipur.

BACKGROUND:

Introduction:

NABH

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

NABH Standards of Hospitals

NABH Standards of Hospitals, 4TH Edition, December 2015 has been released.

"The standards provide framework for assurance of quality and quality improvement for hospitals. The standards of NABH is mainly for patient safety The standards call for continuous monitoring of sentinel events and inclusive remedial action plan leading to building of quality culture at all levels and across all the functions .(2)

The 10 chapters in the standard reflect two major aspects of healthcare delivery i.e. patient centered functions (chapter 1-5) and healthcare organization centered functions (6-10)."

Outline of NABH Standards:

Patient Centered Standards

1. Hospital Infection Control (HIC).
2. Patient Rights and Education (PRE).
3. Access, assessment and Continuity of Care (AAC).
4. Care of Patients (COP).
5. Management of Medication (MOM).

Organization Centered Standards

6. Facility Management and Safety (FMS
7. Continuous Quality Improvement (CQI).
8. Responsibilities of Management (ROM).
9. Human Resource Management (HRM).
10. Information Management System (IMS).

MEDICAL AUDIT

Medical audit also called peer review or clinical audit is defined as evaluation of medical care through review and analysis of medical records.

Aim of the audit is to highlight the discrepancies between genuine practice and standard in order to identify the changes needed to improve the quality of care .

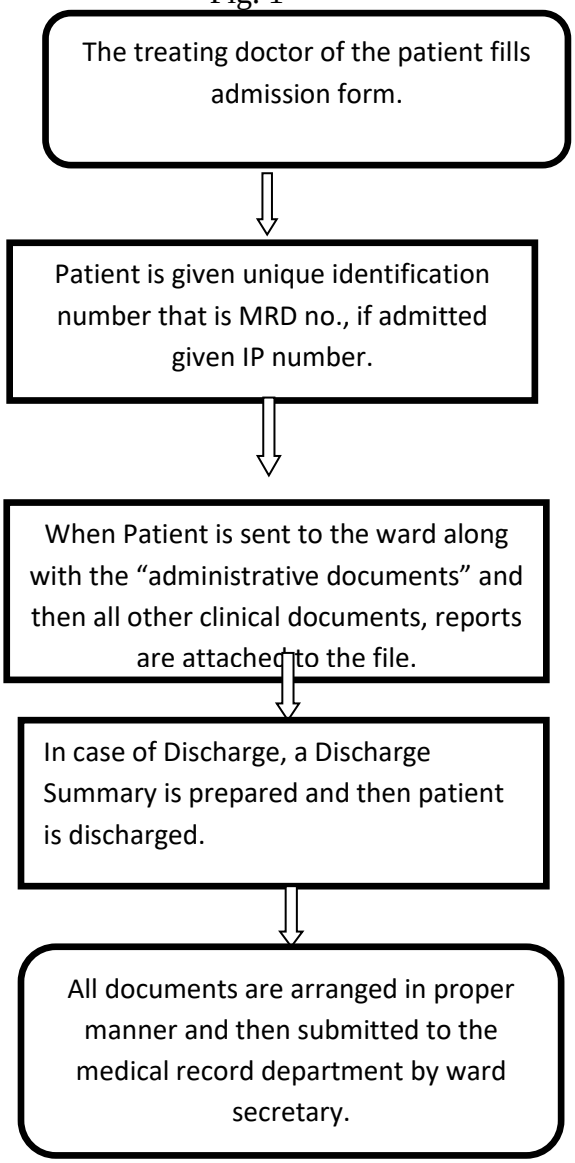
MEDICAL RECORD

"The hospital initiates and maintains a standardized medical record for every patient assessed or treated and determines the records content format and location of entries. The medical record contains sufficient information to identify the patient, to support the diagnosis, to justify the treatment and to document the course and result of treatment. The term are used for both the physical folder that exist for each individual patient and body of information found therein. The hospital determines the specific data and information recorded in the medical record needs to present of each patient assessed or treated on an patient, outpatient or emergency basis."

Medical record is personal documents and there are several ethical and legal issues surrounding them such as third-party access and appropriate storage and disposal .The medical record contain a variety of types of "notes" entered over time by health care professionals, recording observations and administration of drugs, diet 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.

FLOW CHART OF MEDICAL RECORDS IN LA FEMME FORTIS HOSPITAL

Fig. 1



Medical Record File should consist of the following documents

1) General Consent form
2) Face sheet
3) Consent form
4) Admission request form
5) Initial assessment
6) Doctor's progress notes
7) Operation notes(pre-operative, operative procedure ,post operative)
8) Anaesthesia record
9) Drug /medication chart

10) Nursing admission assessment
11) Nurses notes and daily nursing flow sheet
12) Investigation report discharge / discharge on request/ LAMA or death summary
13) Discharge summary

A. **General consent form**: To be Filled prior to the admission in in-patient department.
B. Face sheet: It contain of all identification and demographic data like MRD NO., date of admission and time , Name of patient , Age, Sex, , IPD no., patient Date of birth, Department admitted, etc.
C. Consent form: Before any surgical procedure or diagnostic procedure – consent for anaesthesia, consent for procedure ,consent for HIV TEST consent for transfusion etc should be filled.
D. **Admission request form:** Admission request form filled before the admission by the consultant.
E. **Initial assessment:** It includes chief complaint, past history of patient history of present illness and family history, allergies ,sociological history ,psychological history ,current medication ,pain assessment chart.
F. **Doctors progress notes** : it contains daily notes of doctors where the record each patient's daily progress(2 notes)per day and mention it with date, BLK ID and signature
G. **Operation notes & surgery records:** operation notes consist start and end time of surgery. Immediately after the surgery treating consultant shall write which consist of preoperative diagnosis, description of findings, incision, procedure done and surgical check list, post operative plan, blood loss, mention blood product replaced if any, specimen HPE ,Condition at the end of procedure ,with implant sticker in surgery records should be attached by nursing stall in file.
H. **Anaesthesia record** :Pre and post anaesthetic recovery notes must recorded by anaesthesiologist in the patient record.
I. **Drug chart** : Consist of all medication in appropriate format which were prescribed by doctors during the stay . The drug should be in capital order, dosage ,route ,frequency to be mentioned for each medicine.
J. **Nursing admission assessment** : In Nurse notes/ Daily nursing flow sheet , the assigned nurses should filled all the details which consist of the admission assessment of patient with daily flow sheet and nurses notes.
K. **Investigation report:** Duplicate copy of patient report like lab report , radiology, ultrasound ,or other tests etc. which are done during the treatment,
L. **Discharge/ discharge on request/ LAMA or death summary:** It consist of chief complaints, history of present illness, past history, physical findings during treatment, investigation done, course in the hospital, operative diagnosis and date, condition at time if discharge, treatment and medicine follow up advice if required.

- **Initial Assessment for Doctors:**

a) Time of arrival and assessment
b) Allergies
c) Provisional diagnosis
d) Pain assessment
e) Current medication
f) Plan of care
g) Systemic /general/physical examination
h) Date, time ,sign & name of doctor present
i) Consultant counter signed within 24 hrs of the admission

- **Patient and family education Form**
- **Patient and family communication Record**
- **Progress notes:**

a) Any cutting or over writing in the record
b) Legible handwriting –signature /name readable

- **Medication order:**

a) Medication order in capital
b) Dosage, route, Frequency
c) In case of SOS indication
d) Doctor FORTIS LA FEMME ID, date , time and signature

- **Consent form:**

e) Abbreviations

c) Indication, Alternatives, Risk, Benefits, High Risk reason, Doctor signature, Witness or patient signature

RATIONALE OF STUDY:

Medical records are a reflection of the medical care provided to the patient at the Hospital. It is essential to know the current status of patient care that is provided for the betterment of the care provided. The accrediting bodies responsible for rating the health care organization uses contents of medical records to evaluate services provided to patients, hence medical records require to be audited to check whether they comply with the standards set by accreditation bodies or not. Apart from this, medical record audits help in improving the validity of clinical audits. For audit results to authentic, the data recorded in the medical records should be complete because incomplete or absent the 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 and JCI standards. Hence auditing the medical records for availability of data can point out deficiency and loop holes thereby aiding in solving the issues associated with medical records 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.

Khalis Mahmood Shahid Shakeel, Hyas Saeedi, Zia Ud Din

A study done on " Audit of Medical record documentation of patients admitted to a medical unit in a training hospital NWFP Pakistan" showed that they did retrospective study of medical record certification 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.

Lataief M, Mtiraoui A, Mandhouj O, Ben Salem, Soltani, Behir

Studies done on evaluation of quality of medical records in the Mona stir regional hospital-Tunisia showed that the quality of medical records should be enhanced. Two third of the cases lack 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 highlight the importance of medical and administrative area in the health care management. This could be included in a continuous quality improvement program.

Sinha, Saha.D,

A study 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, narration and physical examination form, radiation form, brachytherapy form, anesthesia 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 dependability 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 and important in case of any legal litigations.

Alireza Ala, Payman Moharamzadeh , Mahbob Pouraghaei , Avat Almasi , Omid Mashrabi and Vahid Jafarlou

A study was done on "Designing a model for medical documentation as per joint commission international in emergency department of Tabriz Imam Reza hospital" this was a cross sectional descriptive analytic study. In this study the documentation of nursing staff was complete in the file, which shows the awareness of nursing personnel about the documentation processes. In study the completeness of the files and the records by physicians was significantly less than records of nursing staff which shows the need for education in interns, residents and physicians.

Prerna Singh, Sakhi John

The study entitled "Analysis of Health Record Documentation Process As Per The National Standards Of Accreditation with special emphasis on Tertiary Care Hospital" reviewed the health records and evaluates them to find the incongruity in the documentation of patient's data by doctors, nurses and other healthcare providers involved in the documentation process. Health records form an imperative part of management of a patient. It is important for the doctor, nurses and medical establishments to properly maintain the records of patient's for two significant reasons. The first reason is that it will help them in the scientific evaluation of patient profile, to analyze the treatment results, and to plan appropriate treatment protocols. The other reason is that it will assist in planning governmental strategies for future medical care.

Carlos M Sotto, Kenneth P Kleinman and Steven R Simon

A study on "Quality and correlates of medical record documentation in the ambulatory care setting " reviewed electronic medical records from 834 patients receiving care from 167 physicians (117 internists and 50 pediatricians) at 14 sites of a multi-specialty medical group in Massachusetts. The present study to measure the rates of documentation of quality of care measures in an outpatient primary care practice setting that utilizes an electronic medical record. The present study measures the rates of documentation of quality of care measures in an outpatient primary care practice setting that utilizes an electronic medical record.

Mahanta Putul , Yadav Mukesh

A study of "Documentation of Medical Records in Day–to-Day medical practice" in which clinical records were structured around the patient's problem rather than medical problems and updated in detail on a daily basis as suggested by Weed. It is also important for the clinician to maintain a proper doctor patient relationship, besides maintaining a good medical record. The patient doctor relationship is a vital concept in health care. A good relationship

increases adherence to treatment recommendations, enhances continuing care and promotes patient satisfaction and can reduce the medical litigation.

Rajesh Kumar Sinha, Nandna Shenoy

A study on "Assessment of Oncology Medical Records as per NABH Standards" this retrospective study was conducted to assess the policies and procedures in relation to medical documentation against NABH.IMS 1–7 standards and NABH.PRE-3 Standards. A total of 520 discharged inpatient records were analyzed to understand the quality of medical documentation. The study results revealed that the attention to compulsorily document patient clinical data in the respective forms of the medical records would enhance the completeness and accuracy of medical documentation of the hospital.

Mittermayer R , Huic M, Mestrovic J.

A study on "Quality of health care, accreditation, and health technology assessment in Croatia: role of agency for quality and accreditation in health." Avedis Donabedian defined the quality of care as the kind of care, which is expected to maximize an inclusive measure of patient welfare, after taking into account the balance of expected gains and losses associated with the process of care in all its segments. According to the World Medical Assembly, physicians and health care institutions have an ethical and professional obligation to strive for continuous quality improvement of services and patient safety with the ultimate goal to improve both individual patient outcomes as well as population health. Health technology assessment (HTA) is a multidisciplinary process that summarizes information about the medical, social, economic and ethical issues related to the use of a health technology in a systematic, transparent, unbiased, robust manner, with the aim to formulate safe and effective health policies that are patient focused and seek to achieve the highest value.

Ladha , Rani S; Dwivedi , Rajeev

A study on "Gaps in the National Accreditation Standards" which analyzed whether the quality standards required by NABH are appropriate for eye care. After a review of the various standards required by NABH and learning more about the processes at Aravind Eye Care System (AECS), they identified a few specific ones that AECS finds onerous. Based on their analysis it seems that these standards while important for other specialties may not be critical for eye care. However mandating those standards for eye care would increase the cost of the care without any significant impact on the outcomes. It may also lead to fewer patients being serviced, which is detrimental for a county like India, given the low level of health care infrastructure and delivery.

RESEARCH QUESTION:

What is the compliance rate for documentation in patient medical record as per NABH standard?

RESEARCH OBJECTIVE:

1.To analyze the patient medical records on the parameters as defined by National Accreditation board for Hospitals and healthcare providers at Fortis La Femme Hospital Jaipur

2.To identify the gaps in the existing documentation procedures

3.To provide suggestions for the improvement in the existing documentation procedure.

METHODOLOGY:

Study area:

Study was conducted in La Femme Fortis Hospital, Jaipur. The total of 200 patient records were observed and recorded in the Audit checklist .The checklist contained parameters out of which compliance rates and non-compliance rates were calculated and represented through the graphs.

Study design Descriptive cross-sectional study

Sampling method: Convenience Sampling

Type of Research: Quantitative Approach

Sample size: 200 files

Time: 10th Feb to 10thMay

Tool: Audit Checklist as per NABH

Data source: Secondary data. (Patient Medical Record)

Research Technique: Concurrent audit was conducted of IPD files with the help of a checklist. The data was collected and marked C (compliant), or PC (partially compliant), or NC (Non compliant), or NA (Not applicable) in the checklist according to the completeness

of parameters. Later the data was analyzed for percentage of compliance of IPD as per the NABH standards and suggestions were given for the problem area.

Steps of clinical audit:

Step 1: **First identify the problem or issue**

In the current study, concurrent audit of medical record documentation (open files) is conducted to check whether the parameters are in compliance or not as per NABH standards.

***Step 2*:Setting criteria and standards**

Medical records have to be audited periodically for certain parameters. These parameters were included in the audit as per NABH standards.

Step 3: **Data collection**

Data was collected through the checklist designed for the concurrent audit. Covered all parameter as per NABH standards.

Step 4: **Compare performance with criteria and standards**

After data collection it was analyzed as per the set criteria and standards of the hospital.

Step 5: **Implementing change**

Suggestions were given to the department for the scope of improvement.

Data Analysis Plan: The data was entered and analyzed using Microsoft excel 2016 software .The data relating to the parameter maintained above were calculated as percentages for comparison purposes.

Ethical considerations: There is no intervention in dealing and care processes of patients, so there was not any ethical consideration in this study and all the information of this study is kept confidential.

Results:

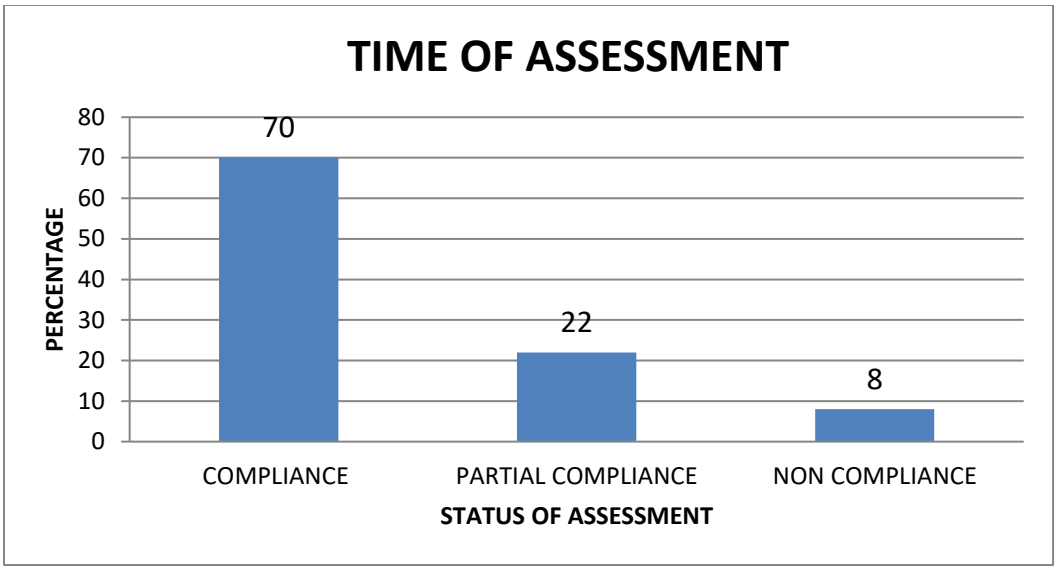
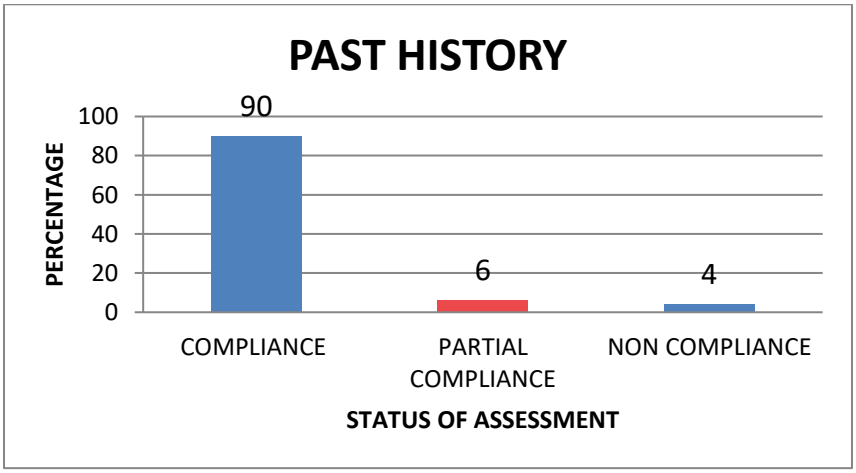


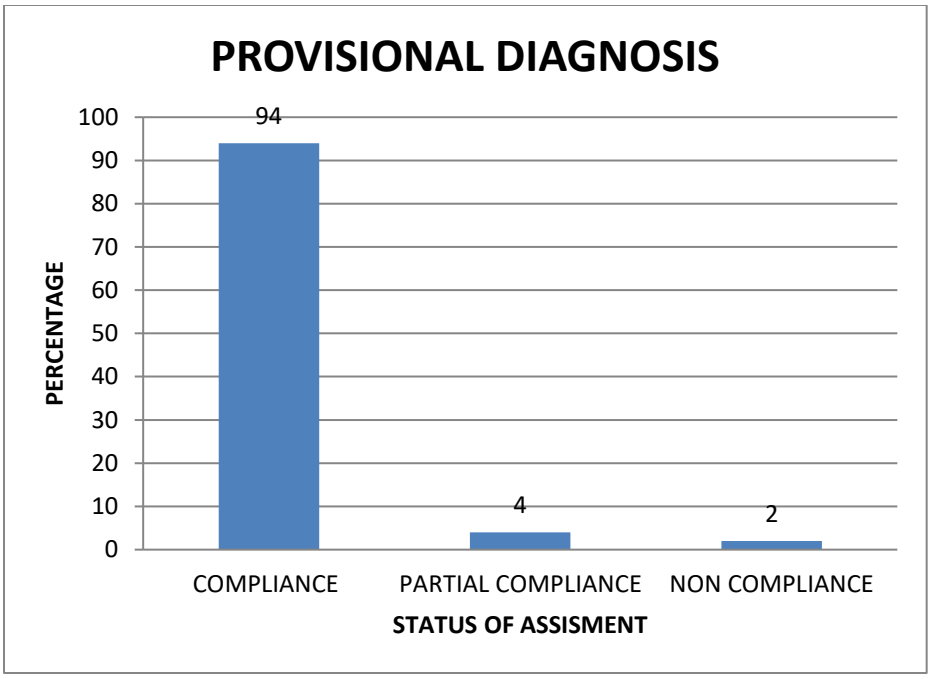
Figure 1. Documentation of time of assessment in department of La Femme Fortis, Jaipur

Interpretation: It was observed that 70% compliance , 22% non-compliance and 8% noncompliance was there for time of assessment.

Graph: 2 Documentation of Past history



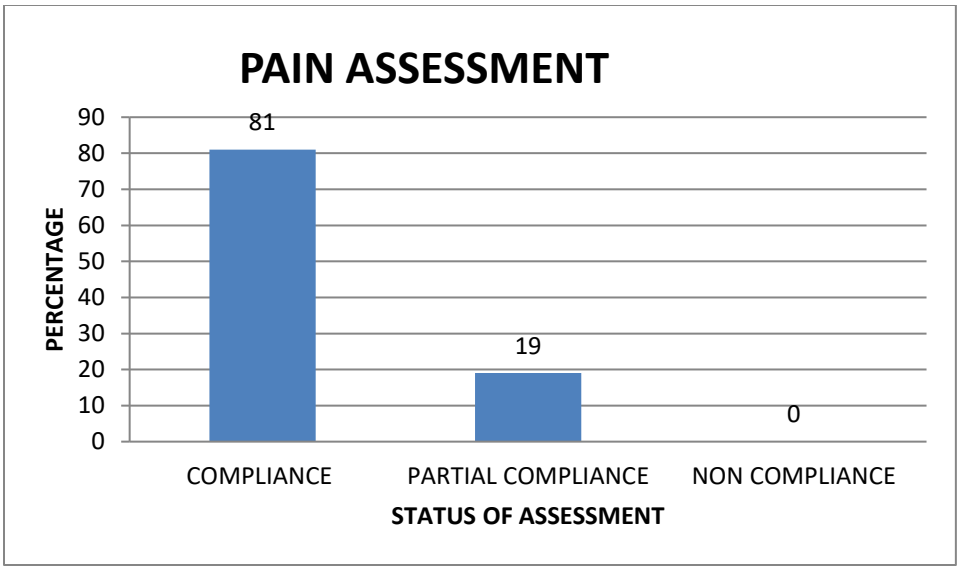
Interpretation :It shows 90% compliance and 4% non-compliance and 6% partial compliance.



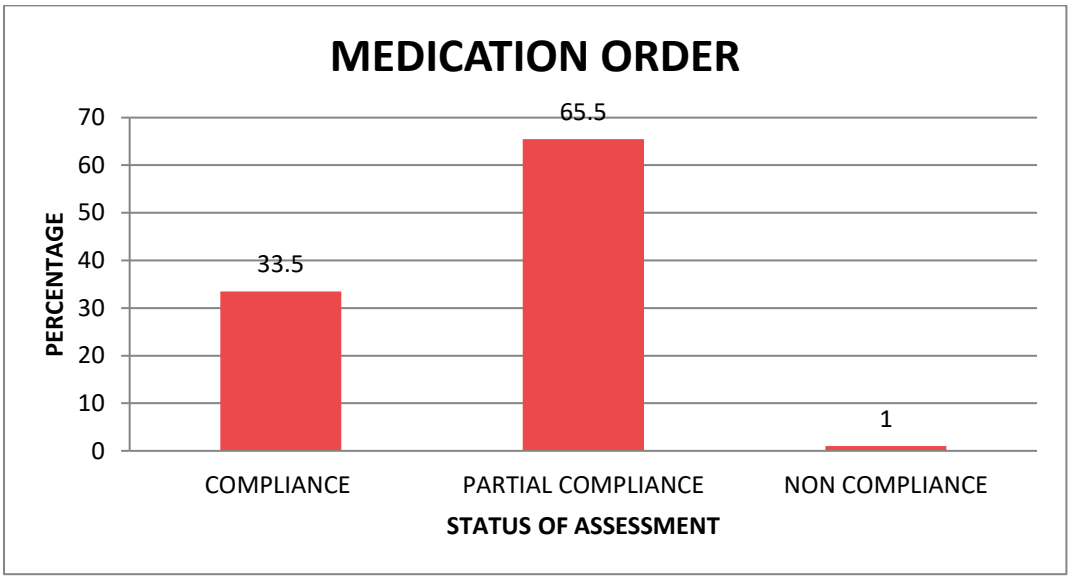
Graph 3-Documentation of provisional diagnosis

Interpretation :It was observed that there is 94 % compliance, 2% non compliance and 4%partial compliance.

Graph: 4 Documentation of pain assessment in Fortis La Femme Jaipur

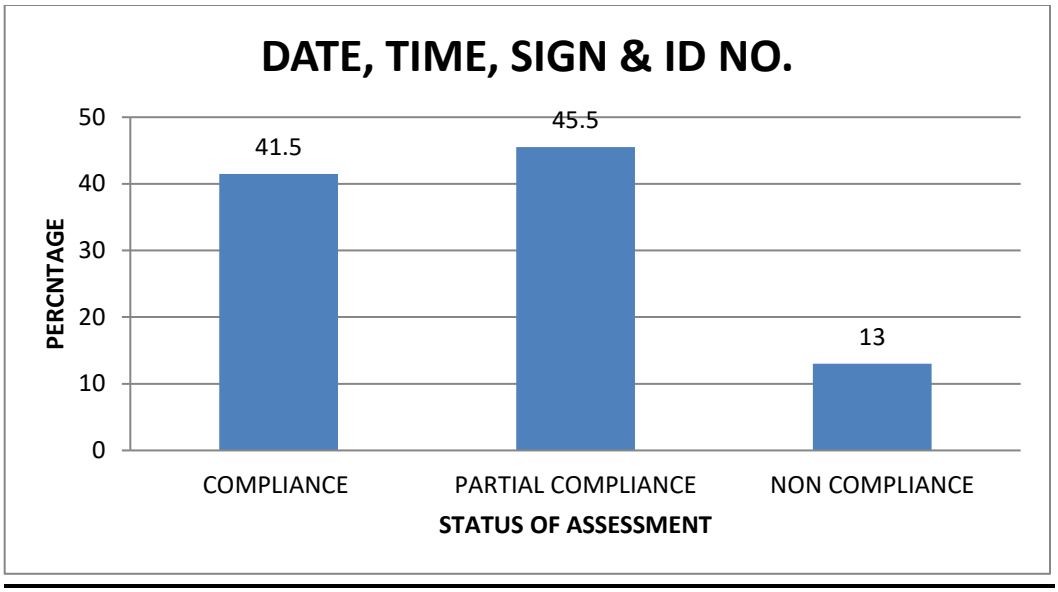


Interpretation: It was observed that there was 81% compliance, 19% partial compliance.



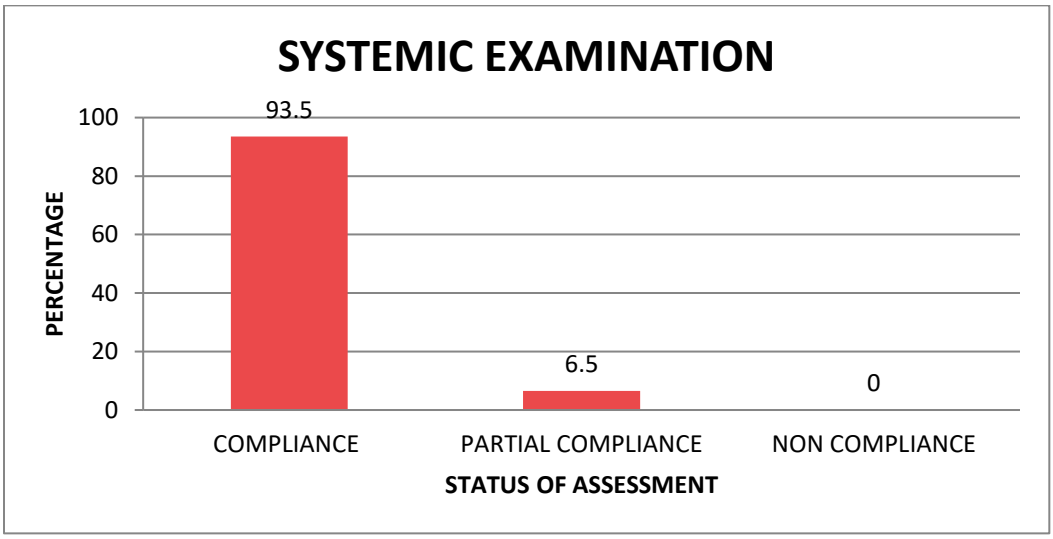
Graph: 5 Documentation of medication order in Fortis La Femme Jaipur

Interpretation: It was observed that there was 33.5% compliance, 65.5% partial compliance and 1% non compliance.



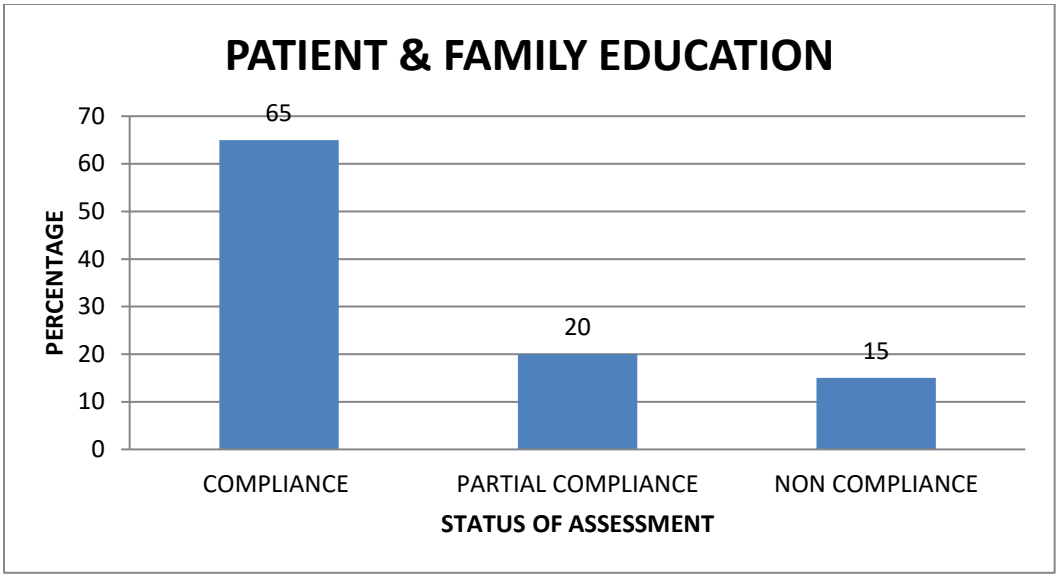
Graph 6: Documentation of Date, Time, Sign Fortis La Femme Jaipur

Interpretation: It was observed that there is 41.5% compliance ,45.5% non-compliance and 13% partial compliance.



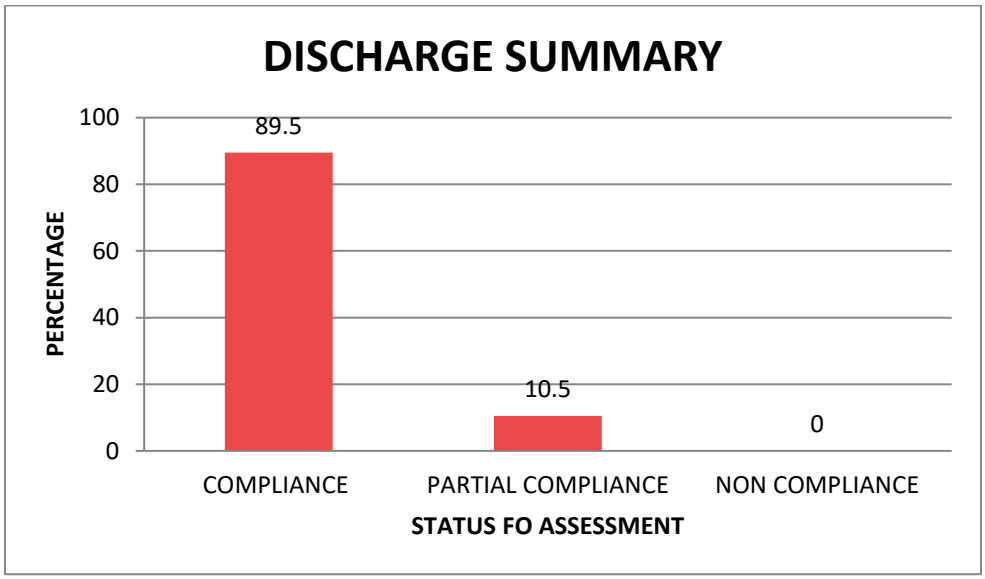
Graph: 7 Documentation of systemic examination in Fortis La Femme Jaipur

Interpretation: It was observed that Department had 93.5% compliance and 6.5% partial compliance.



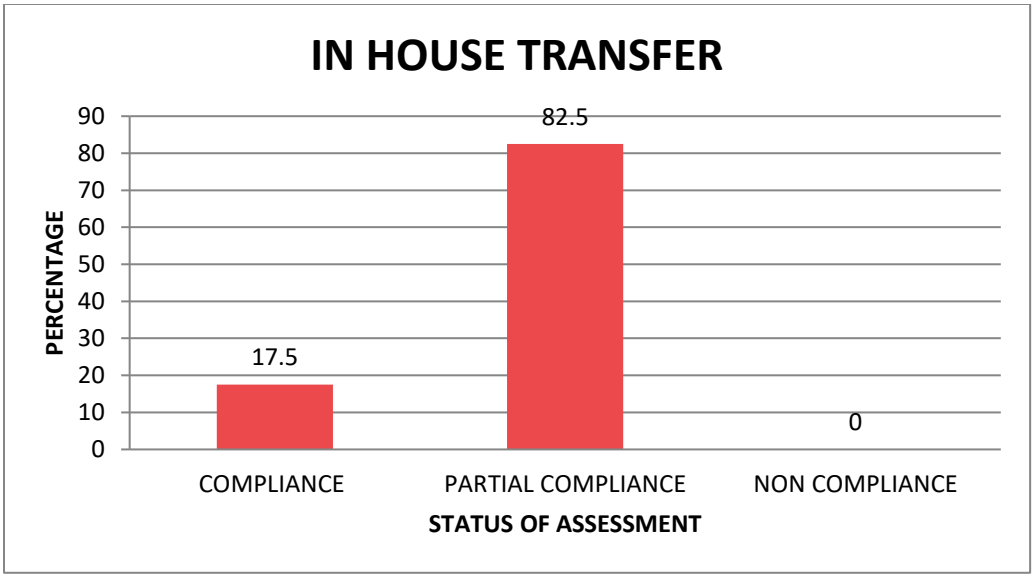
Graph: 8 Documentation of patient and family education

Interpretation: It was observed that in the department there was 65% compliance, 15% non-compliance and 20% partial compliance.



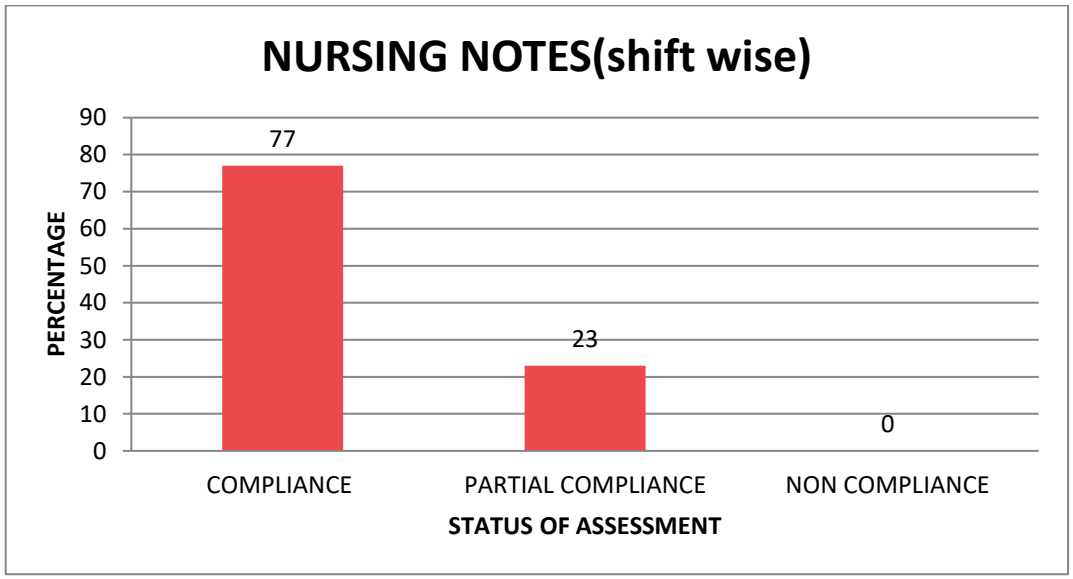
Graph: 9 Documentation of Discharge Summary

Interpretation: It was observed that Department has 89.5% compliance and 10.5% partial compliance.



Graph: 10 Documentation of In house transfer summary in Fortis La Femme Jaipur

Interpretation: It was observed that Department had 17.5% compliance, 82.50% partial compliance .



Graph: 11 Documentation of Nursing notes in each shift in Fortis La Femme Jaipur

Interpretation: It shows 77% compliance and 23% partial compliance for the nursing notes shift wise.

CONSENT	**COMPLIANCE**	**PARTIAL COMPLIANCE**
HIV	**100%**	**0%**
ADMISSION	**96%**	**4%**
BLOOD & BLOOD PRODUCTS	**100%**	**0%**
ANESTHESIA	**99.50%**	**0%**
HIGH RISK	**100%**	**0%**
PROCEDURE	**97%**	**3%**

Table: Compliance check for Consent forms:

DISCUSSION:

The primary purpose of health record is to provide documentation of the care provided to patients. They vary with care settings, legal jurisdiction and location. Records should be maintained in a manner that ensures regulations, accreditation standards, professional practice and legal standards. Maintenance of complete record is important not only for the sake of licensing and accreditation requirements but also to establish the fact that patients received adequate care. The first limitation is the lack of evidence of inter-rater reliability with chart abstractors. It is conceivable that different abstractors judged satisfactory documentation of a measure differently. Misclassification of documentation quality measures could have unfair the results toward the null, and a true connection between some of the physician or patient variables and documentation quality may not have been detected by this study .

A second limitation is the possibility that unmeasured variation in "case-mix" could have accounted for difference in documentation quality. For example, gynecologists with healthy patients might be less likely to document health maintenance items, such as compliance with screening guidelines. On the other hand, physicians might be expected to document more carefully the medications, allergies, and immunization status of more chronically ill patients

CONCLUSION:

Medical record chronologically documents the care of patients and is considered as a vital element for contribution of high quality care. They facilitate:

-Ability of physicians and other health care professionals to assess the immediate treatment and to monitor health care provided.

-Communication along with continuity of care among physicians and health care providers involved in patient care.

Appropriately documented medical record can reduce inconvenience associated with legal processing and may also solve the purpose of legal document. From the above study it was concluded that the documentation of progress notes, nursing notes shows high level of partial compliance. There is scope of improvement in areas of documenting name, signature and id of the assigned consultant. Few of the consent forms contain abbreviations and time during the signature was missing.

SUGGESTIONS:

- The Hospital needs to do focus training for doctors at the time of joining the hospital which includes all the forms and formats used for documentation of the records.
- There should be regular refresher training and audit should be conducted by the medical administration department for documentation compliance as per the NABH guidelines.
- Floor manager should check the files in their daily round. And if the file is not filled properly then it should be communicated to the Assistant Medical supriendentend and department of quality.
- The file should also be checked again by ward incharge before sending it to the MRD. The audit checklist for the ward incharge should be revised.

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ANNEXURE:

Sr. No	Month: Date & Time : Audit: Auditor:

1	MRD
2	Date of Admission
3	Unit
4	Parameter Audited
5	Emergency Assessment
6	Initial Assessment /IPD case note
7	Time of Arrival
8	Time of Assessment
9	Source of History
10	Past History
11	Allergies
12	Provisional diagnosis
13	Pain assessment done or not
14	Current Medication mentioned or not

15	Diet History
16	Plan of care
17	Family History
18	Social/Economical History
19	Psychological Assessment
20	Family Education
21	Systemic/ general/ Physical examination
22	Date, time, sign & name of Doctor present(with in 2 hrs)
23	Consultant counter signed within 24 hrs of the admission
24	Patient and Family education 1. Doctors, Nurse, Physiotherapy and Dietician should be filled. 2. Upper section which includes Healthcare Literacy, Barriers, Beliefs

25	Patient and Family Communication Record: 1. To be filled on each day by Doctor or team member 2. Signature of witness, Patient and doctor
26	Progress notes-Doctors: 1. To check for notes (2 notes) per day 2. ID, Date, Time, name and signature 3. To check for abbreviations
27	Re-assessed at appropriate intervals (at least twice a day)
28	Date, time, sign & name of Doctor present
29	Any cutting or over writing in the record
30	Legible handwriting-Signature/name readable
31	Medication order 1. Orders to be in Capital 2. For SOS indication and maximum dosage for 24 hours 3. Signature, id and name on medication chart 4. Dosage, route, frequency to be mentioned for each medicine. 5. Medication order to be written on the Medication chart.

32	Consent 1. No abbreviations to be used 2. Alternatives, Indication, Risk and benefits to be written 3. Signature of Patient, Witness and doctor.
33	Anesthesia Record: 1. Consent for Anesthesia/Obstetric Analgesia 2. Pre-operative checklist 3. Safety checklist 4. Modified Aldrete Score
34	Operation Notes: 1. Start and end time of Surgery 2. Incision 3. Pre and Postoperative Diagnosis 4. Blood loss 5. Blood Product replaced if any 6. Specimen for HPE 7. Complications 8. Condition at the end of procedure 9. Signature and name of doctor
35	Restrain Order: 1. To check for date and time 2. Reason for restrain 3. Attendant signature
36	ICU: 1. Admission Criteria at the time of admission 2. Discharge criteria at the time of discharge from ICU to ward
37	Denial Consent: In case of denial for any procedure and treatment the from should be filled

38	Others: