Assessment of the patient medical records on the parameters of NABH: La Femme Fortis

BY SHRUTI SHARMA

Under the guidance of
Dr. Sandesh Sharma

NABH

- National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a 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

Medical Records

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 hospital determines the specific data and information in the medical record needs to be present of each patient assessed or treated on an inpatient, outpatient or emergency basis

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.

Research Question

What is the compliance rate for documentation of inpatient medical record as per NABH standards?

Objectives

Phase I

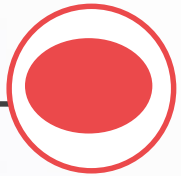
To analyze the patient medical records on the parameters defined by NABH and SOPs of the Fortis hospital

Phase II

To identify the gaps in the existing documentation procedures

Phase III

To provide effective suggestions wherever required



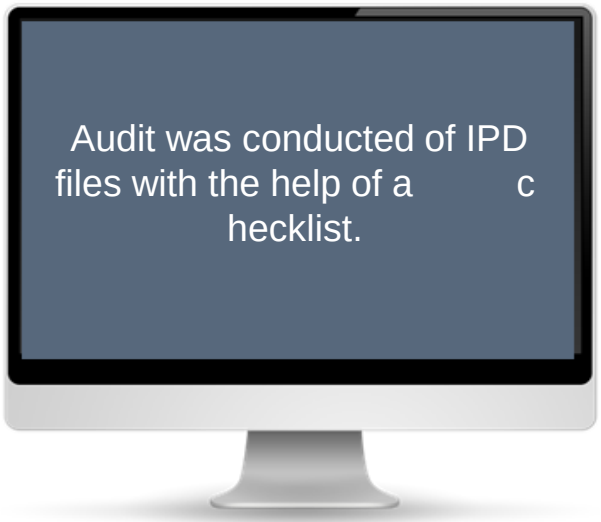
PROJECT OBJECTIVES

Methodology

Research Design

Area of Study

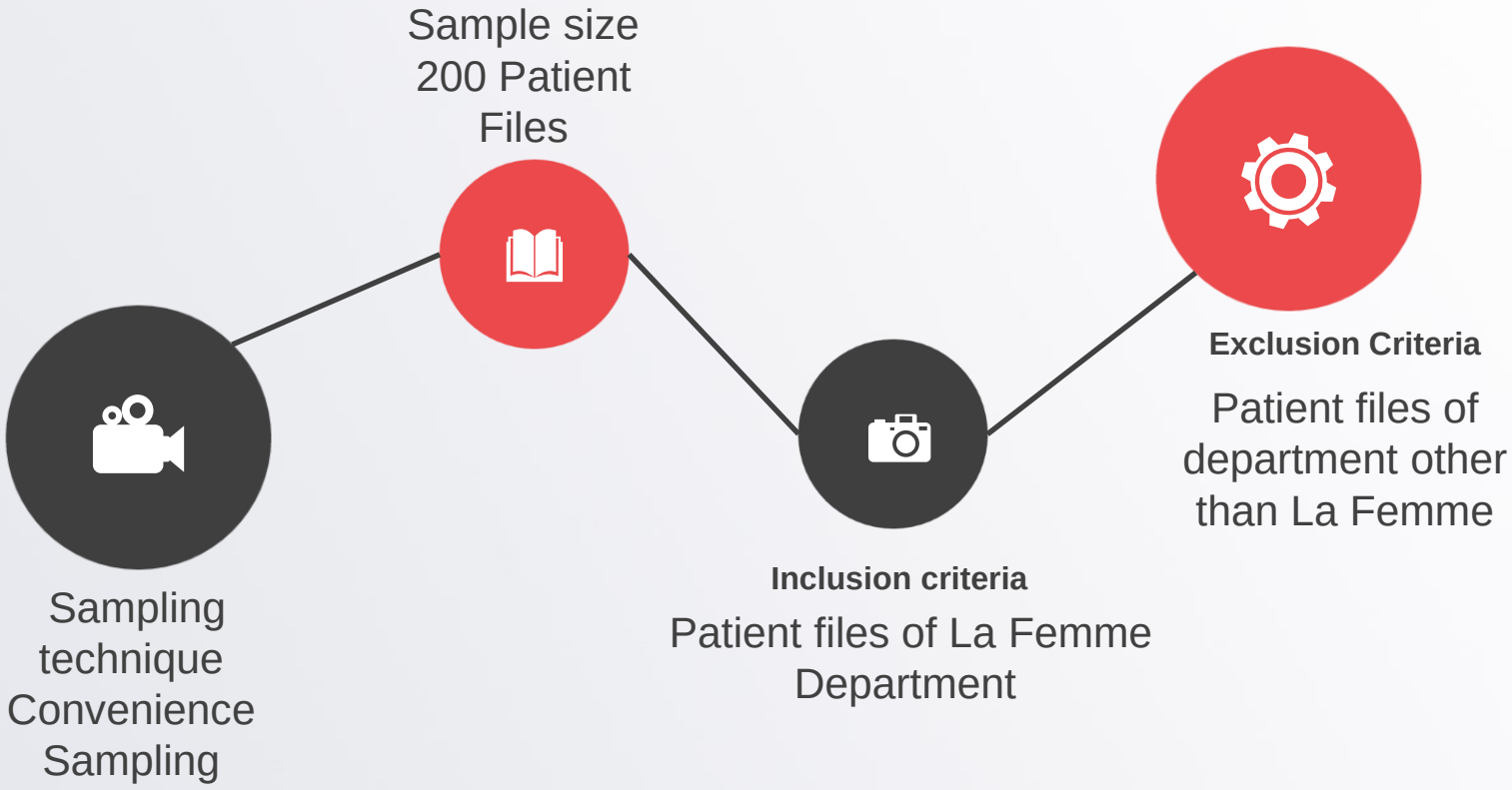
Descriptive & cross sectional



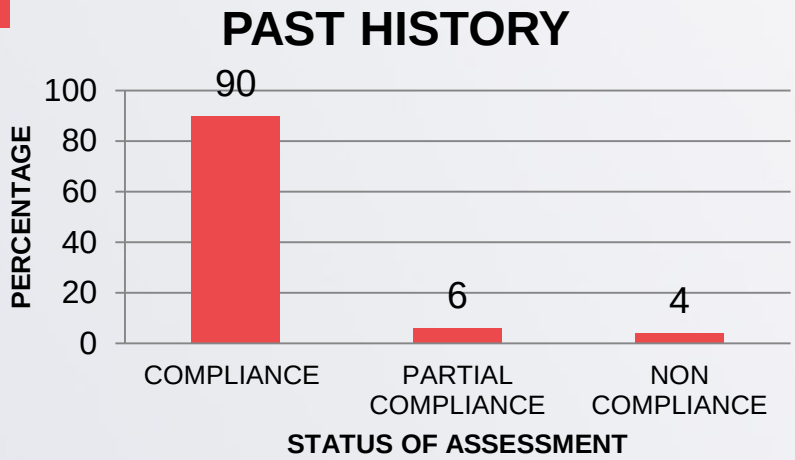
Method of Data Collection

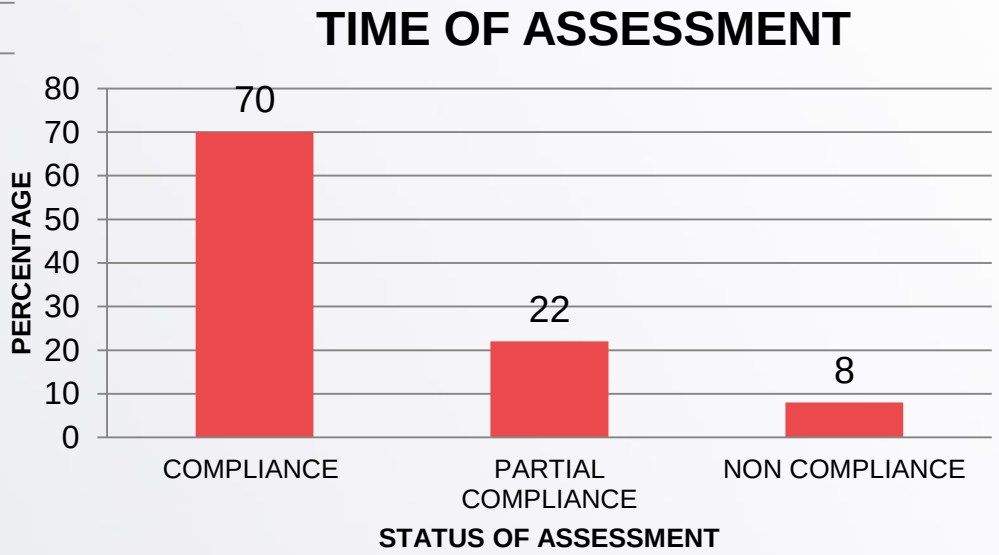
Research Design

Sampling

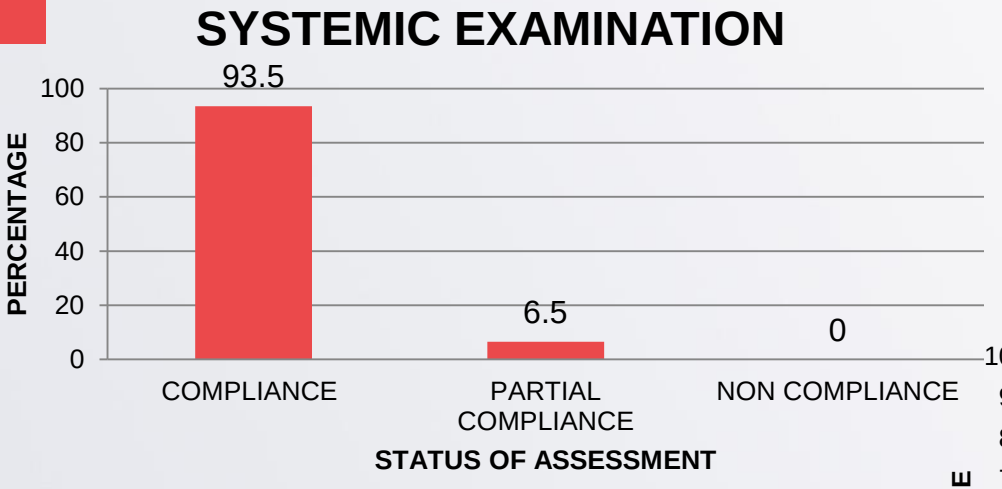


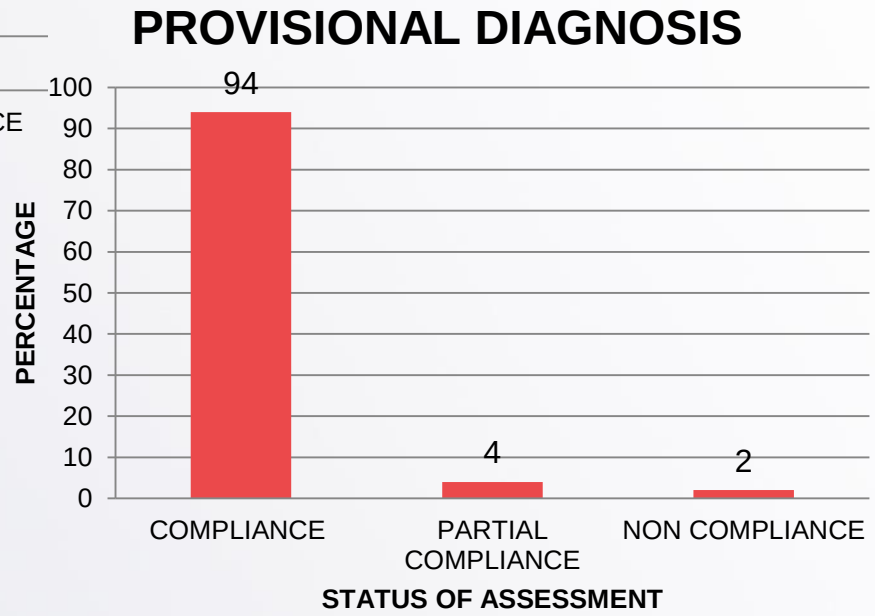
Findings


PAST HISTORY
PERCENTAGE
100
80
60
40
20
0
90
6
4
COMPLIANCE
PARTIAL COMPLIANCE
NON COMPLIANCE
STATUS OF ASSESSMENT

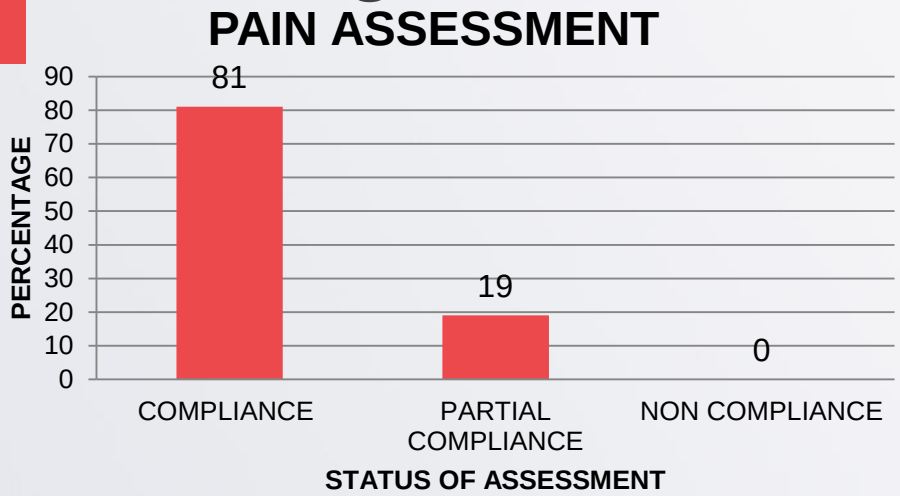

TIME OF ASSESSMENT
PERCENTAGE
80
70
60
50
40
30
20
10
0
70
22
8
COMPLIANCE
PARTIAL COMPLIANCE
NON COMPLIANCE
STATUS OF ASSESSMENT

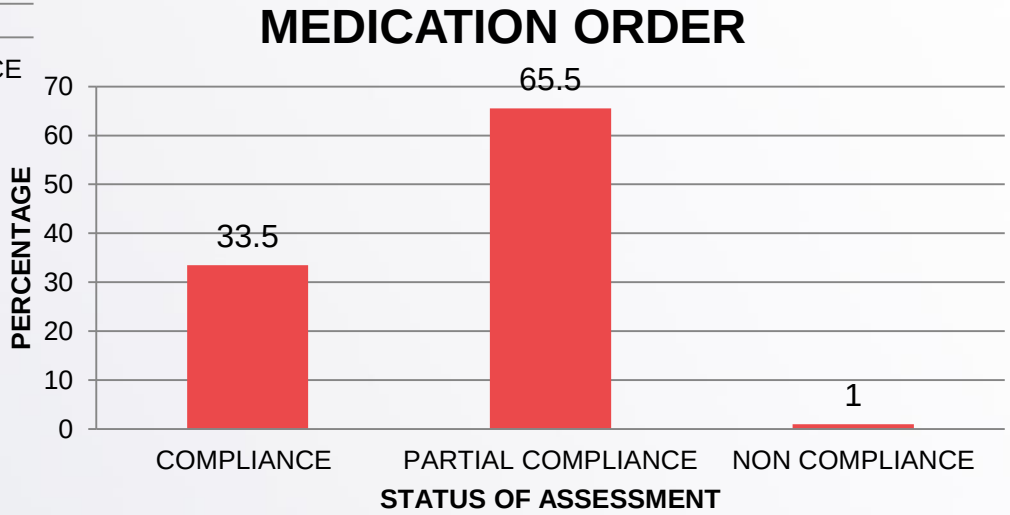
Findings


SYSTEMIC EXAMINATION
PERCENTAGE
100
80
60
40
20
0
93.5
6.5
0
COMPLIANCE
PARTIAL COMPLIANCE
NON COMPLIANCE
STATUS OF ASSESSMENT


PROVISIONAL DIAGNOSIS
PERCENTAGE
100
90
80
70
60
50
40
30
20
10
0
94
4
2
COMPLIANCE
PARTIAL COMPLIANCE
NON COMPLIANCE
STATUS OF ASSESSMENT

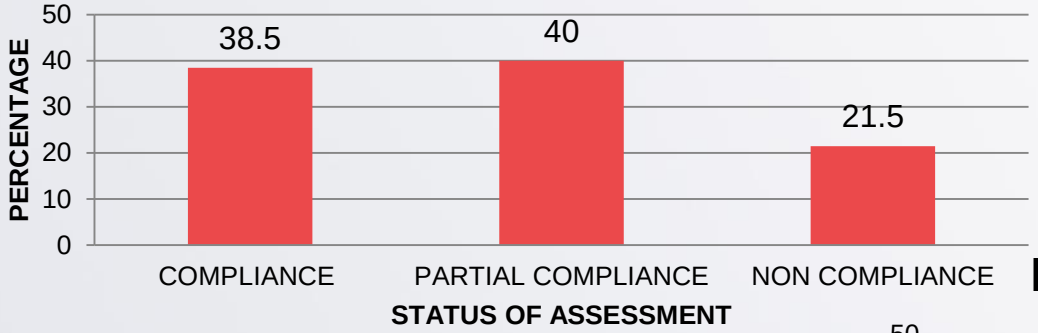
Findings


PAIN ASSESSMENT
PERCENTAGE
90
80
70
60
50
40
30
20
10
0
81
19
0
COMPLIANCE
PARTIAL COMPLIANCE
NON COMPLIANCE
STATUS OF ASSESSMENT

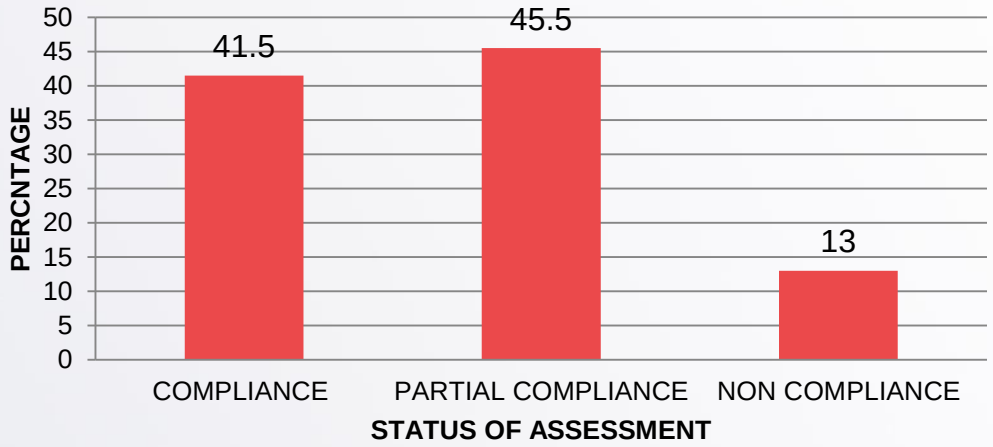

MEDICATION ORDER
PERCENTAGE
70
60
50
40
30
20
10
0
33.5
65.5
1
COMPLIANCE
PARTIAL COMPLIANCE
NON COMPLIANCE
STATUS OF ASSESSMENT

Findings

PATIENT, FAMILY COMMUNICATION RECORD

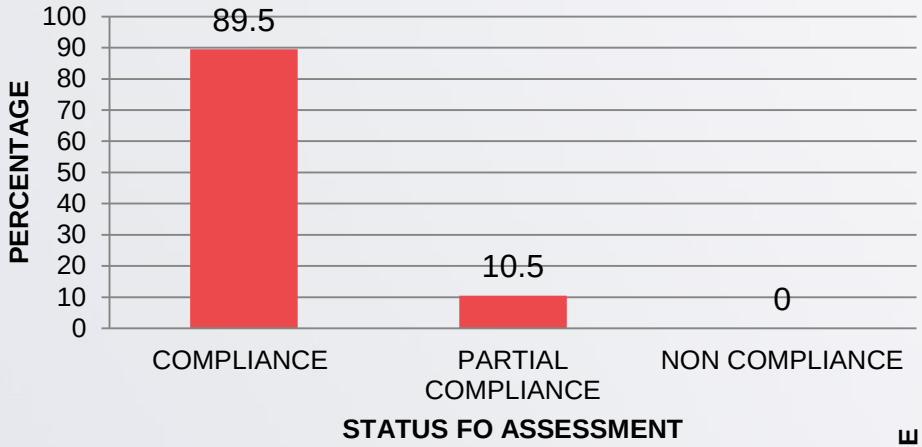


DATE, TIME, SIGN & ID NO.

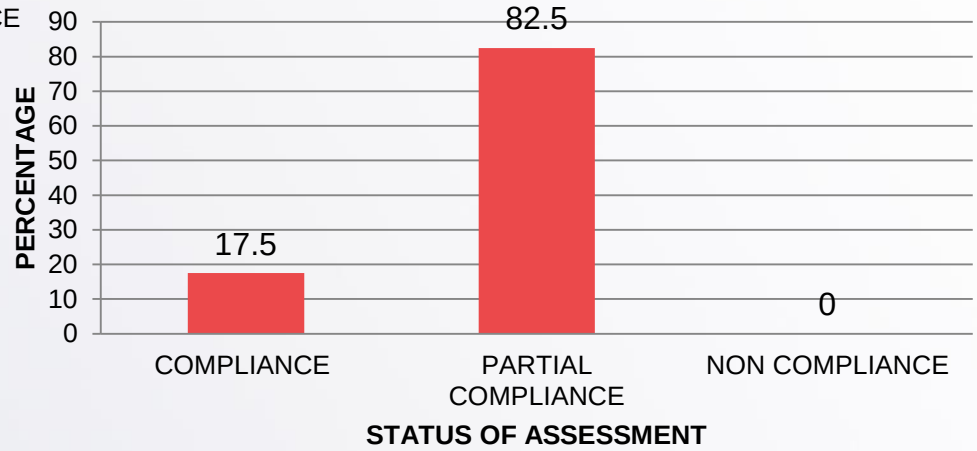


FINDINGS

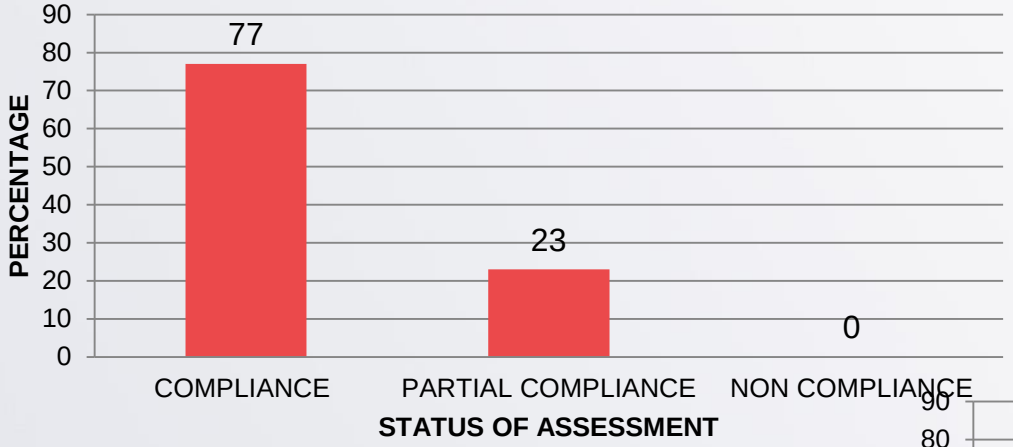
DISCHARGE SUMMARY



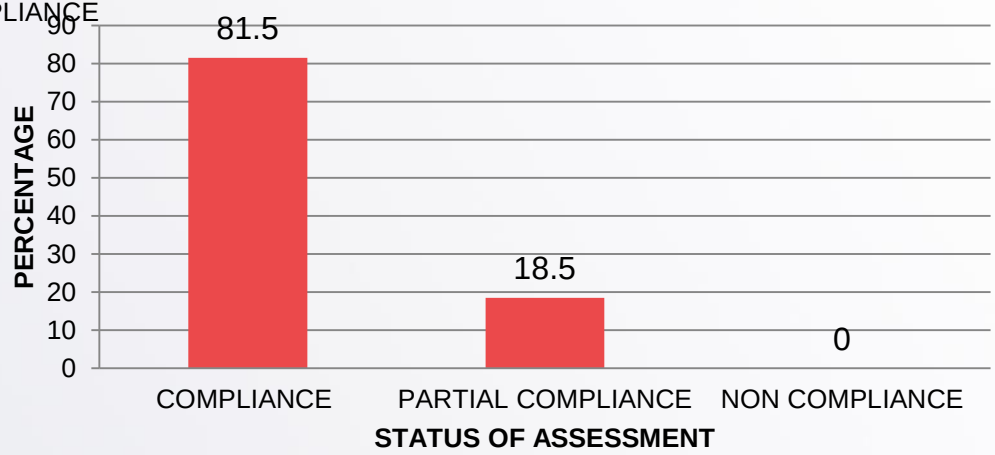
IN HOUSE TRANSFER



NURSING NOTES(every shift)

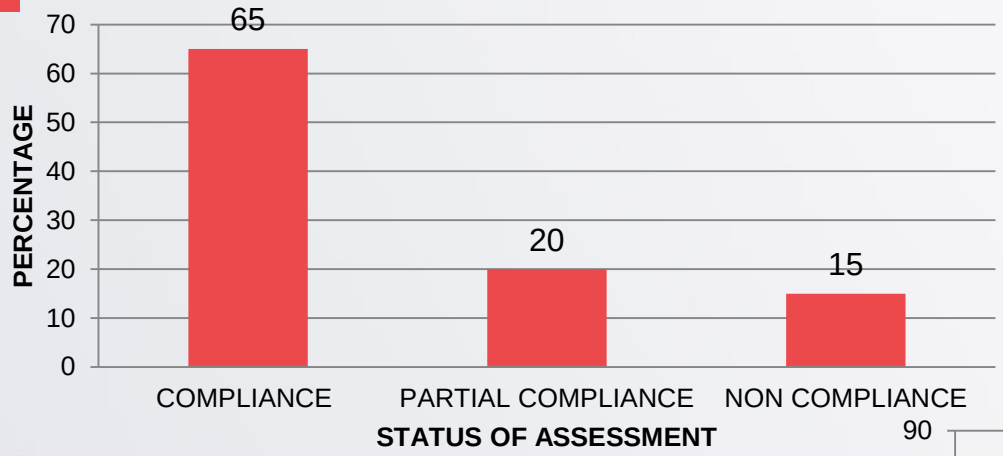


PROGRESS NOTES

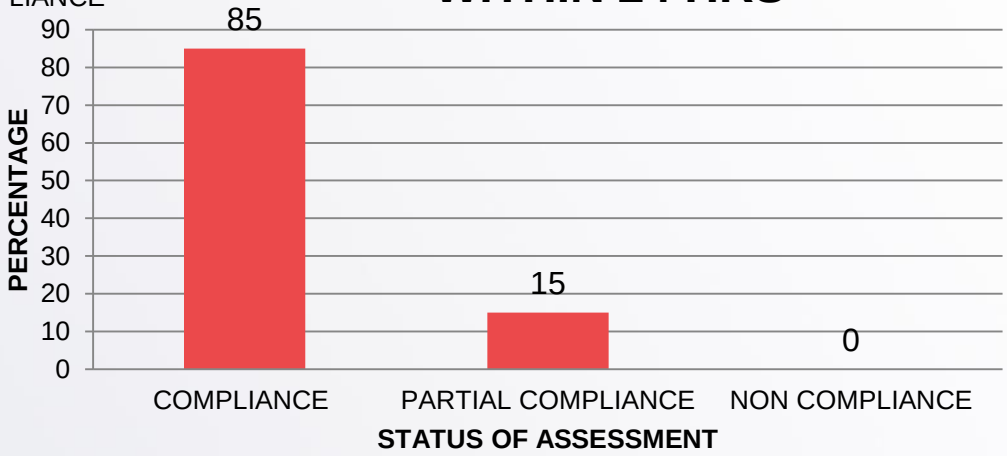


FINDINGS

PATIENT & FAMILY EDUCATION



CONSULTANT COUNTER SIGNED WITHIN 24 HRS



FINDINGS

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%

DISCUSSION

- Lowest level of compliance is found in:
- In house transfer
- Medication order
- Patient family communication record
- Date , time , signature & ID No.
- In order to increase the compliance percentage:
- During SR Connect all the parameters lagging behind were discussed .
- Residents were asked to pay attention towards filling of in house transfer form and patient family communication record
- Emphasis was put on writing the medicines in capital letters
- Residents were asked to mention the date, time an ID No. along with there signature below every note.

Suggestions

01 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.

02 There should be regular refresher training and audit should be conducted by the medical administration department for documentation compliance as per the NABH guidelines.

03 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 department of quality.

04 Result of audit to be shared with concerned stakeholders to sensitize them.

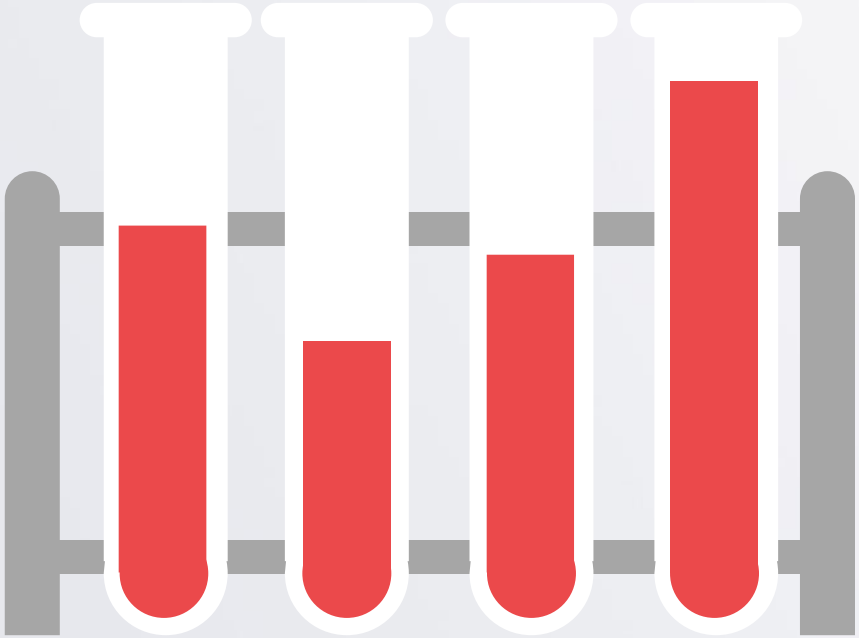
Suggestions

05 Insert separator cards for basic division between in-patient and out-patient episodes.

06 Conduct CME programs titled importance of documentation and complete filling of medical consents.

07 Incomplete files to be tagged with colored sticker and comments written on that to complete patient file documentation.

Conclusion



- Ability of the health care professional to assess & plan patients immediate treatment & to monitor health care over time
- Communication and continuity of care among physicians and other health care professionals involved in the patient's care
- Accurate and judicious claims review and payment
- Collection of data that may be valuable for research and education.

References

Few from around the world

Geoffrey Yeo. Managi ng Public Sector Records: A Study Program. UK: I nternational Records Management Trust; 1999.1.

Ralph V . Seep , Law Revision Counsel. U nited States Code, V olume 34. 2012 ed. USA: United States Government Printing Office Washington; 2 014. 244.

NABH. National accreditation board for hospital and health care providers. Quality Council of I ndia, New Delhi. [Internet] 2015.

Thank you