A study on assessment of patient related documentation in tertiary care hospital

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

By

SONALI TAGGAR

Under the Supervision and Guidance of

Dr. Mahender Kumar

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled **A study on assessment of patient related documentation in a Tertiary Care Hospital** is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature)

Name of Student: Sonali Taggar

Date: 27-06-2021

Shri Mata Vaishno Devi Narayana Superspeciality Hospital

Managed by Narayana Health

COMPLETION CERTIFICATE

This is to certify that Ms Sonali Taggar in partial fulfillment of the requirements for the award of the degree of MBA Hospital and Health Management from the IIHMR University, Jaipur has successfully completed his internship at Shri Mata Vaishno Devi Narayana Superspeciality Hospital during March 22, 2021 to June 19, 2021.

For Narayana Vaishno Devi Speciality Hospitals Pvt. Ltd.

M M Mathavan (M3)
Facility Director

Place:

Date:

Preceptor/Head of the Organization

Name of the organization

CERTIFICATE

This is to certify that dissertation title **A study on assessment of patient related documentation in tertiary care hospital** is a record of the research work undertaken by Sonali Taggar in partial fulfillment of the requirements for the award of the degree of MBA Hospital and Health Management from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide

IIHMR University, Jaipur

Date

School Dean

IIHMR University, Jaipur

Date

ABSTRACT:

The study entitled "Analysis of Health Record Documentation Process as per the National Standards of Accreditation with special emphasis on Tertiary Care Hospital" aims to review the health records and then evaluate them to find the inappropriate documentation of patient's data by doctors, nurses and other healthcare providers involved in the process of documentation. Health records form an imperious part of management of a patient. It is important for the doctor, nurses and medical team 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 report, to analyse the treatment, and to plan appropriate treatment protocols. The other reason is that it will assist in planning governmental strategies for future medical care. There are studies shown that the average time spent by a doctor on a medical record is very less and the scenario is much worse when it comes to critical areas of the hospitals like casualty where the time is very precious in treating the patient and not much of importance is given for documentation[1)] for this purpose the study was conducted in Shri Mata Vaishno Devi Narayana Super speciality Hospital, katra. A total of 200 patients files reviewed and primary data collected by checking the patient files at nursing stations, wards and critical areas. A documentation review audit tool was then prepared (as per objective elements mentioned by NABH) taking into consideration the important aspects of documentation in the health records. Consent forms (n=347) were obtained from the files and various parameters were analyzed from which it was inferred that documentation was not proper in most of the areas in different consent forms to measure this every parameter was analysed and then result was obtained to check the documentation in particular area as well as in consent form that was used i that area, the files were checked as per the parameters mentioned in the audit tool and list down the abbreviations which were used in the consent forms. To measure the compliance, three options were included i.e. Full compliance, Partial compliance and Noncompliance. Then the percentage (%) compliance was calculated for each health record form. Data interpretation and analysis was done and major non-compliances were reported to the doctors, nurses and paramedical staff along with reasons for their non-conformity with the NABH standards. Possible suggestions and recommendations were also reported. This helped in bringing down the percentage of non-compliance.

Acknowledgement

The Dissertation opportunity that I had with Shri Mata Vaishno Devi Narayana Superspeciality Hospital was a great opportunity for me to learn and meet so many wonderful people and professionals who led me throughout.

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TABLE OF CONTENT

Contents

LIST OF TABLES

LIST OF FIGURES

ABBREVATIONS

1) COVID: Corona Virus Disease
2) IC : Intensive Care Unit
3) ITU: Intensive Therapy Unit
4) MRN: Medical Record Number
5) PICU: Paediatric Intensive Care Unit
6) SNDT: Sign, Name, Date and Time
7) NABH: National Accreditation Board for Hospitals
8) HRCT: High –resolution computed tomography
9) CT: computed tomography
10) CSF: Cerebrospinal fluid
11) CAG: Coronary angiogram
12) PTCA: Percutaneous transluminal coronary angioplasty
13) ERCP: Endoscopic retrograde cholangio pancreatography
14) LFT: Liver function test
15) LSCS: Lower segment caesarean section.
16) ORIF: Open reduction and internal fixation
17) PFN: Proximal femoral nail
18) TURBT: Transurethral resection of bladder tumour.

1) INTRODUCTION

Documentation is a communication tool that helps in the exchange of information between caregivers. It is one of the key areas to determine the standard of care rendered by hospital services which enhances professional autonomy as well as critical thinking skills and development of professional knowledge and nursing education[2].Execution of documentation should be done in a way that ensures continuity of care, planning and liability as well as in the furtherance and advancement of practices based on evidence. Good record care also ensures that the hospital's administration is working efficiently, give evidence of the hospital's accountability for its procedures and they form a key source of data for medical research, statistical reports and health information systems. Record keeping is a tool for professional practice and one that should help in the care process, it should be made as soon as possible after the patient enters in the premises of hospital an should be continued till each and every procedure is complete. It is important that appropriate record is made in the patient's profile and should include interventions and any response to it[3].

The concerns associated with poor documentation practices are omitting of medications, improper or double administration of medicines and the legal harm. Incomplete patient report persistently causes doubts and inculpate in the legal jurisdiction since only the fully complete documented medical cases are accepted by the legitimate medical group for verifying and validating medico-legal cases (as Statistically reported from developed countries showed that 74% of the cases are errors of healthcare providers which were reported to judicial authorities).Completed documentation of this medical record is very important because the deficiencies in this documentation, have made the doctor's defenseless in medical negligence cases filed against them .This needs to stress on the "Golden Rule" in documentation i.e. "If it isn't written down, you didn't do it"[3].One of the most important reason of incomplete records is that the doctors and surgeons believed that medical or surgical care required for patients are vital, but documentation of the data concerning to care is not considered as a part of treatment process by them. This is a misconception because the time spent to register and complete the patients' medical records is considered as part of care process. For this, records should be maintained and the concerned person is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes by maintaining proper Medical and Nursing Records, Consent Forms, Medication and vitals sign observation charts, Handover sheets, Patient assessment forms etc. Medical records are the important tools to perform the

affair of treatment and prevention and are known as the reflecting mirror of the medical affairs in an institute. Medical records documentation and dissemination of information, which are used as the foundation of the programming and decision making management in education, research and health are the most valuable criteria of hospital staff professional assessment. Thus in view of a good patient care and to prevent a health care provider from negligence suits, a standardized medical record documentation is very essential. Informed consent has also become the primary paradigm for protecting the legal rights of patients and guiding the ethical practice of medicine. Informed consent means different things in different contexts and is variably practiced and rarely does it achieve the theoretical ideal. A simple consent entails that the patient with decision making capacity freely authorizes a treatment plan aimed at a mutually acknowledged treatment goal. The authorization is informed when the physician discloses and the patient understands the diagnosis, the relevant options for treatment (including no treatment) and any respective risks and a benefit that is why it should be documented properly containing every details[4)].

2) LITERATURE REVIEW:

	AUTHOR	YEAR	RESEARCH QUESTION	STUDY LOCATION	SAMPLE SIZE	SAMPLING TECHNIQUE	SALIENT FEATURES
1	PrenaSingh,Sakhi John	2017	Analysis of health record Documentation process as per the National Standards of Accreditation with special Emphasis on Tertiary care hospital	Delhi	200	Random Sampling	The data shows that full compliance was obsereved in HIV consent, anesthesia consent and high risk procedures, medical assessment documented in 24 hours, medical assessment documented prior to any procedure and the other parameters have partial compliance or less than 100% compliance are focused for appropriate documentation and training sessions are being organized for staff to improve the documentation process.
2	Riyadh A.Hussian ,RajaaA. Mahmoud ,Nihad Q Al Hamadi	2017	Assessment of the documentation completeness level of the medical records in Basrah general	Iraq	268	Random Sampling	Documentation level for the medical records included in the study was generally poor in 78 percent of the records .Surgical

			hospital				department was found to be the worse in documenting patients notes, while gynecology and obstetrics department was found to be worst in documenting the medical examination assessment and the physical note related to the patient state and details of any improvement/ deterioration of his/her condition
3	Ramasamy R. Ganesh Rajendiran,Kagne R.N	2021	Practice of documentation at casualty of tertiary care hospital	Puducherry	680	Random Sampling	Total 680 patient admission case sheets were analyzed, out of which 40 case sheets were analyzed in the pre-intervention period and 340 case sheets in post intervention and a total of 34 variables were analyze in the pre-intervention period and 340 case sheets in post intervention and a total of 34 variables were identified from the admission sheets which were documented and found to have significant

							decencies.
4	Mohd Ai Hatram Khan, Nilima,Jackline Prathibha, Bhaskar Tiwary, Monika Singh	2019	Documentation of in -patient files: A cross sectional study from an East India state	India	80	Convenient sampling	Majority of the nurse (67.5%, n=54) had satisfactory knowledge, attitude and practice Chi-squared test of association revealed no significant relation between gender and knowledge, attitude and practice (x=0.15, df=1 and p=0.697). No significant association of knowledge, attitude and practice was observed with age (x=1.48,df=2 and p=0.477) and years of experience (x=2.3,df=1 and p=0.128)
5	Benyamin Mohseni Saravi, Zolaykha Asgari, Hasan Siamian, Ebrahim Bagherian Farahabadi,Alimorad Heidari Gorji, Nima	2016	Documentation of Medical Record in Hospitals of Mazandaran University of Medical Sciences in 2014	Iran	381	Random sampling	The results showed that 62 percent of registration and all the four forms were in the “poor” category. There was no big difference in average registration among the hospitals. Among the educational

	Motamed, Mohammad Fallahkharyeki, Ramin Mohammadi						groups Gynecology and Infectious were equal and had the highest average of documentation of 68 percent. In the data categories, the highest documentation average belonged to the verification, 91 percent.
6	Madhav. M Singh, Saroj Patnaik,BhandaruSirdhar	2017	Medical Audit of Documentation of Inpatient Medical Record in a Multi-specialtyhospital In India	India	320	Systematic Random Sampling	Gynecology and pediatric department records were not found appropriate. Psychiatry and dermatology dept. record keeping was found appropriate as per laid-down policy. Planned care was not planned as per standard protocol in surgery department.
7	ZS Fadl Elmula,Ahmed K Bolad	2014	Standard documentation of paper based medical records at four main hospitals in Khartoum state,Sudan	Sudan	400	Random sampling	Out of four hundred record files taken for the assessment from the four hospitals, mean of legibility was 36.8 percent for hospital (A, B, C, and D), mean of adequacy was 18.8 percent, mean of accuracy was 34.2 percent, mean of authenticity was

							40.5 percent whereas using prohibited abbreviations was reported with a mean of 33.2 percent. All the four hospitals showed sub moderate/poor level of practice regarding criteria of standard documentations.

Table 1: Literature review:

3) METHODOLOGY

a) **Research questions:**

1) What is the compliance rate of the documentation in the facility under consideration in accordance to NABH standards?

2) What are the key causes of non –compliances in documentation at the facility under consideration?

3) Are the forms and formats in use obey the corporate/ hospitals policies?

b) **Research objectives**:

1) To assess the compliance of documentation as per NABH standards.

2) To list the major casual factors for non-compliance in documentation as per the NABH standards.

3) To asses and identify any gaps in the forms and formats currently in use at the facility.

c) **Research design**: Descriptive Cross sectional study.

d) **Study setting**:

1) The study was conducted at Shri Mata Vaishno Devi Narayana super speciality Hospital, Katra, Jammu and Kashmir with help of the Medical administration and quality department. The study was conducted through 1April 2021-31 May 2021.

2) Files for the active and passive patients and consent forms were observed and the non-compliances was noted.

3) All the forms and formats from all departments (clinical and non-clinical) across the facility where observed for non-compliance and updating.

e) **Study population**:

Inclusion criteria- Files from both Active and passive patients are taken; only admitted patients are taken.

Exclusion criteria-

1) MLC and DAMA files are not considered

2) Files of COVID patients are not considered.

3) Files of gynaecology patients are not considered.

f) **Research procedure/approaches**: Mixed (Quantitative and qualitative assessment)

g) **Study approach**:

Study duration: 3 Months

Sampling technique: Convenience sampling

Sample size: 200 files of patient

Study instrument: Data collecting format for Active and Passive files, consent forms and format of all the forms and registers used in organisation.

Statistical method: Microsoft excel

h) **Operational definitions**:

1) Medical Records: A record of patient's medical information (as medical history, care or treatment received, test results, diagnose and medications taken).
2) Documentation: It is a communication tool that helps in the exchange of information stored between caregivers.
3) Inpatient: A person who lives within the hospital while under treatment.
4) Anaesthesia: It is a state of controlled, temporary loss of sensation or awareness that is included for medical purpose.
5) Serology: The scientific study for the examination of blood serum.
6) Accreditation: A process of officially recognizing someone as having a particular status.
7) Informed Consent: Permission granted in full knowledge of the possible consequences.
8) Quality: The degree of excellence of something.

4) RESULT

1) To check the documentation in consent forms:

It was done to identify different consent forms in patients file whether they are documented properly or not. The below table represent the consents form which are observed in two hundred files (n=200) in different departments of hospital. The departments from where the consent forms are obtained are general ward, ICU, ITU, PICU etc, various parameters were identified on the basis of which further study was done to analysis which area is under documented as well as which parameter is least and most notified in which department.

Table 2: Consents forms

NAME OF CONSENTS	FREQUENCY
General Consent	100
Operational/Procedure Consent	70
Anesthesia Consent	29
Serology Consent	46
Diagnostic Consent	56
High Risk Consent	19
Transfusion Consent	16

PARAMETERS

SNTD of Patient
SNTD of Attendant
SNDT of Witness
Name of Procedure
SNTD of person performing
Risk and Benefits Mentioned
Explained in Patients Own Language
Consent within Time Frame

Table 3: Parameters used in consent forms

AREA	SNDT of Patient	SNDT of Attendant	SNDT of Witness	Name of Procedure	SNDT of Person Performing the Procedure	Risk and Benefit Mentioned	Procedure Explained in Patients Language	Consent within Time Frame	Total
General ward	31	42	3	50	35	39	46	39	63
ICU	13	54	6	57	48	31	68	58	74
ICU 2	18	61	5	57	48	52	64	68	72
PICU	15	55	3	58	40	37	63	55	70
ITU	17	58	10	58	57	46	58	67	68

Table 4: Compliance of parameters in different areas.

Figure1: Compliance of different parameters in different areas.

From above observation that general ward is the area where consent with the time frame, procedure explained in patient language, SNDT of the person performing the procedure, SNDT of witness, SNDT of attendant, Name of the procedure was least in documentation and ICU is the area where consent of risk and benefits and SNDT of patients was least in documentation as compared to other areas.

Consent Name	SNDT of Patient	SNDT of Attendant	SNDT of Witness	Name of Procedure	SNDT of Person Performing the Procedure	Risk and Benefit Mentioned	Procedure Explained in Patients Language	Consent within Time Frame	TOTAL
General consent	9	71	4	78	59	57	83	26	100
Anesthesia consent	26	35	2	31	30	26	29	31	37
Diagnostic consent	7	45	3	48	40	28	54	53	56
High Risk consent	2	10	6	10	9	10	14	15	19
Operation/Procedure consent	40	59	10	57	50	34	58	57	70
Restrain consent	0	2	0	2	2	2	3	2	3
Serology consent	6	37	2	41	29	37	45	42	46
Transfusion consent	5	13	1	15	12	11	14	15	16

Table 5: compliance of parameters consent wise.

Figure 2: Documentation in general consent and anesthesia consent.

The parameter which was least filled in the general consent form was SNDT of witness (n=4, 1.03%) and most filled was procedure explained in patient language (n=83, 21.45%), and in Anesthesia consent the least filled parameter was SNDT of witness (n=2, 0.95%) and most filled parameter was SNDT of patient (n=35, 16.67%).

Figure4: Documentation in Diagnostic consent.

Figure 5: Documentation in Restrain consent.

In diagnostic consent least filled parameter was SNDT of witness (n=3.1.08%) & most of the parameter which was documented was procedure explained in patient language and in restrain consent least filled was SNDT of patient (n=0) & SNDT of witness (n=0), most filled was procedure explained in patient language (n=3.23.08%).

Figure 6: Documentation in high risk consent.

Figure 7: Documentation in operation/procedure consent.

In high risk consent least filled parameter was SNDT of patient (n=2, 2.63%) and most filled was consent within time frame (n=15, 19.74%) and in operation/procedure consent form least filled parameter was SNDT of witness (n=10, 2.74%) and most filled was SNDT of attendant (n=59, 16.16%).

Figure 8: Documentation in serology consent.

Figure 9: Documentation in transfusion consent.

In serology consent the parameter which was least filled was SNDT of witness (n=2, 0.84%), most filled was procedure explained in patients language (n=45, 18.83%).In transfusion consent least filled parameter was SNDT of witness (n=1, 1.16%) and most filled was consent within time frame and name of the procedure (n=15, 17.44%).

Table 6: List of abbreviations used in consent forms.

ABRREVATIONS	FREQUENCY
HRCT	20
CT	2
CSF	1
CAG	3
CAG,PICA	1
CAG,PTCA	1
CVP	1
ERCP	2
HRCT,MRI	1
L SEC	1
LFTS	1
LSCS	1
ORIF	1
PFN	1
RIF	1
TURBT	1
R	1

Figure10: Frequency of abbreviations used in consent forms

Figure 3: Abbreviations used in consent forms.

2) To check the compliance rate in patients files

In order to check the compliance rate audit was done by preparing the checklist to check the compliance rate in patients files (n=200) in the month of April and May and various parameters were observed which were divided in to different sections of doctors and nursing which include under the category of doctor patient details, admission order, admission consent, emergency initial assessment, initial assessment on admission, doctors progress notes, consultation cross referral form, medicine card long stay short stay, consent forms, blood transfusion form, anesthesia documents, operation documents, narcotic drugs, Cath history and physical record, nutritional documents, physiotherapy documents, discharge and death summary and sub category is described in below table.

Table 7: Compliance of the parameters filled in patients file by the doctors in the month of April and May

ADMSSION ORDER	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
INSTRUCTION FOR ADMISSION CLEARLY GIVEN	78	22	0	78%	77	23	0	77%
NAME AND SIGNATURE OF ADMITTING CONSULTANT	74	26	0	74%	76	24	0	76%
ADMISSION CONSENT	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
NAME AND SIGNATURE OF PATIENT/RELATIVE	100	0	0	100%	100	0	0	100%
NAME AND SIGNATURE OF STAFF TAKING	98	2	0	98%	100	0	0	100%

CONSENT								
IS THE LANGUAGE OF THE CONSENT UNDERSTOOD BY THE PATIENT	99	1	0	99%	100	0	0	100%
Admission Consent	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
CHIEF COMPLAINTS CLEARLY STATES PROBLEM	93	7	0	93%	98	2	0	98.00%
PAST HISTORY STATES ANY DRUGS, DIAGNOSIS OR TREATMENT TAKEN	93	7	0	93%	98	2	0	98.00%
PATIENT CONDITION AT DISCHARGE/ TRANSFER CLEARLY MARKED	50	50	0	50%	46	54	0	46.00%
Initial assessment on Admission (Adult/ Paediatric)	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
ALLERGY HISTORY	91	9	0	91%	84	16	0	84%
CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS ARE CORRELATING WITH EMERGENCY ASSESSMENT FORM	85	15	0	85%	85	15	0	85%
TREATMENT PLAN IS LEGIBLE	89	11	0	89%	85	15	0	85%
DISCHARGE PLANNING	80	20	0	80%	73	27	0	73%
INITIAL ASSESSMENT DONE WITHIN 1 HR OF ADMISSION BY	82	18	0	82%	80	20	0	80%

JUNIOR DOCTOR								
INITIAL ASSESSMENT COUNTER SIGNED BY THE ADMITTING CONSULTANT WITHIN 24HRS OF ADMISSION	72	28	0	72%	52	48	0	52%
DOCTORS PROGRESS NOTES (WARD)	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
DAILY WRITTEN (AT LEAST ONCE IN 24HRS)	84	16	0	84%	83	17	0	83%
DOCUMENTATION OF CONDITION OF PATIENT AND PLAN OF CARE	86	14	0	86%	83	17	0	83%
NAME AND SIGNATURE OF THE DOCTOR	82	18	0	82%	76	24	0	76%
DATE AND TIME OF THE NOTES	86	14	0	86%	80	20	0	80%
MEDICAL OFFICERS HANDOVER DOCUMENTATION	74	26	0	74%	71	29	0	71%

CONSULTATION CROSS REFERRAL FORM (PATIENT REQUIRING CROSS REFERRALS: 109)	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
REQUEST FOR REFERRAL DOCUMENTED	25	4	71	86.20%	32	1	67	97.05%
REFERRAL TYPE (URGENT, ROUTINE)	23	5	72	82.14%	31	1	66	96.87%

REFERRAL DOCTOR NOTES DOCUMENTED	26	3	71	89.65%	33	1	66	97.05%
DATE, TIME AND SIGNATURE OF THE REFERRAL DOCTOR	26	5	69	83.87%	34	41	25	45.33%
MEDICINE CARD LONG STAY & SHORT STAY	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
ALL MEDICATION ORDERS WRITTEN IN CAPITAL LETTERS	79	14	7	79%	32	8	60	32%
ONGOING PAST MEDICATION	22	67	11	24.71%	46	29	25	61.33%
ALLERGY HISTORY DOCUMENTED	68	25	7	73.11%	30	27	43	52.63%
DOSE/ ROUTE/FREQUENCY MENTIONED IN PRESCRIPTION	79	13	8	79%	31	18	51	31%
NAME AND SIGNATURE OF THE DOCTOR	80	13	7	80%	31	19	50	31%
CONSENT FORMS	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
Serology Consent (Name, Date, Signature of patient and doctor) completeness	80	9	11	89.88%	30	14	56	68.18%
Operation Consent/ Procedure consent completion	67	5	28	93.05%	19	31	50	38%
Radiology Consent	49	6	45	89.09%	14	25	61	35.89%
High Risk Consent	26	11	63	70%	7	48	45	12.72%
BLOOD TRANSFUSION FORMS(PATIENT REQUIRING CONSENT:74)	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21

CONSENT FOR BLOOD TRANSFUSION (NAME, DATE, SIGNATURE OF PATIENT & DOCTOR)	21	2	77	91.30%	17	51	32	23.94%
ANAESTHESIA	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
PRE ANAESTHETIC CHECK (DOCUMENTED , NAME , DATE , SIGNATURE OF DOCTOR)	63	7	30	90%	24	56	20	30%
ANAESTHESIA CONSENT (NAME, DATE, SIGNATURE OF PATIENT & DOCTOR)	64	5	31	92.75%	25	56	19	30.86%
NAME, DATE , SIGN OF DOCTOR	57	12	31	82.60%	23	52	35	30.66%
Operation Documents (Surgery)	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
Verification checklist completeness	55	6	39	90.16%	22	54	24	28.94%
Surgical Safety Checklist - Completeness (Time in , Time Out, Prophylaxis and Sign)	55	5	40	90.66%	24	52	24	31.57%
Operation Notes – SNDT	50	10	40	83.33%	23	45	33	30.26%
Documentation of Implantable Prosthesis	7	7	86	50%	16	61	23	20.77%
Documentation of Post op Instruction including Medicine	44	10	46	81.48%	23	52	25	30.66%
Transfer Form (Patient Requiring Transfers)	33	10	56	76.74%	18	51	31	26.08%

NARCOTIC DRUGS	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
Progress Notes Clearly states Name of medication	39	4	57	90.69%	20	47	33	29.85%
Route, Dose, Frequency clearly written	33	10	56	76.74%	23	45	32	33.82%
Consultant-Name, Date, Signature and time	39	4	57	90.69%	23	45	32	33.82%
Narcotic Form Filled completely	42	1	57	97.67%	22	45	33	32.83%
CATH PROCEDURE NOTES	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
Pre Procedure Details completeness (Vital, Time out)	11	1	88	91.66%	12	54	34	18.18%
IntraProcedure Record are filled(Time puncture, Medication	11	1	88	91.66%	12	54	34	18.18%
Finding/Diagnosis are clearly written	10	1	89	90.90%	9	53	38	14.51%
Post Cath Diagnosis	9	1	90	90%	14	55	31	20.28%
Name, date , sign of Doctor	11	1	88	91.66%	11	63	26	14.86%
NUTRITIONAL DOCUMENTS	YES	NO	NA	% COMPLIANCE APRIL'21	YES	NO	NA	% COMPLIANCE MAY'21
NUTRITIONAL RE ASSESSMENT - (INTAKE CALORIES, DATE , TIME , SIGN) DONE DAILY	88	12	0	88%	32	68	0	32%
PATIENT AND FAMILY EDUCATION DOCUMENTATION	92	8	0	92%	31	69	0	31%
PHYSIOTHERAPY DOCUMENTS	**YES**	**NO**	**NA**	% COMPLIANCE				% COMPLIANCE

				APRIL'21				MAY'21
ASSESSMENT DONE WITHIN 24HRS	9	0	91	1%	14	51	35	21.50%
REASSESSMENT	9	0	91	1%	14	51	35	21.50%
NAME, DATE , SIGN	9	0		1%	14	61	25	18.66%

Figure 11: Compliance of instructions for admission

In the admission order the instruction for admission was clearly mentioned in 78.78 percent in the month of April and in month of May it was 77.77percent out of 200 hundred files (n=200).

Figure 12: Compliance of name and signature of patient/relative

In admission consent the name and the signature of the patient as well as the relative was documented 100 percent both in the month of April as well as May.

Figure 13: Compliance of chief complaints which clearly states problem.

In admission consent the chief complaint which is the most important part to be documented is present in 93.93 percent in April and 98.98 percent in the month of May.

Figure14: Compliance of initial assessment counter signed.

In initial assessment form was observed and found that in April it was 72 percent and in the month of May it was 52 percent countersigned.

Figure 15: Compliance of assessment done within 24 hours.

In physiotherapy documents the assessment done within 24 hours was present in 91 percent of the files but in the month of May it was present only in the 51 percent of files.

Figure 16: Compliance of all medication orders written in capital letters.

In medical card of the patient whether the medicines which were prescribed was documented in capital letters was observed in 79 percent in the month of April and 60 percent in May.

5) DISCUSSION

Health records serve for different purposes. Their primary purpose is to document the care and services provided to patients, health records must be maintained for evidential purposes too. Health records must be maintained in a manner that complies with applicable regulations, accreditation standards, professional practice as well as legal standards. These standards may vary based on care setting and location. Therefore, an organization must ascertain the content required for its legal health record as well as the standards for maintaining the integrity of that organization, the present study includes majority of the records were found to be poorly documented[1)]. In a study done in Ethiopia in 2015 to assess the difference of medical records' completeness, it was found that there was an improvement from 14% to 84% in the completeness of documenting medical records after a year of a quality intervention programme. Another comparative study done in Rwanda to assess the improvement in completeness of medical records in the maternity unit found that there was an improvement from 25% to 67% over a period of a year of a quality improvement strategy in the hospital[6)].The present study confirmed a clear weakness in documenting the ongoing medications on the medical card ,instruction on the admission form is also not clearly mentioned and there is no proper documentation of consent forms SNDT of

patient, SNDT of witness and the procedure explained in patients own language is the consent which was least filled by the doctors and nursing staff, it was also observed that in most of the consents forms abbreviations were commonly used which are not allowed according to the standards of NABH and it was observed that the most used abbreviation which was seen in the three hundred forty seven consent was HRCT.

6) CONCLUSION

So an overall guidance, it seems that inclusion of continuous and progressive educational plans of documentation and considering the various and quick changes in the science of patient care is necessary plus inevitable, the required documents which are registered and the method of instructions for documentation is beneficial and needs the team work, continuous monitoring and organized examinations. The medical record chronologically documents the care of the patient and is an essential part that is contributing to high quality care[1].An apparently documented medical record will reduce many of the inconvenience associated with claims processing and may serve as a legal document which can validate and is the legal document which proves the care provided by the hospital. It is totally true that storing the health care information and protecting that is an ever increasing challenge of the hospital administration of the organization. The result of this study shows that there was no full documentation present in the consent forms which are used in the hospital and are the important part of every procedure to be done and in most of the areas, in the files of the patients full compliance is achieved in some of the parameters and noncompliance was present in most of the areas. The results are focused for appropriate documentation and educational and training sessions which should be provided for staff (including doctors, nurses and paramedical) to improve the process of documentation process. This study also implies that hospital should pay attention to compulsory documentation of the patient health record data in the respective forms of the medical as well as the surgical records which will further improve the completeness and accuracy in the health record documentation and will also help to achieve NABH standards[5].

The present study confirmed obvious incompleteness of documenting medical data for the inpatient records. This is specifically found in different consent forms where SNDT of witness, SNDT of patient as well as the procedure explained in patient language consent was not properly documented and in patients files awareness about the complete documentation on medical records was present only in

certain areas whereas other areas had not been given much importance while documenting or been neglected.

7) RECOMMENDATIONS

Based on the findings following suggestions were made from the study.

1) In hospitals who collect and store large amount of notes for patient record instead of doing this, the best practice is to insert separators which will not only provide a clearly defined location for the summary sheet but will also allow other types of document to be filled separately.

2) The well-designed forms should be in use that will save the time of staff and helps to ensure that the necessary information is recorded. It also make easier for every assessor who go through that file to locate the king of information they are seeking for particular procedure.

3) A hospital based quality improvement project to increase the medical record documentation completion is recommended to be implemented by the group of trained personnel and periodic random assessments by the quality unit of NH.

4) Health care providers should be trained by keeping check on them regarding documentation of patients file.

5) In complete documents should be tagged with colored stickers and comments written on them.

6) Files should be reviewed on regular basis to ensure the documentation of documents as per the policy of the hospital.

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ANNEXURE

Audit specifications	**File 1**	**File 2**
NAME OF PATIENT		
DATE OF ADMISSION		
NAME OF PRIMARY CONSULTANT		
MRN		
DATE OF DISCHARGE		
FINAL DIAGNOSIS		

Patient details		
Does the Record have MRN No. (Y/NO/NA)		
Does the documents in patient file has ID stickers/Identifiers (Y/NO/NA)		
Admission order		
Instruction for admission clearly written (Y/NO/NA)		
Name & Signature of Admitting Consultant (Y/NO/NA)		
Admission consent		
Name & Signature of the Patient/Relative (Y/NO/NA)		
Name & Signature on the consent taken by Staff (Y/NO/NA)		
Is the Language understood by patient is filled (Y/NO/NA)		
Emergency initial assessment		
Chief Complaints clearly states problem (Y/NO/NA)		
Past History states any drugs, diagnosis or treatment taken (Y/NO/NA)		
Patient condition at discharge/ transfer clearly marked (Y/NO/NA)		
Initial assessment on admission (adult/paediatric)		
Allergy History Noted (Y/NO/NA)		
Chief complaints & History of present illness are correlating with emergency assessment form (Y/NO/NA)		
Treatment Plan is clearly legible (Y/NO/NA)		
Discharge Planning States possible need at home (Y/NO/NA)		
Initial Assessment done within 1 hour of admission (Y/NO/NA)		
Initial Assessment Counter signed by the admitting consultant within 24 hours of admission (Y/NO/NA)		
Doctors progress notes		
Daily written (At least once in 24 hours) (Y/NO/NA)		
Documentation of condition of patient, diagnosis, treatment and plan of care (Y/NO/NA)		
Name and signature of the doctor (Y/NO/NA)		
Date & Time of the notes (Y/NO/NA)		
Medical Officers handover documentation (Y/NO/NA)		
Consultation cross referral form		
Request for Referral documented (Y/NO/NA)		
Referral Type (Urgent/Routine) (Y/NO/NA)		
Referral doctor notes documented (Y/NO/NA)		
Date, Time and signature of the referral doctor (Y/NO/NA)		
Medicinecard long stay & short stay		
All Medication orders written in capital letters (Y/NO/NA)		
Ongoing past medication (Y/NO/NA)		
Allergy history documented (Y/NO/NA)		
Dose/ Route/ Frequency mentioned in Progress notes (Y/NO/NA)		
Name & Signature of the Doctor (Y/NO/NA)		
Consent forms		
Serology Consent (Name, Date, Signature of patient and doctor (Y/NO/NA)		
Operation Consent/ Procedure consent completion (Y/NO/NA)		

High Risk Consent (Y/NO/NA)		
Radiology Consent (Y/NO/NA)		
Blood transfusion form		
Consent for Blood Transfusion(Name, Date, Signature of patient and doctor) (Y/NO/NA)		
Anaesthesia documents		
Pre Anaesthesia check is completely documented (Y/NO/NA)		
Anaesthesia Consent (Name, Date, Signature of Patient & Doctor) (Y/NO/NA)		
Name, Date, sign of Doctor on PAC (Y/NO/NA)		
Operation documents		
Verification Checklist (Pre &Post-operative) (Y/NO/NA)		
Surgical Safety Checklist-Completeness (Time in, Time out, Prophylaxis and sign) (Y/NO/NA)		
Operation Notes-SNDT (Y/NO/NA)		
Documentation of Implantable Prosthesis (Y/NO/NA)		
Documentation of Post op Instruction including Medicine (Y/NO/NA)		
Transfer Form is complete (Y/NO/NA)		
Narcotic drugs		
Progress Notes Clearly states Name of medication (Y/NO/NA)		
Route, Dose, Frequency clearly written (Y/NO/NA)		
Consultant-Name, Date, Signature and time (Y/NO/NA)		
Narcotic Form Filled completely (Y/NO/NA)		
Cath history and physical record		
Pre Procedure Details complete (Vital, Time out) (Y/NO/NA)		
Intraprocedural Record are filled (Time puncture, Medication) (Y/NO/NA)		
Finding/Diagnosis are clearly written (Y/NO/NA)		
Post Procedure Instructions Clearly written (Y/NO/NA)		
Consultant-Name,Date,Signature and time (Y/NO/NA)		
Nutritional documents		
Nutritional Re-assessment -(Intake Calories, Date, Time, Sign) done daily (Y/NO/NA)		
Patient and family education documentation (Y/NO/NA)		
Physiotherapy documents		
Assessment done within 24 hours (Y/NO/NA)		
Reassessment (Y/NO/NA)		
Name, Date, sign (Y/NO/NA)		
Discharge		
Date of discharge (Y/NO/NA)		
Reason for admission (Y/NO/NA)		
Significant Findings (Y/NO/NA)		
Procedures Performed (Y/NO/NA)		
Medication and other treatment (Y/NO/NA)		
Implant Details where applicable (Y/NO/NA)		
Patient condition at discharge (Y/NO/NA)		
Discharge Medication and follow up instructions (Y/NO/NA)		
When and how to obtain urgent care (Y/NO/NA)		

Death summary		
Death Summary (Y/NO/NA)		
Death Certificate complete (Y/NO/NA)		
Is the ICD code documented in patient Death Summary (Y/NO/NA)