Gap Analysis in Internal Assessment Against NABH Standards Audit of Documentation of Medical Record

By

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Dissertation submitted for the partial fulfillment of the
MBA Hospital and Health Management

Academic year, 2014-2016

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Internship Training

At

Max Super Speciality Hospital, Mohali

1) "Gap analysis in Internal Assessment against NABH Standards"

2) "Audit of Documentation of Medical record"

By

Dr. Jasmeen Bawa

Under the guidance of

Dr. Susmit Jain

MBA Hospital and Health Management

2014-2016

The IIHMR University, Jaipur

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

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Jasmeen Bawa** student of MBA Hospital and Health Management (PGDHM) from The IIHMR University, Jaipur has undergone internship training at **Max Super Speciality Hospital, Mohali** from Feb. 8, 2016 to Apr. 30, 2016.

The Candidate has successfully carried out the study designated to him 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
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MAX HEALTHCARE

Ref: MOH/TR/CP/J106

April 30th, 2016

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr. Jasmeen Bawa has completed her training in Max Super Speciality Hospital, Mohali as Trainee in the department of Medical Quality from 08th February 2016 to 30th April 2016 and has successfully completed her project on:

1. Gap analysis in internal assessment of the hospital against NABH standards.
2. Audit of documentation of medical record audit.

During her training she was part of hospital set up and was reporting to Ms. Dolly Singh (Deputy Manager – Medical Quality). She comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning

We wish her all the best in her future endeavors.

For Max Super Specialty Hospital

Authorized Signatory
Human Resource

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation **Gap Analysis in Internal Assessment against NABH Standards & Audit of Documentation of Medical Records** and submitted by **Dr. Jasmeen Bawa** Enrollment No. **IIHMR-U/MBA-HM/2014-16/19-1557** under the supervision of **Dr. Susmit Jain** for award of **MBA Hospital and Health Management** (PGDHM) of the University carried out during the period from **Feb. 8, 2016** to **Apr. 30, 2016** 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.

Jasmeen Bawa
Signature

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Abstract:

A gap analysis report is necessarily a document, which evolves as per circumstantial requirements of the client organization and to know scope of activities required to meet standards to achieve project goal i.e. National Accreditation Board of Hospital and health care (NABH) accreditation status. The board is structured to cater to much desired needs of the consumers and to set benchmarks for progress of health. In this project audits were carried out in various departments of the hospital against 3rd edition NABH standards. Document reviews, physical observation of the departments and informal interviews from the staff members were taken and various gaps were found.

Gaps were intimated to the concerned persons of the departments along with their dates of closure. Various actions were taken to close these gaps with the help of findings and suggestions given at the end of the project. The outcome of gap analysis activity is a clear understanding of the quality gaps leading to the estimation of time and resource that would go in achieving quality accreditation.

Auditing the Medical Record is maintained by 'proper management of health records and accurate, comprehensive record-keeping. Ensuring quality of patient care documentation can be attainted through its completeness in its medical record. This parameter is essential in the continuity of care rendered by different health professionals in the hospital. 206 files of in-patients from the period of 11th April to 20th April were audited according to certain parameters described during the audit that was preplanned and structured. The type of data collected was primary and the source was the files of the in-patients in various departments of the hospital and CPRS system of the hospital. It was entered in an excel sheet and results against compliance were found. In accordance to compliance standards CAPA (Corrective action- Preventive action) was done. The goals of an audit are to provide efficient and better delivery of care and to improve the financial health of your medical provider.

ACKNOWLEDGEMENT

I extend my sincere gratitude to **Ms. Dolly Darshan Singh (Quality Deputy Manager)**, who has been my mentor for the dissertation project & has been instrumental in helping me shape this study in a desirable way and for giving me the opportunity to do this study and undergo the process of learning at MAX SUPER SPECIALITY HOSPITAL, Mohali. I thank her for all the trust and faith she posed in me and I only hope that I have been able to live up to her expectations. Her guidance and support was helpful in enhancing my work. I would also like to thank **Mr. Sandeep Dogra** (V.P. Operations) **Dr. Jatinder Arora** (Medical superintendent) **Ms. Lily Sahota** (HR Head) and **Dr. Rowina Hans** (member of quality team) for supporting my work all along. Last but not the least the entire **staff of Max Super Speciality Hospital** for their support and guidance.

I would like to express my sincere thanks to **Dr. S.D. Gupta (President, IIHMR University)**, **Col.** (**Dr.) Ashok Kaushik (Dean, Academics and Student Affairs)**, and **Dr. Susmit Jain (Assistant Professor & Guide)** of IIHMR university for their proper guidance and cooperation during my dissertation. I am also grateful to my parents, my family and my friends for giving me moral support.

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List of abbreviations

1.	Access Assessment and Continuity of Care	AAC
2.	Care of Patients	COP
3.	Management of Medication	MOM
4.	Patient Rights and Education	PRE
5.	Hospital Infection Control	HIC
6.	Continual Quality Improvement	CQI
7.	Responsibility of Management	ROM
8.	Facility Management and Safety	FMS
9.	Human Resource Management	HRM
10.	Information Management System	IMS
11.	Echocardiogram	ECG
12.	Echocardiography	Echo

13.	Treadmill test	TMT
14.	Electroencephalogram	EEG
15.	National Accreditation Board for Hospitals	NABH
16.	National Accreditation Board for Testing and Calibration Laboratories	NABL
17.	Emergency	ER
18.	Surgical Intensive Care Unit	SICU
19.	Medical Intensive Care Unit	MICU
20.	Operation Theatre	OT
21.	Critical Care Unit	CCU
22.	Bio Medical Engineering	BME
23.	Catheterization Laboratory	Cath Lab
24.	Medical Record Department	MRD
25.	Central Sterile Service Department	CSSD
26.	Human Resource	HR
27.	High Dependency Unit	HDU
28.	Venous Thrombo Embolism	VTE
29.	Senior Resident	SR
30.	Computerized Patient Record System	CPRS
31.	Medical Record Department	MRD
32.	In Patient	IP

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Annexure A: Audit tool

1 GAP ANALYSIS IN INTERNAL ASSESSMENT AGAINST NABH STANDARDS

1.1 Introduction

1.1.1 Background of the study

The NABH accreditation is currently a voluntary scheme but the Quality Council of India plans to cover all the hospitals in India, both, in the Voluntary sector and the Government Hospitals. The advantage to the hospital would be its national recognition as a Quality Care hospital. The Health Insurance sector, various industries and Companies, National and International Funding Agencies, etc will subsequently utilize only these NABH accredited hospitals for their health needs. In fact, those hospitals WITHOUT NABH accreditation will lose out on their credibility and even be excluded from any form of currently universally available subsidy, loans, exemptions from notified taxes and duty payments, etc. The Government of India will thus pave the way to extend all benefits ONLY to NABH accredited hospitals and the citizens of India will have access to formally "recognize" and "accountable" QUALITY HEALTH CARE.

In order to give technical input for re-accreditation, the hospital has requested PAN Max and a team visited the hospital in the month of March.

The Assessment has revealed many non-compliance issues as per NABH standards, which need to be addressed. These needs (or "gaps") will be elaborated in the ensuing pages. As per the scheduled Plan of Action, it is recommended that the Hospital will attempt to fill the identified gaps until the next Gap Assessment is carried out. Thus, in a phased manner of serially scheduled Gap Assessments, the hospital will be able to attain the standards prescribed by the NABH. Once the stage is set wherein the standards have been achieved, the NABH Assessment Team from the Quality Council of India can be invited to formally assess the hospital and accord the Accreditation.

The role of the consultants from the Max hospital (Mohali, PAN Max) will be to progressively facilitate identification of gaps, preparation of documentation and ongoing training, thus aiding the hospital in reaching a state of preparedness for the formal NABH Accreditation.

The preparatory assessment process follows criteria and processes similar to those that will be followed by the NABH Team for the actual assessment Process. Therefore, it is imperative to do a thorough analysis of areas of "not compliant" as per NABH

standards. However, this does not cast any form of doubt about the successful process of the time tested patient care system that has been in place in this hospital since its inception. NABH is merely an enhancement of these processes to conform to National and International standards. Thus it is re-iterated that Non-compliance suggests enhancement of current level of performance in order to placate the actual NABH Assessment Team. This enhancement action thus becomes inevitable. Thus, in conclusion, it can be stated with confidence that these enhancements can be made as per the NABH requirement details outlined in the NABH Manual. The facilitation effort on the part of the team from Max hospital is to enable the Hospital to attain accreditation. Thus, in conclusion, it can be stated with confidence that these enhancements can be made as per the NABH requirement details outlined in the NABH Manual.

The GAP analysis for the hospital was conducted by the team of 3 members from PAN Max. A visit to hospital premises and personal interviews of all categories of hospital staff was organized during this period. The purpose was to assess the functional areas of hospital services with a view of preparing the hospital for NABH Accreditation. The following points indicate the need for further intervention and enhancement, in order to meet the standards set by the NABH. Hospital Care system has been broadly divided into two categories specifically for this hospital. This includes base line assessment of the hospital as per normal workflow and basic system and processes followed and other criteria includes quality parameters followed in the department which includes documentation and assessment by the way of indicators.

The hospital has staff who are very well aware of the guidelines to be practiced and are motivated enough to implement the changes and elevate the standard for delivery of Health care. Re-Accreditation for the institution is merely a step away and all the staff members are oriented to recent advancements. The need of the hour is to re-modulate the system and processes as per the laid down guidelines, with the involvement of all staff members which includes the grass root employees too. In totality hospital has high potential for re-accreditation.

1.1.2 Aim

Aims of this project are:

1. Compare the best practices with the processes currently in place in your organization.
2. Determine the "gaps" between your organization's practices and the identified best practices.

1.1.3 Objectives

1. To evaluate Max Hospital – Mohali compliance to 3rd Edition NABH & Max Medical Quality Standards
2. To assess the gaps in the compliance.
3. To suggest methods/ action plan for the closure of the gaps.

1.2 Literature review

1.2.1 Definition

Gap Analysis is a very extensive, major and important activity after the decision for going ahead with quality accreditation has been taken by the top management of a healthcare facility. The idea for conducting a detailed gap analysis is to have clear resource and time implications and strategy formation for the complete quality accreditation project. The outcome of gap analysis activity is a clear understanding of the quality gaps leading to the estimation of time and resource that would go in achieving quality accreditation. This is also a requirement for any accreditation process. The findings can be used later for comparison with the findings of internal assessment after QMs implementation to look for exact improvement that has taken place over that period.

1.2.2 Description

Gap Analysis is a very powerful tool to kill the ambiguity in the decision of going ahead with quality accreditation as a lot of clarifications and objectivity in decision making is built in by this activity.

The internal assessment was carried out on the basis of 3rd Edition NABH and Max Medical Quality standards. The implementation of these standards is an excellent way to promote organizational development, sustaining and improving the culture of patient centered high quality care and patient safety.

The ultimate beneficiary is the patient – as it results in improved patient satisfaction and clinical outcomes and consequent reduction in adverse events. The standards provide a basis for internal and external benchmarking and also provide direction for continuous upgrading of the levels. Compliance also reduces the risks of complaints, malpractice, organizational disrepute, and improves disaster preparedness. Staff benefits result with higher professional satisfaction, team environment, improved confidence and professional reputation.

Hospital carried out **General audit** against NABH Standards in the month of **FEBRUARY** and later

the Internal assessment was carried out by the hospital with the team of three members from the Max Hospital ,(PAN Max) at the starting of the month of March.

Gap Assessment was carried out during this period

1.3 Methodology

1.3.1 Research question

1. What are the gaps and compliance of the hospital to 3rd Edition NABH & Max Medical Quality Standards?

1.3.2 Study design

Study design selected for this project keeping the aims and objectives of the project in mind is as following:

- **Type of Study**: Non-experimental, cross-sectional and observational (which is done in two parts i.e. present status of the department and compliance against NABH standards)
- **Location of study**: Following various departments of the Max Super Speciality hospital, Mohali

- Oncology Day Care and Radiation day care
- OPD and Front office
- Radiology
- IP and OP pharmacy
- Emergency and ambulatory day care
- Laboratory and sample collection
- Nuclear medicine

- F&B ,Dietetics
- Labor room, NICU and Nursery
- Cath Lab & CCU
- OT-1st Floor
- MICU
- SICU, SICU1,SICU2
- HR and Eco ward
- Biomedical engineering
- OT- 2nd Floor
- Engineering
- Physiotherapy
- MRD,IT
- Security, Mortuary
- Blood Bank
- House keeping
- 2nd floor Wards
- CSSD
- 3rd Floor Wards
- Endoscopy and dialysis
- CTVS ICU

1.3.3 Study respondents

Nurse, customer care staff, duty doctors and staff of the departments.

1.3.4 Sampling

Random Sampling

1.3.5 Types of Data & Collection Methods

- **Type of data –** Both Quantitative & Qualitative type of data was collected.

- **Methods of data collection:**

  - ✓ Document Review
  - ✓ Physical Observation
  - ✓ Informal Interviews – semi-structured interviews (Nurses, customer care in-charge, Duty Doctors and Staff of the departments)

- ✓ The assessment was carried out across all the departments, and the standards were evaluated in an integrated manner, both horizontally and vertically.
- ✓ Departmental process review was done for all the listed departments.

1.3.6 Instruments and Tools used

Checklists for the various NABH standards.

1.4 Result

1.4.1 General Audit

Regular general audits were conducted by the quality team along with the Medical Superintendent in the month of February and following are the areas covered in this study.

Following table shows the areas where gaps were found and targets for the closure of the same were given and action taken are mentioned:

Table 1

ONCOLOGY DAY CARE				
S.No.	**Observation Points**	**Responsibility**	**Target of Closure**	**Action Taken**
1.	Medication for the patient is ordered before the preparation of the medication chart. There is a verbal order given which can cause medication errors.	Dr. Sachin Gupta- to brief junior doctors	9th Feb 2016	The briefing was done to the junior doctors about the medication for the patient which is ordered before the preparation of the medication chart.
2.	Junior Resident present in the department is not BLS trained.	Dr. Manpreet Sahi- to plan the BLS Training for JRs.	15th Feb 2016	BLS training was given to the Junior Residents
3.	Expired patient	Ms. Kamaljit	9th Feb 2016	The expired patient

	medication was found in the Refrigerator of Admixing Lab.	Kaur		medication which were found in the refrigerator of Admixing Lab were Discarded.
4.	MSDS of Ravisol was not available in Brachytherapy Unit.	Sr. Neelam	9th Feb 2016	MSDS of Ravisol was available in the Brachytherapy Unit.
5.	Scope of Services is displayed only Radiation Oncology and that too only in English and not in the vernacular language.	Dr. Sachin Gupta/ Dr. Sunandan Sharma- to provide Scope of services in English Mr. Vishal Sharma- to assist in translation and making standees.	15th Feb 2016	Scope of services was updated in the vernacular language and standees were made as well displaying the same in the department.
6.	Records of Discarded Lead Aprons in all departments were not available with the RSO.	Mr. Ansari	9th Feb 2016	Proper Records of Discarded Lead Aprons in all departments are now available with the RSO.

Table 2

OPD and FRONT OFFICE				
S.No	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	Display for the following was missing: Scope of Services of Hospital Scope of Services for paediatric patients Scope of High Risk Obstetric Patients. Vision, Mission and Values of Hospital All these need to be displayed in English as well as vernacular language.	Mr. Abhinav	20th Feb 2016	Display of the scope of the services near the entrance was updated in English as well as in vernacular language.
2.	Hospital Directory needs to be updated.	Mr. Abhinav	20th Feb 2016	The Hospital Directory is updated.
3.	Nutritional Screening is not done in OPD patients.	Ms. Shivani Gulati	10th Feb 2016	Nutritional Screening is now being done for OPD patients
4.	Patient Information Sheet and General Consent on Face sheet to be available in Local Language.	Mr. Abhinav	20th Feb 2016	Patient Information Sheet and General Consent on Face sheet is now available in Local Language.
5.	The records of pus culture/ swabs were	Ms. Mukti	10th Feb 2016	Proper records of pus culture/swabs

	not maintained in Dressing Room.			are now maintained in Dressing Room.
6.	Patients are not transported safety in OPD. Many patients were transported without safety belt.	Mr. Kirti	10th Feb 2016	Patients are being transported safely and safety belts are tied properly.
7.	One of the stretchers did not have the locks on wheels and other did not have a side rail and patients were transported on these.	Mr. Sharvan	10th Feb 2016	The stretcher which did not have the locks on wheels along with the other which did not have a side rail is not being used for the transportation of the patients anymore.
8.	Consultants do not mention the next follow up date on OPD Prescription.	Dr. Jatinder	10th Feb 2016	Consultants have started the practice of mentioning the next follow up date on OPD Prescription.
10.	Staff needs to be re-trained on Hospital Wide policies viz. POSH, Emergency Codes, Scope of services.	Mr. Abhinav	10th Feb 2016	Staff was re-trained on Hospital Wide policies viz. POSH, Emergency Codes, Scope of services.
11.	Expired Medication was found in hypoglycaemia kit, 25 % Dextrose.	Ms. Mukti	5th Feb 2016	Expired Medication which was found in hypoglycaemia kit, 25% Dextrose was cleared from the kit.
12.	Old version documents	Mr. Deepak	10th Feb	Old version

	of year 2007 used in Treatment Room.		2016	documents of year 2007 used in Treatment Room were upgraded to the latest version

Table 3

RADIOLOGY				
S.No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	Expired ETO Item (Biopsy Gun) available in Ultrasound Room.	Ms. Nisha	6th Feb 2016	Expired ETO Item (Biopsy Gun) was removed from the ultrasound room.
2.	There are no proper records in the department for testing of lead aprons and the lead aprons which are discarded.	Mr. Subin	10th Feb 2016	The records for testing of lead aprons and the lead aprons which are discarded were maintained properly.

Table 4

OP Pharmacy				
S.No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
	Documented policies for department like procurement, storage, drug formulary are not available in the department.	Mr. Ishwinder	12th Feb 2016	Documented policies for department like procurement, storage, drug formulary are now available in the department.
	The pharmacists who are	Dr.	12th Feb	All the pharmacists

	not yet registered are dispensing medicines at night and signing the bills.	Vishavdeep	2016	are registered now who are dispensing medicines at night and signing the bills.
	Following discrepancies are observed in storage of High Alert Medication: List of the drugs is not available. High Alert are not colour coded in Refrigerator. Chemotherapeutic Medication are not storage as per high alert colour coding.	Mr. Ishwinder	12th Feb 2016	The discrepancies which were observed in storage of High Alert Medication were removed : a)List of the drugs is now available. b)High Alert are now colour coded in Refrigerator. C)Chemotherapeutic Medication are now stored as per high alert colour coding.
	The camera in OP Pharmacy faces only the cash counter but not towards medication storage. Measures need to be taken to prevent pilferage.	Dr. Vishavdeep	20th Feb 2016	New cameras have been installed which faces all the areas.

Table 5

IP Pharmacy				
S.No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
	Bulk Stock to be labelled.	Mr. Arjun	12th Feb 2016	Bulk Stock was labelled.
	Separate Red coloured bags for dispensing high alert medication are not been used.	Mr. Arjun	12th Feb 2016	Separate Red coloured bags for dispensing high alert medication are now being used.

Table 6

Emergency				
S.No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	Stretcher present in the ER is without locks. This can lead to fall of patient.	Mr. Sharvan	20th Feb 2016	Stretcher present in the ER without locks was discarded.
2.	Allergy Assessment for patient (150148822) was not done.	Ms. Sarita	12th Feb 2016	Allergy Assessment for patient (150148822) was done later.
3.	Expired ETO Items and Near Expiry medication was found in Refrigerator, Ambulance Bag and Code Blue Bag.	Ms. Sarita	12th Feb 2016	Expired ETO Items and Near Expiry medication was found in Refrigerator, Ambulance Bag and Code Blue Bag.
4.	Clinical Pathways for	Dr. Sumeet	20th Feb	Clinical Pathways

	various emergencies like Acute MI, GI Bleed and Trauma to be framed and displayed in ER.	Arya- to make pathways Ms. Dolly- to get printed.	2016	for various emergencies like Acute MI, GI Bleed and Trauma to be framed and displayed in ER.
5.	The nursing staff in ER is only BLS trained and that too the training was conducted 2 years back.	Ms. Girija	20th Feb 2016	The nursing staff in ER is ACLS certified by **AHI**
6.	Calibration and PM stickers were missing in suction machine in resuscitation room.	Mr. Sharvan	12th Feb 2016	Calibration and PM stickers were placed in suction machine in resuscitation room.
7.	Frequency for the checking of Disaster Cupboard needs to be defined.	Ms. Girija	12th Feb 2016	Frequency for the checking of Disaster Cupboard is maintained
8.	There is no record maintained for the Code Blue Bag to check the expiry of the medication.	Ms. Sarita	12th Feb 2016	Proper record is maintained for the Code Blue Bag to check the expiry of the medication.

Table 7

Ambulance				
S.No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
	Near Expiry medication found in the ambulance and medication was not removed from ambulance after arrival.	Ms. Sarita	12th Feb 2016	Near Expiry medication found in the ambulance and medication was removed from ambulance after arrival.
	There is no list of defined medication to be kept for outsourced ambulance. It is done on need base.	Dr. Sumeet Arya	12th Feb 2016	There is a defined list of medication which is kept for outsourced ambulance and is done on need base.
	There is no clarity to the department on the ownership of the outsourced ambulance. There were expired medication found in outsourced ambulance.	Dr. Vishavdeep	20thFeb 2016	The ownership is with the vendor but emergency staff of the hospital checks it on regular basis.

Table 8

Day Care				
S.No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
	The list of procedures done in the observation room needs to be defined and displayed.	Dr. Sumeet Arya- in discussion with Dr. Rishi Dhawan	12th Feb 2016	The list of procedures done in the observation room were defined and displayed.
	High Alert Medication was not stored properly in refrigerator but correct during the audit today.	Ms. Pooja		High Alert Medication is now stored properly in refrigerator.

Table 9

Nuclear Medicine				
S.No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
	Reporting time for Routine or Emergency studies need to be defined in the department.	Mr. Santosh	15th Feb 2016	Reporting time for Routine or Emergency studies is now defined in the department.
	Nuclear Medicine manual needs to be updated.	Mr. Santosh- to provide relevant documents to finalize	15th Feb 2016	Nuclear Medicine manual is updated now.
	The humidifiers in department are filled with water since a week. This is a source of	Ms. Mukti	15th Feb 2016	The humidifiers in department were cleared which were filled with water

	infection if used.			since a week.
	There are discarded lead aprons lying in the department which needs to be condemned.	Mr. Sharvan	20th Feb 2016	There are discarded lead aprons lying in the department which will be discarded according to the protocol and their date is due, so will be discarded soon.

Table 10

F & B				
S.No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	Records of surveillance cultures to be available in the department.	Mr. Bishan	15th Feb 2016	Records of surveillance cultures are now available in the department.

Table 11

Dietetics				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
	Departmental Manual needs to be updated.	Ms. Shivani Gulati	20th Feb 2016	Departmental Manual is up to date
	Counselling register to be maintained with patient's / relative's signature for records.	Ms. Shivani Gulati	20th Feb 2016	Counselling register is now maintained with patient's / relative's signature for records.
	Patients are not being	Ms. Shivani	25th Feb	Patients are now

	counselled for any other food drug interaction except for with Vitamin K. The list for food drug interactions need to be defined for the organization and patients to be counselled for the same along with patient education pamphlets.	Gulati	2016	being counselled for other food drug interaction along with Vitamin K. The list for food drug interactions is now defined for the organization and patients are counselled for the same along with patient education pamphlets.

Table 12

Labour Room				
S.No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	Initial Medical Assessment of patients in Labour Room was not done. JRs/ SRs to complete within 1 hr.	Dr. Manpreet Sahi	20th Feb 2016	Initial Medical Assessment of patients in Labour Room was completed within the given time.
2.	Sharp container in Delivery Room was lying there since 27th Jan 2016.	Ms. Anita	15th Feb 2016	Sharp container in Delivery Room which were lying there since 27th Jan 2016 were removed.

Table 13

NICU and Nursery				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	Staff needs to be trained on NALS.	Ms. Girija	20th Feb 2016	Staff was trained on NALS
2.	Neonates are administered Midazolam for sedation. It needs to be discussed and decided whether the consent to be taken and monitoring to be done for neonates for the same.	Ms. Santosh- to discuss with Dr. Arpinder Gill	20th Feb 2016	Only non-Ventilated Neonates are administered Midazolam for sedation decided and the consent is taken and monitoring is done for neonates for the same.

Table 14

SICU-1				
S.No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	Nursing staff to be ACLS trained in ICU.	Ms. Girija	29th Feb 2016	Nursing staff is ACLS trained in ICU
2.	Plan of care by doctor is not appropriately mentioned in ICU.	Dr. Sunny Rupal	20th Feb 2016	Plan of care by doctor is now appropriately mentioned in ICU
3.	ICU Chart has a column to monitor and record Sedation Score but this is not recorded by staff.	Dr. Sunny- to brief the nursing staff regarding same.	20th Feb 2016	Sedation Score column is now being recorded and monitored in the ICU chart.

Table 15

Old SICU				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	Nursing staff to be ACLS trained in ICU.	Ms. Girija	29th Feb 2016	Nursing Staff is ACLS trained
2.	Narcotics register being used in the department is obsolete and not updated.	Ms. Manisha	20th Feb 2016	Narcotics register being used in the department is now up to date.
3.	There was no consent for Cranioplasy in patient 150093426.	Dr. Ashish Gupta	15th Feb 2016	Consent for Cranioplasy in patient 150093426 was taken.
4.	The consent for patient 150107483 was incomplete.	Dr. Nitin Yogesh	15th Feb 2016	The consent for patient 150107483 was completed.
5.	Staff needs to be trained on policies like Spill management, Nursing empowerment and restraint.	Ms. Manisha	20th Feb 2016	Staff is trained on policies like Spill management, Nursing empowerment and restraint.
6.	MSDS for Ravisol is not available.	Ms. Manisha	20th Feb 2016	MSDS for Ravisol is now available.

Table 16

OT				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	The consents of Anaesthesia, Surgery , HIV and High Risk Consent in cardiac surgery were not signed.	Dr. Virendar Sarwal	20th Feb 2016	The consents of Anaesthesia, Surgery , HIV and High Risk Consent in cardiac surgery were signed later.
2.	The sharp container in TSSU was overflowing and had a potential for sharp injury.	Mr. Sanjay Dhar- to brief housekeeping	20th Feb 2016	Briefing was done to housekeeping in regard to the sharp container in TSSU was overflowing which had a potential for sharp injury
3.	MSDS of various hazardous material used in OT Store was not available.	Ms. Kavita	20th Feb 2016	MSDS of various hazardous material used in OT Store is now available.
4.	There is no distinction in usable and discarded lead aprons in OT. It is possible that even discarded ones are being used.	Mr. D V Singh	20th Feb 2016	The distinction in usable and discarded lead aprons is now done in OT.
5.	Aldrete Scoring to be displayed in Pre/ Post Op Area.	Dr. Sunny Rupal	20th Feb 2016	Aldrete Scoring to is now displayed in Pre/ Post Op Area.

Table 17

MICU				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
6.	There were no ID bands tied to few patients for their identification.	Ms. Manpreet	20th Feb 2016	All the patients were tied with ID bands for their identification
7.	Nursing IP Assessment of patients transferred in to ICU from ward is not being done.	Ms. Manpreet	20th Feb 2016	Nursing IP Assessment of patients transferred in to ICU from ward is now being done.
8.	NITP not conducted for the TL of	Ms. Girija	29th Feb 2016	NITP was conducted for the TL of MICU
9.	Photocopy of reaction form is not present in patient's file where in details of blood transfusion are mentioned.	Ms. Manpreet	20th Feb 2016	Never used to do, has now brought into practice
10.	Events during CPR are not recorded in CPR form. This can be done only for those patients in whom cardiac arrest occurred because of an untoward event.	Dr. Deepak Bhasin/ Dr. Harpal	29th Feb 2016	Events during CPR are now being recorded in CPR form. This can be done only for those patients in whom cardiac arrest occurred because of an untoward event.
11.	Nurse was found recapping	Ms. Manpreet	20th Feb 2016	Briefing to the

	the needle.			nurse was done.
12.	Prognostication Score is not mentioned in all patient's records.	Dr. Deepak Bhasin/ Dr. Harpal	29th Feb 2016	Prognostication Score is not mentioned in all patient's records.
13.	All staff are not trained in ACLS.	Ms. Girija	29th Feb 2016	All staff are ACLS trained
14.	Consents in MICU are inappropriately filled wherein, the name of procedure/ name of person performing the procedure as well as patient specific risks are missing.	Dr. Deepak Bhasin/ Dr. Harpal	29th Feb 2016	Consents in MICU are now appropriately filled wherein, the name of procedure/ name of person performing the procedure as well as patient specific risks are mentioned.
15.	Pain Score monitoring is missing in few patients.	Ms. Manpreet	20th Feb 2016	Pain Score monitoring is now being done for all the patients.
16.	MSDS not available for Ravisol, acetone, Hydrogen peroxide.	Ms. Manpreet	29th Feb 2016	MSDS is available for Ravisol, acetone, Hydrogen peroxide.
17.	There is a drug coding followed in MICU for infusions. Since, this policy is specific to MICU, this needs to be displayed for staff awareness.	Dr. Deepak Bhasin/ Dr. Harpal	29th Feb 2016	The drug coding policy followed in MICU for infusions was displayed for staff awareness.

Table 18

ECOWARD				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	The nursing assessment for the patients transferred in the ward from ICU is not documented.	Ms. Lakhbir	25th Feb 2016	The nursing assessment for the patients transferred in the ward from ICU is properly documented.
2.	The general consent on face sheet of patient 150150583 was not signed.	Mr. Abhinav	25th Feb 2016	The general consent on face sheet of patient 150150583 was signed later.
3.	A standard format is copy pasted in Nursing Care Plan in ward which relates to Infection Control. This should address the need of specific individuals e.g. prevention of bed sores, prevention of DVT, etc.	Ms. Girija	25th Feb 2016	The nursing staff is guided properly and specific nursing care plan is made according to the specific patient.
4.	Look Alike drugs were not segregated properly. Also, Alprax was stored in the ward which is not allowed.	Ms. Lakhbir	25th Feb 2016	Look Alike drugs were segregated properly. It is stored when required, otherwise not.

5.	There are no blood transfusion notes or verification by doctor in case of transfusion. (150148323)	Dr. Manpreet Sahi	25th Feb 2016	Blood transfusion notes were added later.
6.	When and How to Obtain Urgent care is missing in discharge summary of 150150039.	Dr. Manpreet Sahi	25th Feb 2016	When and How to Obtain Urgent care was filled later in discharge summary of 150150039.
7.	MSDS for hydrogen peroxide is missing.	Ms. Lakhbir	25th Feb 2016	MSDS for hydrogen peroxide is there.

Table 19

Cath Lab				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	Surgical Hand Rub poster is missing on scrub station.	Ms. Taran	25th Feb 2016	Surgical Hand Rub poster is now there on scrub station.
2.	Staff to be made aware on Cath Lab and Radiation Safety Manual.	Mr. Sharan	25th Feb 2016	Staff is now made aware on Cath Lab and Radiation Safety Manual.

3.	Turn Around Time for reporting of CAG is not defined in Cath Lab.	Dr. Sudheer Saxena	25th Feb 2016	Turn Around Time for reporting of CAG is aleady defined in Cath Lab.
4.	There was a lot of discarded material as well as storage material lying in the control unit of Cath Lab. This needs to be sorted and stored properly.	Mr. Taruvar	25th Feb 2016	There was a lot of discarded material as well as storage material lying in the control unit of Cath Lab. This is now sorted and stored properly.

Table 20

CCU				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Target Action**
1.	There are no blood transfusion notes or verification by doctor in case of transfusion. Also, consent does not specify the product being transfused.	Dr. Manpreet Sahi	25th Feb 2016	**Pending**
2.	The consent for CAG was not signed for patient	Dr. Dheeraj	25th Feb 2016	The consent for CAG was

	150150423. Also, Nursing IP Assessment not documented in the same patient.	Ms. Anju		signed later for patient 150150423. Also, Nursing IP Assessment was documented in the same patient.
3.	The consent for IABP, Central Line, Intubation and HIV was not signed by the doctor and also was not filled appropriately as person performing the procedure was missing. (150150584)	Dr. Dheeraj	25th Feb 2016	The consent for IABP, Central Line, Intubation and HIV was signed by the doctor later and was filled as well.
4.	Doctors and Nurses in CCU to be trained in ACLS.	Dr. Manpreet Sahi/ Ms. Girija	25th Feb 2016	Doctors and Nurses in CCU are ACLS trained.
5.	MSDS was not available for Diethyl ether.	Ms. Anju	25th Feb 2016	MSDS is now available for Diethyl ether.

Table 21

BME				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Target Action**
1.	Audiometry test to be conducted annually for the employees working in manifold room as a part of occupational health hazard.	Mr. Sharvan	29th Feb 2016	Audiometry test has started conducting annually for the employees working in manifold room as a part of occupational health hazard.

Table 22

HR				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Target Action**
1.	X-Ray reports as a part of health check at the time of admission are not available in some files.	Ms. Mandeep	29th Feb 2016	X-Ray reports as a part of health check at the time of admission are available in all the files.
2.	Annual health check is not done for the staff who are 2 to 3 years old in the organization.	Ms. Lily	29th Feb 2016	Annual health check is being done now for the staffs who are 2 to 3 years

				old in the organization.
3.	Format for Health check at the time of admission needs to be updated as ECG and Montaux test is not done anymore.	Ms. Lily	29th Feb 2016	Format for Health check up is up-dated.

Table 23

OT 2ND FLOOR				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	Aldrete Score sheet to be filled for the patients while shifting them out of recovery area to ward.	Dr. Vaneet Nagpal	29th Feb 2016	This practice has been started.
2.	2 different types of PAC forms are used in OT.	Mr. Deepak	29th Feb 2016	Getting it changed and will be using one format (Deepak had a talk with Dr. Sunny)

Table 24

ENGINEERING				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	Rubber Mats need to be provided in front of Electric Panel in Chiller Room.	Mr. Chandehoke	29th Feb 2016	Rubber Mats are provided in front of Electric Panel in Chiller Room.
2.	A lot of unwanted material is kept for temporary purpose in Chiller Room which can be a fire safety issue.	Mr. Chandehoke	29th Feb 2016	A lot of unwanted material kept for temporary purpose in Chiller Room which can be a fire safety issue.
3.	Audiometry test as a part of occupational health hazard needs to be done for the workers in chiller room and STP as these workers do not use ear plugs while working in these areas.	Mr. Chandehoke- to coordinate with HR for health check	29th Feb 2016	Audiometry test as a part of occupational health hazard is being done for the workers in chiller room and ear plugs have been provided to the workers working in chiller area.

4.	Safety Instructions in various areas of Engineering dept needs to be translated in Punjabi and displayed as most of the workers do not understand English.	Mr. Chandehoke	29th Feb 2016	Safety Instructions were translated in Punjabi and were displaced in various areas of Engineering department
5.	Fire Equipment Room's door was not accessible as a lot of non functional beds and furniture was stored in front of it.	Mr. Kirti	29th Feb 2016	They are removed and the door is now accessible
6.	There is a box for emergency key fixed outside door leading to terrace on 4th Floor, but there is no key in the box. Absence of key doesn't serve the purpose of putting the box for emergency key.	Mr. Vinod	29th Feb 2016	He has kept the key now inside the box

Table 25

Physiotherapy				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	MoU with Max Hospital should be available in department with the In charge.	Dr. Preeti	29th Feb 2016	MoU with Max Hospital is now be available in department with the In charge.
2.	The consent for physiotherapy procedures need to be signed by the patient and not relatives.	Dr. Preeti	29th Feb 2016	This Practice has been started
3.	Staff needs to be trained on BLS.	Dr. Preeti- to get in touch with Dr. Manpreet Sahi for training along with doctors.	29th Feb 2016	Staff is BLS trained

3.6

Table 26

MRD				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	TAT for retrieval of files from Warehouse needs to be defined in case of emergency and routine requirement.	Hema/ Shashikant	29th Feb 2016	TAT for retrieval of files from Warehouse is now defined in case of emergency and routine requirement.
2.	When to obtain urgent care in discharge summary is missing in most files audited in MRD.	Dr. Manpreet Sahi	29th Feb 2016	When to obtain urgent care in discharge summary is now there in all of the files which were audited in MRD.

Table 27

Blood Bank				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
1.	MSDS document needs to be updated for latest version.	Dr. Kuldeep Singh	1st Mar 2016	MSDS document was updated to the latest version.
2.	There is no signature by the blood bank staff in Request Receiving Register.	Dr. Kuldeep Singh	1st Mar 2016	The Request Receiving Register is duly signed by the blood bank staff
3.	Blood Bags (Consumables) kept in Cartons are stored in Blood Bank on floors. This should be avoided.	Dr. Kuldeep Singh	1st Mar 2016	Blood Bags are now being stored in the storage area of the blood bank.

Table 28

Housekeeping				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Action Taken**
	Housekeeping SOPs need to be updated.	Mr. Sumit	10th Mar 2016	Housekeeping SOPs are up to date
	Infected linen is being transported in Blue or Black bags as observed but it is yellow as per Max	Mr. Sumit/ Ms. Girija	5th Mar 2016	Briefing is done to the TLs and Mr.Kirti has briefed his staff

	Policy.			as well
	There are lots of caps, masks and gloves found in OT linen and then these are mixed and thrown in one bag in the segregation area in laundry. These are later segregated as told by staff. This is a wrong practice.	Mr. Sumit/ Ms. Girija/ Mr. D V Singh	5th Mar 2016	Briefing is done

Table 29

2nd Floor wards				
S. No.	**Observation Points**	**Responsibility**	**Target Date for Closure**	**Taken Action**
	Vulnerable patient sign was in black colour instead of green as per policy.	Ms. Gurinder	5th Mar 2016	Been replaced with green
	No signature by JRs in Ward medication Chart. (150146761, 150048988).	Dr. Manpreet Sahi	5th Mar 2016	Ward medication Chart was signed by JRs later (150146761, 150048988).
	The monitoring for restraint was not done for patient and also the nursing care plan did not mention anything about care of restraint patient. (150146761).	Ms. Gurinder	5th Mar 2016	The monitoring for restraint was done for patient and also the nursing care plan mentioned about care of restraint patient later(150146761).
	The generic informed consent for a surgery was incomplete as it did not	Dr. Manpreet Sahi	5th Mar 2016	The generic informed consent for a surgery was

	mention the name of the surgery, name of the surgeon, diagnosis, etc. (150084890)			completed and the name of the surgery, name of the surgeon, diagnosis, etc. Was mentioned later. (150084890)
	KTP Investigation sheet used in RICU is without max logo. Attached is the sheet provided to be used.	Dr. Jagdish Sethi/ Dr. Manpreet Sahi	5th Mar 2016	Max logo sheets are now being used for KTP investigation in RICU and the provided attached sheet is being used now.
	BCMA was not done bedside but after the patient was administered the medication.	Ms. Girija	5th Mar 2016	Briefing is done
	Nursing staff are not aware of Nursing Manual.	Ms. Girija	5th Mar 2016	They have been told and the briefing is done
	Discharge summaries (150152046, 150151202), used abbreviations such as BD and OD for patient's discharge medication.	Dr. Manpreet Sahi	5th Mar 2016	Instead of abbreviations BD and OD which were written in Discharge summaries was replaced with the full forms of the same.

The gaps observed during the general audit were informed to the concerned staff and dates for the closure of the same were given. Regular check was done for the above whether the points raised were being closed against the date of their closures or not.

1.4.2 Internal Assessment (Internal Audit)

Internal Audit was carried in the month of March (1st, 2nd and 3rd) by the team of three Assessors naming:

Dr. Uday Kapur , Dr. Shalini Chhiber and Dr. Natasha Bhasin from PAN Max.

Following are the areas audited during Internal Assessment along with the name of the auditor who audited that Area/Department:

Table 30

S. No.	Area/ Department	Auditor
1.	SICU	Dr. Uday Kapur
2.	CQI	Dr. Uday Kapur
3.	OT Complex	Dr. Uday Kapur
4.	CSSD	Dr. Uday Kapur
5.	IP Pharmacy	Dr. Uday Kapur
6.	Endoscopy and Bronchoscopy	Dr. Uday Kapur
7.	CTVS ICU	Dr. Uday Kapur
8.	Radiology and Imaging	Dr. Uday Kapur
9.	Facility round, Fire safety with Engineering ,BMW and Housekeeping	Dr. Uday Kapur
. 10.	Biomedical Gases storage and Equipment	Dr. Uday Kapur
. 11.	HRM	Dr. Uday Kapur
. 12.	Day Care Oncology	Dr. Shalini Chibber
. 13.	Non Invasive Cardiology	Dr. Shalini Chibber
. 14.	Kitchen/Dietetics/Canteen	Dr. Shalini Chibber
. 15.	Physiotherapy	Dr. Shalini Chibber
. 16.	CTVS HDU	Dr. Shalini Chibber
. 17.	OP Pharmacy	Dr. Shalini Chibber
. 18	Sample Collection	Dr. Shalini Chibber
. 19.	Mortuary	Dr. Shalini Chibber
. 20.	Wards 2nd floor MSP1, 3rd floor and ECO Ward	Dr. Shalini Chibber

. 21.	MICU	Dr. Shalini Chibber
. 22.	MRD	Dr. Shalini Chibber
. 23.	Emergency	Dr. Natasha Bhasin
. 24.	Ambulance	Dr. Natasha Bhasin
. 25.	Out Patient Department And Front Office	Dr. Natasha Bhasin
. 26.	Blood Bank	Dr. Natasha Bhasin
. 27.	Dental Department	Dr. Natasha Bhasin
. 28.	Nuclear Medicine	Dr. Natasha Bhasin
. 29.	Radiation Oncology	Dr. Natasha Bhasin
. 30.	Dialysis	Dr. Natasha Bhasin
31.	HDU	Dr. Natasha Bhasin
. 32.	CCU	Dr. Natasha Bhasin
. 33.	Labour Room	Dr. Natasha Bhasin
. 34.	Laundry	Dr. Natasha Bhasin

Following tables mention the gaps/observations observed during Internal Assessment along with the responsible person for their closures and the required actions taken for their closure:

Table 31

SICU				
S. No.	**Std & OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	PRE 4d	In some of the file, which was audited, it was found that patient was signing the Inform consent for procedures in Punjabi but the consent form used was English.	Ms. Dolly- for translation.	Most commonly used consents have been translated to Punjabi.
2.	MOM 9 a	Narcotic drug was getting administered to a patient but proper labeling with color-coding was not done as per HCO and guidelines.	Ms. Rajwinder/ Ms. Manisha	We have not defined any color coding for Narcotics. These need to be kept in double lock and key. Training for the same conducted.

Table 32

CQI				
S. No.	**Std & OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	CQI 2 a	There was no documented patient safety program.	Ms. Dolly	Patient safety program is now documented.

2.	CQI 6 a, b, d, e	HCO were not doing Clinical audits, which could show remedial measures and implementation on ground.	Ms. Dolly	Clinical audits in place and in process.

Table 33

OT complex				
S. No.	**Std & OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	FMS 8E	Some of the staff working in OT area were not able demonstrate how to handle spillage in OT store area.	Mr. Kirti	Training on spill management is conducted.
2.	FMS 8b	MSDS sheet were not displayed in the HCO uniformly where they were storing Hazardous material.	Mr. D V Singh	MSDS is now uniformly displayed in OT.
3.	HIC 2 j	Engineering control system was found lacking in OT complex 1 as the OT entrance doors in sterile zones were broken and not repaired even after the user logged the complaint. Similarly the OT pressure meters of OT 1, 2, 4, and OT 5 were not working properly which could lead to wrong reading, which can lead to infections.	Mr. Chandehoke	OT corridor entrance wooden door repaired. Also positive pressure has been corrected & log book provided for monitoring positive pressure in every shift.

Table 34

Endoscopy and Bronchoscopy				
S. No.	**Std & OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	COP 12a ,c	Procedure of administration of moderate sedation and who can give and who can monitor the sedation has to relook as nurse who was administrating sedation was not qualified as she was a GNA.	Ms. Girija/ Dr. Dilawari	The staff who administers and monitor sedation is qualified and trained, hence privileged to work in endoscopy dept.

Table 35

Radiology and Imaging				
S. No.	**Std & OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	AAC 11 e	Radiation safety devices were not periodically tested uniformly as many lead apron were not marked by the RSO and the procedure of how to test these devices were not know by the RSO interviewed.	Mr. Ansari	1. Lead markers frequently stick off. So no need to sick it on lead aprons for online review (onsite review). Only identification number has been put with permanent maker. 2. The radiation

				safety devices and monitoring devices have been checked & calliberated periodically and CDs of lead aprons Scans are available with RSO. 3. Three faulty lead aprons have been discarded on the basis of scan checkup and already submitted to Biomedical deptt.

Table 36

Facility round, Fire safety with Engineering, BMW and Housekeeping				
S. No.	**Std & OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	PRE 2b	There was no signage of CCTV inside the lift which leads to breech in patient and family privacy	Mr. Vinod	Signage order had been placed – by 28.03.16 it will be placed. Meanwhile A4 signage has been placed .
2.	FMS 5b	Storage of medical gases	Mr. Vinod	All parked vehicle

		was not found to be safe and secure as the Liquid oxygen area was parked with vehicles near it.		had been removed and entrance is being barricaded.
3.	FMS 8b	MSDS sheet were not displayed in the STP area where they were storing hazardous material	Mr. Chandehoke	MSDS is displayed on board in STP area.
4.	HRM 7 a, b	Health checkups of the out sourced workers working in areas like HK, BMW, STP were not done in consonance with law of the land like the blood test was done the report of the same was not evident the record, certificate showed worker is not having communicable disease but no X-ray was done for the same, Worker working in STP area where the sound levels were very high and no audiometry test was done etc.	Mr. Chandehoke/ Mr. Kirti	Health checkup / Audiometry test will be conducted on 27.03.16 (for engineering outsourcing staff also max staff). None of the staff from HK Dept is permanently deployed in the STP area. Whenever the staff goes to perform the service, he wears ear plugs.
5.	FMS 8 e	Staff working in the DG set area was not aware of diesel/oil spill protocol for management of the same.	Mr. Chandehoke	MSDS attached near DG area also sand spill kit provided.

Table 37

Biomedical Gases storage and Equipment				
S. No.	**Std & OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1`.	FMS 8 a, b	Mobi oil was stored in near the vacuum pump with no std. precaution and no display of MSDS sheet.	Mr. Sharvan	Storage space is changed and MSDS is now available.

Table 38

HRM				
S. No.	**Std & OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	HRM 7d	There was no documentary evidence to show that the occupational health hazards are addressed as part of health care needs of the staff.	Ms. Lily	Policy on Occupational health hazard is framed and available for all staff in Medical Policy Folder.

Table 39

Day Care Oncology				
S. No.	**Std & OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	PRE 4 e	In file no. SSN 142431 the consent for Chemotherapy was found to be given by the mother and not by the patient, even though the patient was fully conscious and in sound mind.	Dr. Sachin Gupta	Doctors in Oncology dept briefed about getting the consent signed by patient only if conscious.
2.	MOM 10 b	Chemotherapeutic drugs	Ms. Harpreet	The drugs

		kept in refrigerator in Oncology day care was not highlighted as high alert through color-coding.		have been marker orange.

Table 40

Non Invasive Cardiology				
S. No.	**Std & OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	AAC 9 g	Critical test reporting of imaging like ECG, TMT and Echocardiography though being done but documentation of the same could not be evident.	Ms. Deepshikha	A register has been maintained for the critical test reporting in Non Invasive cardiology dept.

Table 41

Kitchen/ Dietetics/ Canteen				
S. No.	**Std & OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	HIC 5d	The staffs were not found to be immunized as per NABH policy. Typhoid vaccination etc. found lacking	Mr. Bishan	All new joiners have vaccinated against the Typhoid on 22nd March 2016. Record was kept with ICN and F&B both.
2.	COP19f	Food kept in the	Mr. Bishan	All Food Items

		Refrigerator though was dated but the preparation time was not mentioned.		kept in Refrigerator are now with Date and preparation time.

Table 42

Physiotherapy				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	COP 17 c	Though the Physiotherapists are interacting and discussing the care provided by them to the concerned consultant but the documentation of the same is not evidenced uniformly.	Dr. Preeti	Physiotherapists are now documenting the interaction and discussion with the concerned consultant.

Table 43

CTVS HDU				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	CQI 2 j	The food was being served to one patient with the bed no. and not by the Name and ID number of the patient.	Mr. Bishan	Food is served to all Patient with the Bed No., Patient's Name, SSN and IP NO
2.	COP 7 d PRE 4 d	In Blood Transfusion Consent form risk of allergy and other risk whether been explained to	Dr. Virendar Sarwal	The Blood Transfusion Consent mentions risk

		the patients could not be ascertained.		of allergy.
3.	COP 4 b	Staff in CTVS ICU is not ACLS trained.	Ms. Girija	ACLS on job Training conducted by Dr. Goswami.

Table 44

OP Pharmacy				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	MOM 8	Staff was unaware about near miss, medication error, adverse event and incident reporting.	Ms. Anamika	Trainings conducted for the staff.
2.	MOM 5 b	Staff totally unaware about recall policy.	Ms. Anamika	Trainings conducted for the staff.

Table 45

Sample Collection				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	HIC 2 c	Hand Washing poster was not displayed in the hand washing area.	Ms. Taran	Hand hygiene posters have been provided to sample collection room.
2.	HIC 5 b	Inadequate provision for washing hands (soap was not present in the dispenser).	Mr. Kirti	Soap was provided in the dispenser and checked

				regularly.
3.	HIC 2 d	The staff was observed recapping the needle after withdrawing sample of the patient.	Dr. Anjali	Vacutainer have lock which when pressed needle goes in , so no recapping . In case needle is used , all have been again told not to recap needle .Injury while recapping is taught to all .

Table 46

Wards 2nd floor 3rd floor and ECO Ward				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	AAC 12 d	Written hand over's in shift change needs to be strengthened of nurses and doctors.	Ms. Girija/ Dr. Manpreet Sahi	Written handovers during shift change are documented appropriately by nurses and doctors.
2.	MOM 4 i	RMO's were not aware of verbal order policy. Training on the same	Dr. Manpreet Sahi	Training conducted for RMOs on

		needs to be strengthened.		verbal order policy.
3.	FMS 2 c	Fire exit signage in 2nd floor MSP1 is directing towards OT complex area and needs more specificity.	Mr. Chandehoke	Fire Signage for correct directions fixed.
4.	AAC 14 f	In patients file SSN 150000402 in the discharge summary when to obtain and how to obtain urgent care was not mentioned.	Dr. Manpreet Sahi	When and how to obtain urgent care is now mentioned in all discharge summaries.

Table 47

MRD				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	PRE 4 d	In one of the death files informed consent form for a CABG surgery was in English language but the patient has signed in Punjabi There was no evidence of Interpreter signature also in the file.	Ms. Dolly- for translation	CABG consent is translated in Punjabi.

Table 48

Emergency				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	COP5d	Nursing care plan was not aligned and integrated with the overall patient care. Eg: Patient 88 yrs/male visited ER with the c/o hypoglycaemia wherein care plan documented was for infection prevention.	Ms. Sarita	Nursing care plan is now aligned with the overall patient care.
2.	MOM 3c	Sound inventory control practices that guide the storage of medications was found lacking in resuscitation room in ER – Alphabetical storage found lacking.	Ms. Sarita	Medication now stored in alphabetic order.
3.	COP2b	MLC report was not sent to the police uniformly as per the policy.	Mr. Vinod	As a process every MLC had been reported to concerned police station but during out stationed MLCs (HP, HR etc) telephonic intimation is given & in some cases

				keeping distance in mind Police personnel dont turn up and take information on phone. In this case, name of the police and phone no. Is mentioned on MLC form.

Table 49

Ambulance				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	COP3g	Emergency medications were not been checked prior to dispatch.	Dr. Sumeet/ Ms. Sarita	Emergency medications are now checked prior to dispatch. A checklist is designed for the same.
2.	COP3e, FMS2k	The headlight of BLS ambulance was not working for about 7 – 10 days wherein complaint was verbally been informed to the concerned	Mr. Vinod	To keep a trace on Ambulance, R & M register has been started.

		personnel. Response times of complaints also cannot be captured.		
3.	MOM 3c	Drug Consumption record was not evident in cases where the administration took place during resuscitation in ACLS ambulance.	Dr. Sumeet / Ms. Girija	Registers have now been maintained and regular checking of stock is done every time the ambulance is back.

Table 50

Out Patient Department And Front Office				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	AAC 4a	The content of initial assessment for the outpatients was not been defined and documented by the HCO uniformly. Eg: SSN 134729	Mr. Abhinav- to provide templates.	The template is uniformly available in Hospital and used by the consultants in OPD.
2.	MOM 4c, MOM 4g	The medications orders were not written in Capital letters in OPD Prescription and do not legibly state the Name and signature of the prescribing doctor uniformly.	Ms. Anamika	Communication is being circulated to consultants on regular basis.

3.	COP 11b	Display of the scope of pediatric services provided by the HCO was not evident.	Mr. Vishal	English and Punjabi Pediatric Scope of services are displayed in OPD
4.	COP 9e	Training on policy for vulnerable patient requires strengthening. E.g.: EMP C-1083, 531 and 273.	Mr. Kirti	Trainings conducted for outsourced staff.

Table 51

Blood Bank				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	PRE 4a. PRE 5f,	The HCO does not have HIV counselor in the facility. The blood bank staff (EMP ID C 88) has undergone training on the same but could not suffice the requirement fully. Counseling of HIV patients to be looked into.	Dr. Kuldeep	Completed
2.	COP 7f	The concerned staff was not aware about the policy for issuance of blood and its components. Eg: EMP ID C 51.	Dr. Kuldeep	Trainings conducted and documented.
3.	CQI 3f	The computation of TAT for issue of blood and its components does not include the time the	Dr. Kuldeep	The time the component reaching the clinical unit is

		component reaching the clinical unit.		being monitored now.

Table 52

Dental Department				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	PRE 4d	The consent forms being used for various dental related procedures were not bilingual.	Dr. Gaurav- to share consents for translation	Generic Dental Treatment consent has been translated in Punjabi.
2.	ROM 2a	The HCO does not have a requisite license to store the spirit wherein 5ltrs bottle for the same is being available in the department.	Dr. Gaurav	The spirit is removed from the dept.

Table 53

Nuclear Medicine				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	CQI 1f	Though the departmental SOP is available but was not stating adequate document control.	Mr. Santosh	Document control is provided in the manual.
2.	AAC 10a	The Quality Assurance program was not available.	Mr. Santosh	QA program is now available.

3.	COP 6d	The concerned doctor was on leave till 06.03.2016 wherein the DTPA scan was conducted by the RSO and the consent for the same as taken by him.	Dr. Pattanayak	The consent is taken by the Consultants in charge only. In his absence, the consent is taken by the primary consultant recommending the scan.

Table 54

Radiation Oncology				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	AAC 11c, FMS 8b	Though the hazmat material was stored under lock and key but the display of MSDS sheets for the same not evident.	Sr. Neelam	MSDS have been now displayed.
2.	MOM 4h	The Medication orders in discharge summary include abbreviations like OD, BD etc. E.g.: SSN 150146772.	Dr. Pankaj Kumar	The medication orders are corrected as per approved guidelines.

Table 55

Dialysis				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	PRE 4g	The informed consent is not taken uniformly (only once in a month)	Point not acceptable as already mentioned on consent and manual.	The consent is attached which is used.
2.	HIC 3a	Surveillance mechanism requires strengthening i.e. the schedule to be prepared such that at least all machines undergo surveillance once in a quarter.	Ms. Taran	Surveillance culture documentation has been maintained to cover all the machines and culture are send labelled with machine no.
3.	CQI 2j, COP 9b	None of the patients in dialysis were identified via placement of ID bands.	Sr. Anjana	ID bands are now tied to all the patients coming for dialysis.
4.	COP 9e, MOM 5f, CQI 2j	Training on High risk medications, vulnerable patients, patient identification found lacking. Eg: EMP ID – 1206.	Ms. Dolly	On job and classroom trainings conducted for all staff.

Table 56

HDU				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	COP 9b	Vulnerable patient policy as defined by HCO was not followed uniformly ie marking of patient file with "V".	Ms. Girija	Vulnerable patients are being marker V on face sheet.

Table 57

CCU				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
2.	MOM 4i	Although the concerned nursing staff available on duty was aware about when to follow verbal policy, but still for the administration of insulin verbal orders were followed and the same was not been documented by the prescribing doctor.	Dr. Dheeraj/ Ms. Anju	The training was conducted on verbal order policy.
3.	HIC 3g	The feedback regarding HAI rates prevailing in the CCU was not provided to the appropriate personnel. The doctor on duty was not aware about the same. EMP ID C-1166	Ms. Taran	As Discussed in HICC , HIC data is shared with ICU In charges and all heads of the department on monthly basis

				and monthly quality indicators sheet shared with all departments on monthly basis.

Table 58

Labour Room				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	MOM 3b	The medications were stored in the refrigerator showing temp of about 18.9 degree C. The thermometer is calibrated and stands valid till 8/01/2017.	Ms. Anita	The temperature is maintained now.

Table 59

Laundry				
S. No.	**Std& OE**	**Observation**	**Responsibility for Closure**	**Action Taken**
1.	HIC5d, HRM 7d	The concerned staff working was not Hepatitis B vaccinated as he had got Needle stick injury while segregating linen.	Ms. Taran	GDA Staff is undergoing vaccination. 2 doses of Hep B have been given on 30/12/2015 and 3/2/2016 and last dose is due in the month of June 2016.

1.4.3 Actions

- The hospital leadership may please ensure that all deficiencies are addressed on priority.
- The VP Operations, MS, Quality Manager and departmental Heads to ensure that they are familiar with the NABH & Max Medical Quality standards and these are thoroughly implemented.
- The deficiencies are listed department wise along with the corresponding NABH standards. There are common training and implementation issues that may not have 53been mentioned to avoid duplication, but these should also be addressed.
- The Quality Manager will work closely with all the departments to ensure they are provided with guidance and support, including training as required.

1.4.4 Outcome of Detailed Gap Analysis

- A detailed assessment of the facility on all elements that are otherwise also very crucial for patient care and safety
- Legal non-compliance awakening
- Safe building plans
- Guidance for optimizing manpower and equipment
- Process gap identification leading to motivation for change
- Road map for quality programme & accreditation

1.5 Discussion

1.5.1 Findings

The findings are based on sampling, and involved patient and staff interviews, observation of facilities, equipment, infrastructure and review of documents and records. These are:

1. The Compliances, partial compliances and non-compliances were recorded as per the given standards.
2. The major non-compliance as observed was due to lack of documented procedures and policies.
3. A major gap regarding training and orientation of the staff was observed.
4. Medication stock was not updated and stored as per the SOP’s in few areas.
5. Display of essential posters like MSDS were lacking in some areas in the hospital.
6. Appropriate signage was missing at some places such as display of tariff, OPD timings, etc.
7. Some machines were found un-calibrated.

8. Improper sterilization practices were observed as expired ETO stock was found at some places.
9. Consents were not being taken appropriately.
10. Pain score was not being measured in some wards.
11. Infection Control practices were not as per the SOP's. For example there was no mechanism for surveillance (observed in Dialysis Department)
12. Markings for vulnerable patient were missing.
13. The Abbreviations which were not allowed were being used.
14. There were gaps in the security system like absence of cameras in the pharmacy area.

1.6 Conclusion

1.6.1 Suggestions

1. ACLS and BLS training should be given to all the staff.
2. Medication stock should be evaluated in every shift by the nursing team leader.
3. Essential Posters (like MSDS) should be placed at appropriate places.
4. Appropriate signage should be displayed.
5. Doctors need to be sensitized regarding complete filling of informed consents.
6. Nursing needs to be trained for mandatory pain assessment.
7. Trainings to be enhanced for nursing for management of vulnerable patients including marking on files.
8. Allowed list of abbreviations need to be displayed in the doctors OPS's.
9. Documentation of surveillance mechanism needs to be strengthened.
10. Special training sessions should be conducted for doctors and nurses regarding the importance of complete and effective documentation.

2 AUDIT OF DOCUMENTATION OF MEDICAL RECORD

2.1 Introduction

2.1.1 Background of the study

Quality health care is based on accurate and complete clinical documentation in the medical record. The best way to improve your clinical documentation and the livelihood of your health care organization is through medical record audits. They are necessary to determine areas that require improvements and corrections.

The goals of an audit are to provide efficient and better delivery of care and to improve the financial health of your medical provider. Medical record audits specifically target and evaluate procedural and diagnosis code selection as determined by physician documentation. Once areas of weakness are revealed through an audit, you can present the audit findings and identify opportunities for training in your health care organization.

2.1.2 Aim

Aims of this project are:

1. To assess whether the existing documentation procedure is in accordance with the SOP established by the hospital.
2. To identify the lacunae in the same and to propose some possible solutions.

2.1.3 Objectives

1. To assess whether the documentation is being done as per the SOPs of the hospital.
2. To recommend effective solution wherever required.

2.2 Literature Review

2.2.1 Definition

"Quality is degree to which set of inherent characteristic fulfills requirements". The standards define requirements as need or expectation.

2.2.2 Description

Quality of a product or service refers to the perception of the degree to which the product or service meets the Medical record is a systematic documentation of a patient's personal and social data, history of his/her ailment, clinical findings, investigations, diagnosis treatment given, and an account of follow-up and final

outcome. The quality of a patient record depends largely on the individuals making record entries. All healthcare practitioners and others who enter patient information into patient records must understand the importance of creating complete and accurate records, as well as the legal and medical implications of failing to do so.

A medical record enables healthcare professionals to plan and evaluate a patient's treatment and ensures continuity of care among multiple providers. The quality of care a patient receives depends directly on the accuracy and legibility of the information the medical record contains.

2.3 Methodology

2.3.1 Research questions

This project was conducted to obtain answers of the following questions-

1) Is the existing documentation procedure in accordance with the SOP established by the hospital?
2) What are the lacunae in the existing documentation procedure?

2.3.2 Study design

Study design selected for this project keeping the aims and objectives of the project in mind is as following

- **Type of study**: It is a descriptive, cross-sectional and prospective study.
- **Location of Study:** The project was conducted in Max Super Speciality Hospital, Mohali

2.3.3 Sample size

206 files of in-patients from the period of 11th April to 20th April

We have also described certain parameters during our audit that was preplanned and structured.

List of variables used:

1. Face sheet
2. Admission Request
3. Referral Consultant
4. Initial assessment/ Initial history and IP Record

5. Doctor's Progress Notes
6. Informed consent/High risk consent form
7. List of preoperative investigations
8. Blood transfusion Notes
9. Anesthesia Record
10. Pre-Operative Notes/Operative notes/Post-Operative Notes
11. Medication order sheet
12. Vulnerable patient
13. VTE assessment

2.3.4 Types of Data & Collection Methods

- **Time frame for data collection –** The data was collected from 11st April to 20th April 2016
- **Type of data –** Both Quantitative & Qualitative type of data was collected
- **Methods of data collection –** An Audit tool with a structured checklist was developed keeping few of the quality indicators as the benchmark.

2.3.5 Instruments and Tool Used

Data collection – The type of data collected was primary and the source was the files of the in-patients in various departments of the hospital and CPRS system of the hospital. The techniques applied were Survey and Observation.

2.3.6 Data analysis

Data collected was entered in the excel sheet and following were the results shown:

PHYSICIAN DOCUMENTS		**COMPLIANCE**	**EXCLUDED**	**PERCENTAGE**
Face sheet	Signature of SR/Treating Consultant	**180/206**	0 NA	**87.3**
	Provisional diagnosis	**175/206**	0 NA	**84.9**
				86.1
Admission	Provisional diagnosis	**187/206**	0 NA	**90.7**

Request				
	Name of physician	**180/206**	0 NA	**87.3**
	Signature of physician	**172/206**	0 NA	**83.4**
	Procedure /Reason for admission	**187/206**	0 NA	**90.7**
	Proposed Date of admission	**179/206**	0 NA	**86.8**
				87.78
Refferal Consultant	Name of consultant	**135/157**	49 NA	**85.9**
	Sign of consultant	**139/157**	50 NA	**88.5**
	Date/Time	**120/156**	50 NA	**76.9**
				83.766667
Initial assessment / Inpatient history and IP Record	Signature of source of history	**205/206**	0 NA	**99.5**
	Date/Time	**205/206**	0 NA	**99.5**
	Counter sign/Consultant signature and date /Time	**176/206**	0 NA	**85.4**
				94.8
Doctor's Progress Notes	Date/Time	**200/202**	4 NA	**99**
	Name of SR/Consultant	**200/203**	3 NA	**98.5**
	Counter signature of Consultant for SR Notes	**174/203**	3 NA	**67.9**
				88.466667

Informed consent/High risk consent form	Patient detail	**180/189**	17 NA	**95.2**
	Diagnosis	**167/188**	18 NA	**88.8**
	Name of Procedure/Surgery	**166/188**	18 NA	**88.2**
	Patient Sign	**182/188**	18 NA	**96.8**
	Witness Sign	**179/188**	18 NA	**95.2**
	Signature of Doctor	**170/188**	18 NA	**90.4**
	Name of Doctor	**169/188**	18 NA	**89.89**
	Date	**173/188**	18 NA	**92.02**
	Time	**99/188**	18 NA	**52.6**
				87.678889
List of preop investigations	Date/ on Time	**121/130**	76 NA	**93.07**
Blood transfusion Notes	doctor's Notes date/time	**50/50**	156 NA	**100**
	nurse Notes date/time	**50/51**	157 NA	**98.03**
				99.015
Anaesthesia Record	PAC	**108/110**	96 NA	**98.1**
	Intraop monitoring	**95/110**	97 NA	**86.3**
	Post anaesthesia care	**92/110**	98 NA	**83.6**
	Date/Time	**91/110**	99 NA	**82.7**
				87.675

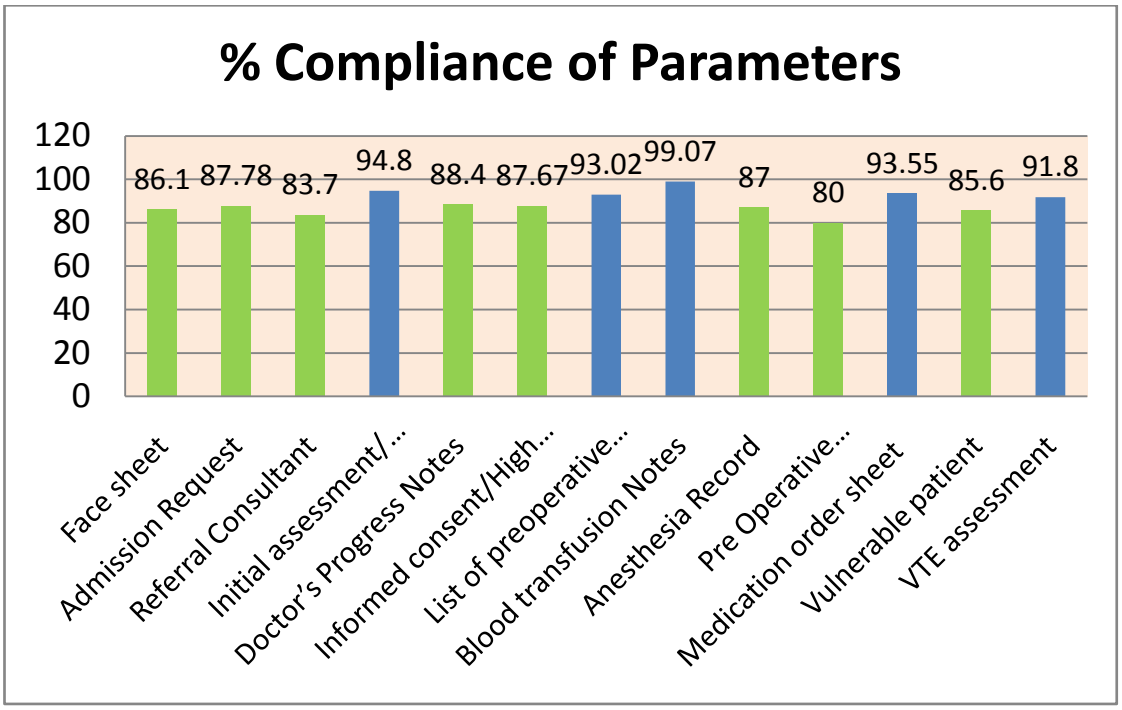
Pre Operative Notes	Date/ Time/ Notes	**88/110**	100 NA	**80**
Operative Notes	Date/ Time/ Notes	**88/110**	100 NA	**80**
	Name of surgeon	**88/110**	100 NA	**80**
	Sign of surgeon	**87/110**	100 NA	**80**
	Date/Time	**88/110**	100 NA	**80**

Post Operative Notes	Date/ Time/ Notes	**88/110**	100 NA	**80**
				80
Medication order sheet	Date	**200/204**	2 NA	**98.3**
	Time	**194/204**	2 NA	**95.9**
	Route	**201/204**	2 NA	**98.5**
	Frequency	**202/204**	2 NA	**99.01**
	Dosage	**201/204**	2 NA	**99.5**
	Signature of SR	**189/204**	2 NA	**92.6**
	Name of SR	**147/204**	2 NA	**71.04**
				93.55
Vulnerable patient	Marking (if applicable)	**131/153**	53 NA	**85.6**
VTE Assessment	Information filled	**171/183**	23 NA	**93.4**
After 48 hours of admission	Name of Dr	**171/183**	23 NA	**93.4**
	Signature	**171/183**	23 NA	**93.4**
	Date	**171/183**	23 NA	**93.4**
				91.84

2.4 Result

2.4.1 Graphical representation of the results

Figure 2.1 Graphical representation of the results



2.5 Discussion

Observations:

- More than 90% compliance was observed in following five Parameters:

1. List of pre-operative investigations.(93.07%)
2. Blood transfusion notes(99.01%)
3. VTE Assessment(91.84%)
4. Medication sheet(93.55%)
5. Details of Initial assessment(94.8%)

- Least compliance was observed in the following parameters(less than 90%)

1. Details regarding Referral consults (83.7%)
2. Pre-operative, Operative, Post-operative Notes(80%)
3. Details of Face sheet(86.1%)
4. Details of Admission request(87.78%)
5. Doctor's progress notes(88.4%)
6. Informed consent(87.6%)
7. Anaesthesia record(87.6%)
8. Markings for Vulnerable patients(85.6%)

2.6 Conclusion

2.6.1 Corrective Actions Taken

1. The compliance rate was discussed with the concerned consultants in MRD committee meet.
2. It was emphasised that date and time should be mentioned by the signing consultant.
3. The results of the audit were shared with the concerned stakeholders to sensitize them.
4. In some files where the date/time/notes were found missing, concerned were asked to fill there and then only.
5. As major non-compliance was observed in entering time for various parameters, this parameter was involved in various nursing training programmes.
6. Physicians were asked to positively mention the proposed date for admission in admission request form.
7. Consultants were sensitized for counter signing for SR's notes within the required time frame.
8. Nursing Team Leaders of various departments were instructed to check for vulnerable patient marking (V Stamp).

2.6.2 Preventive Actions Taken

1. CME programme was conducted titled relevance importance of documentation w.r.t. Medico-legal cases. Moreover topics related to complete filling of medical consent forms were also discussed.
2. It was suggested and decided in MRD Committee Meeting that open file audit shall be conducted regularly once in 3 months.
3. Regular sharing of audit results in the concerned committee meetings, shall be done.

Appendix A: Audit checklist

Area :											
Audit date:											
SSN											
Date of admission											
Admiting clinician											
PHYSICIAN DOCUMENTS											
Face sheet	Signature of SR/Treating Consultant		□		□	□	□	□	□	□	
	Provisional diagnosis	□	□	□	□	□	□	□	□	□	□
Admission Request	Provisional diagnosis	□	□	□	□	□	□	□	□	□	□
	Name of physician	□	□	□	□	□	□	□	□	□	□
	Signature of physician		□		□	□	□	□	□	□	
	Procedure /Reason for admission	□	□	□	□	□	□	□	□	□	□
	Proposed Date of admission	□	□	□	□	□	□	□	□	□	□
Refferal Consultant	Name of consultant										
	Sign of consultant										
	Date/Time										
Initial assessment / Inpatient history and IP Record	Signature of source of history										
	Date/Time	□	□	□	□	□	□	□	□	□	□
	counter sign/Consultant signature and date /Time		□	□	□	□	□	□	□	□	□
Doctor's Progress Notes	Date/Time		□								
	Name of SR/Consultant	□	□	□	□	□	□	□	□	□	□
	Counter signature of										

	Consultant for SR notes										
Informed consent/High risk consent form	Patient detail	□	□	□	□	□	□	□	□	□	□
	Diagnosis	□	□	□	□	□	□	□	□	□	□
	Name of Procedure/Surgery	□	□	□	□	□	□	□	□	□	□
	Patient Sign	□	□	□	□	□	□	□	□	□	□
	Witness Sign	□	□	□	□	□	□	□	□	□	□
	Signature of Doctor	□	□	□	□	□	□	□	□	□	□
	Name of Doctor										
	Date		□		□	□	□	□	□	□	□
	Time	□	□								□
List of preop investigations	Date/ on Time										
Blood transfusion Notes	doctor's notes date/time										
	nurse notes date/time										
Anaesthesia Record	PAC										
	Intraop monitoring										
	Post anaesthesia care										
	Date/Time										
Pre Operative Notes	Date/ Time/ Notes										
Operative notes	Date/ Time/ Notes										
	Name of surgeon										
	Sign of surgeon										
	Date/Time										
Post Operative Notes	Date/ Time/ Notes										
Medication order sheet	Date										
	Time										
	Route	□	□	□	□	□	□	□	□	□	□

	Frequency	□	□	□	□	□	□	□	□	□	□
	Dosage	□	□	□	□	□	□	□	□	□	□
	Signature of SR										
	Name of SR	□	□	□	□	□	□	□	□	□	□
Vulnerable patient	Marking (if applicable)	□	□	□	□	□	□	□	□	□	□
VTE Assessment	Information filled	□	□	□	□	□	□	□	□	□	□
After 48 hours of admission	Name of Dr										
	Signature										
	Date										

Bibliography

References

1. NABH 3rd edition book for hospitals, Jaypee Brothers.
2. B.M.Sakharkar Principles of Hospital Administration and Planning, Jaypee Brothers Medical Publishers (P) Ltd., New Delhi. 1999 Edition.
3. C.M.Francis, Mario C de Souza Hospital Administration, Jaypee Brothers Medical Publishers (P) Ltd., New Delhi. 2000 Edition.
4. C.R.Kothari, Research Methodology Methods and Techniques.
5. Chandra Ballabh, Healthcare Services in Hospital, Alfa Publications, First Edition.
6.. Dr.A.G.Chandorkar, Hospital Administration and Planning, Paras Medical Publisher, Hyderabad. 2004 Edition.
7. Dubin, R, (1958) The World Of Work: Industrial Society and Human Relations, Prentice – Hall, Englewood Cliff, NJ - p 213.
8. Effective Hospital Management, Pragna Pai, The National Book Depot, Mumbai. 2002 Edition.
9. Express Healthcare, Author Sonal Shukla..
10.*"Personal Health Records" (PDF). CMS. April 2011*
11."American Health Information Management Association". Ahima.org. 2012-03-22. Retrieved 2012-04-14.
12. "Health Information Privacy". Hhs.gov. Retrieved 2012-04-14
13.Judson, Karen, B.S.; Harrison, Carlene, Ed.D., C.M.A. (2010). "Chapter 6: Medical Records and Informed Consent". Law & Ethics for Medical Careers (5th ed.). New York: McGraw-Hill Higher Education.
14. Privacy Rights Clearinghouse - Medical Privacy Information
15. Privacy Rights Clearinghouse's Chronology of Data Security Breaches
16. Health and Human Services HIPAA Privacy Rule for health information.

JOURNALS:

1. Abdellah, F. G. & Levine, E. (1957). Developing a measure of patient and personnel satisfaction with nursing care. Nursing Research, 5(3), 100-8.
2. Abrahamsen, B. (2010). Deltidsarbeid på retur? En sammenlikning av tre kull sykepleiere utdannet i 1977, 1992 og 2003 (Part-time work on return? A comparison of three classes of RNs graduated in 1977, 1992 and 2003).Søkelys på Arbeidslivet, 27 (1-2), 5-18 (in Norwegian).
3. Abramowitz, S., Cote, A. A. & Berry, E. (1987). Analyzing patient satisfaction: A multianalytic approach. Quality Review Bulletin, 13(4), 122-130.

4. Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. Journal of American Medical Association, 288(16), 1987-1993.

5. Akoijam B S, Konjengbam K, Biswalatha R and Singh T A (2007), "Patient's Satisfaction with Hospital Care in a Referral Institutes in Manipal", Indian Journal of Public Health, Vol. 51, No. 4.

6. Alice Hall, (2012), "Health Promotion", British Journal of Midwifery, 156.

7. Altman, D. G. (1999). Practical statistics for medical research. London: Chapman & Hall/CRC.

8. Andrabi Syed Arshad, Hamid Shamila, Rohul and Jabeen Anjum Fazli (2012), "Measuring Patient Satisfaction: A Cross Sectional Study to Improve Quality of Care at a Tertiary Care Hospital", Health Line, Vol. 3, No. 1

9. Antonovsky, A. (1987). Unraveling the mystery of health. San Fransisco: JosseyBass.

10.Antonovsky, A. (1993). The structure and properties of the sense of coherence scale. Social Science Medicine, 36(6), 725 – 733. 11.Arentz, J. E. & Arentz, B. B. (1996).