

QUALITY INITIAL ASSESSMENT

**Internship Training
at
Global Health Private Ltd., New Delhi**

**By
Sanghamitra Chauhan**

**Under the guidance of
Dr. Santosh Kumar**

**MBA Hospital & Health Management
2013–15**


**Institute of Health Management Research
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Dissertation

At a Multi Super specialty Hospital,

Delhi NCR

Quality Initial Assessment

By

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Under the guidance of

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MBA Hospital and Health Management

Year 2013-2015



Institute of Health Management Research

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TO WHOMSOEVER MAY CONCERN

This is to certify that Sanghamitra Chauhan, student of MBA Hospital and Health Management from IIHMR University, Jaipur has undergone internship training at Medanta, The Medicity, Gurgaon from 2nd Feb 2015 to 31st Mar 2015.

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

The Internship is in fulfillment of the course requirements.

I wish her all success in all his future endeavors.



Col.(Dr Ashok Kaushik)
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Date 04.05.15

INTERNSHIP COMPLETION LETTER

This is to certify that Ms. Sanghamitra Chauhan, student of MBA (Major in Hospital & Healthcare Management), Batch 2013 -15 Indian Institute of Health Management Research, Jaipur has successfully completed her internship with us.

- Project Title - Quality Initial Assessment
- Project Duration - 02nd Feb 2015 to 31st March 2015

During the period of her internship programme with us she was found to be punctual, hardworking and inquisitive.

For GLOBAL HEALTH PVT LTD


MONICA MUDGAL

SENIOR VICE PRESIDENT & HEAD - HUMAN RESOURCES

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled Quality Initial Assessment and submitted by (Name) Sanghamitra Chauhan Enrollment No. IIHMR-U/01 /2013-15/0094 under the supervision of Dr Santosh Kumar for award of MBA Hospital and Health Management/ MBA Pharmaceutical Management of the university carried out during the period from 2nd Feb2015 to 31st Mar 2015 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.

Signature *(Sanghamitra Chauhan)*

STUDY ON QUALITY INITIAL ASSESSMENT

EXECUTIVE SUMMARY

Author: Sanghamitra Chauhan

This study on Quality Initial Assessment aims to assess the existing quality of initial assessment performed for IPD patients and also to ensure that highest quality of assessment is performed by the doctors. It is a cross sectional, quantitative study spread over duration of eight weeks. The initial assessment forms of over 23 specialties were audited as per a designed audit checklist. The sample size was taken as 10% of the average monthly admissions of that specialty in two weeks time. The total no. of file audits was 260. The top four non compliances related to care related findings were consultant oversight on plan of care within 24 hrs, allergy history, current medications information and past medical history. In the meantime, a training module was designed by competent clinicians on MOODLE for the doctors doing initial assessment. The training pilot was conducted in two specialties and post training audits were conducted. There was an improvement in compliance by 12% in one and 8% in another specialty. Hence the training module could be implemented across the entire hospital.

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1. INTRODUCTION

Assessment is the first part of the patient care, and thus forms the basis of the plan of care. Initial assessment of patient is not only history taking but also includes detailed examination done by doctors and nurses to effectively plan and manage patient care. An effective evaluation of the patient will result in making decisions about the immediate and ongoing medical needs in emergency cases, elective, or planned care and when the patient's condition changes⁽¹⁾. Quality is a distinctive attribute or characteristic of a service. In hospitals According to the World Health Organization, quality is the key factor in improving the outcomes of health as well as providing efficient services⁽²⁾. Quality in initial assessment is a key factor in determining outcome of patient's treatment. The essential requirement of accurate assessment is to view patients holistically and thus identify their real needs⁽³⁾. When a patient has been registered or admitted to a hospital for inpatient or outpatient care/treatment, a complete assessment needs to be performed related to the reason(s) the patient has come for care⁽⁴⁾.

Patients are well informed of the services that an organization provides. Only those patients who can be cared for by the organization are admitted to the organization. Patients that match the organizations resources are admitted using a defined process. Patients cared for by the organization undergo an established initial assessment and periodic and regular reassessments⁽⁵⁾.

Importance of assessment skills⁽⁶⁾

- Patients expect relief of suffering. This is fundamental to the goals of medicine as cure or control of disease
- Assessment is key diagnostic tool to assess each dimension of suffering
- Assessment coordinates the team of health professionals

- Because the physician is the one who coordinates and directs care, it is important that the physician be able to assess each dimension of suffering
- However, the physician is unlikely to elicit a complete assessment working alone
- Other members of the health care team (such as nurses, social workers, and chaplains) can conduct important components of this assessment
- They bring unique skills to the task
- They may learn important information that the patient or family may not have shared with the physician
- Assessment can have therapeutic effects
 - The physician can discuss with the patient or proxy the meaning of the information and his or her assessment of the patient's situation
 - This can help convey information to the patient regarding prognosis and the need for advance planning and personal preparation, particularly in the setting of overall deterioration
 - Of equal importance, it conveys compassion
 - It initiates the physician's therapeutic role

JCI has conducted many studies on initial assessment. A JCI study on root causes and percentages of all sentinel events states that in 37% cases of sentinel events, it is the improper assessment responsible for that particular event which could have been easily prevented.

⁽⁷⁾.Another study by JCI talks about most frequently identified root causes of sentinel events.

Among all the root causes, faulty assessment has continuously been ranked as fourth important cause of sentinel events. ⁽⁸⁾

Dr Fereshteh Farzianpour et al has conducted a study on Assessment of Patient (AOP) standards in selected Teaching hospitals in Iran. This study was the cross-sectional descriptive-analytic study examined in 10 hospitals covered by Tehran University of Medical Sciences. In this study, two questionnaires on AOP standards and measurable elements of AOP standards were used to collect data. Score of assessment of patient standards in public hospitals was more than specialized ones.⁽⁹⁾

Assessments also include planning for utilization of laboratory and imaging services. The laboratory and imaging services are provided by competent staff in a safe environment for both patients and staff. These assessments result in formulation of a definite plan of care⁽⁵⁾. Standard AAC 4 of NABH states that patients cared for by the organization undergo an established initial assessment. JCI also talks about initial assessment of patients in Assessment of Patients (AOP) Chapter.

Important parameters of initial assessment

There is a printed format used at the hospital under study for initial assessment. There are separate sections for assessment by doctors and nurses. Nurses assess vital signs, pain status, fall risk, bed sore risk and prioritize nursing interventions. Doctors record presenting complaints, allergy history, past medical and surgical history, in addition to performing physical examination

Research questions

1. Is quality initial assessment being done in the hospital for IPD patients as per JCI Standards?
2. What are the major non compliances in patient assessment which may affect care?

Objectives of the study

To ensure highest quality of initial assessment is done in the multi super specialty hospital.

1. To assess the existing quality of initial assessment in the hospital under study.
2. To identify areas of concern if any
3. To develop solutions to address the concerns.
4. To study the impact of solutions on quality of assessment

Rationale of the study

JCI has given AOP (Assessment of Patient) standards as a Chapter. The hospital under study being JCI accredited has to sustain its standards and ensure compliance in Initial assessment of patients. It was observed that the doctors performing initial assessment are missing out on certain important parameters while doing the assessment. They were not evaluating psychological status and other important parameters like current medication history. One way to improve the quality of initial assessment is to assess the existing quality first. Hence this study was undertaken across the entire hospital.

2. **METHODOLOGY**

This Chapter talks about research questions, study design, study area, tools used, sample size and sampling technique and data management.

This hospital has all the major specialty units like Medical oncology, Cardiology, Cardio Thoracic Vascular Surgery, Neurosciences, Urology, Nephrology etc. and in-patient departments are available for all these specialties. Audits were done in 23 specialties as per the audit checklist

Study design-This study is a Quantitative, analytical cross sectional study

Study area- All the IPDs of the hospital were covered under study

Study duration-The duration was of 8 weeks out of which review of literature and finalization of checklist took 2 weeks, data collection in 2 weeks, analysis in one week, training and reaudits in last 3 weeks.

Data type: Primary data was collected by audits of initial assessment form filled by doctors and nurses.

Data collection instrument-Audit checklist was designed based on important parameters of initial assessment

Data collection method-Auditing the IPD files for initial assessment form using the checklist, few checkpoints required patient interview and observation like observing bands for allergy prone/vulnerable patients. Both these methods fulfilled the objective of assessing existing assessment quality.

Data collection approach-Primary and quantitative

Sample size-10% of the average admissions per month in each specialty for 2 weeks period

Sampling technique-Purposive sampling

Inclusion criteria-Active files of admitted patients in IPDs

Exclusion criteria-

1. Files of discharged IPD patients
2. Files of admitted patients in ICUs, HDUs, Emergency and pediatric patients

Training tool for doctors-Audiovisual was made by competent clinicians of the hospital to train the doctors performing initial assessment. This completed the objective of developing solution to address the problem. The module was named as Quality Initial Assessment(QIA) module.

Description of the module:-QIA Module has been designed for training the doctors performing initial assessment in the in-patient departments. It is an audio visual with a maximum duration of 45 min made on MOODLE in a lucid language followed by a simple post-test. It has been prepared by competent clinicians keeping in mind all the important aspects which are often overlooked by doctors while taking history from patients. Learning through this module is quite easy and interesting since it can be done within the IPD itself; all it needs is a desktop and a headset. It would be beneficial for all the doctors since the initial assessment form has been updated recently with few additional components.

Objectives of QIA Module:-The overall objective of this module is to ensure that highest quality of initial assessment is done in the hospital.

To gather feedback from the doctors after the training session

A pilot of this training was conducted in two specialties and thereafter audit was done again to see the impact of training in both.

Data management Data collected through audit checklist is entered on Microsoft Excel as Yes/No and then coded. 'Count if' function is used to calculate non compliance percentage for every checkpoint. The overall non compliance is then calculated. Bar graphs are used to show overall non compliance and the top five non compliances. Hence it helped to fulfill objective of identifying areas of concern.

Re audits are done again after conducting training pilot in two specialties. The proposed solution was thus implemented .Bar graph is used to show the impact of training on overall non compliance and other areas of concern.

3. DATA ANALYSIS

This Chapter contains findings of five major specialties which had higher no. of average admissions per month, overall findings across the hospital, and impact of pilot training in 2 specialties and summary of all specialties in terms of overall non compliance in tabular form.

Findings for major specialties

The specialty analysis wise is divided into two major categories-clinician related and nursing related non compliances.

Fig 3.1 shows overall non compliance of 30% in Internal Medicine and its breakup into clinician and nursing non compliances.

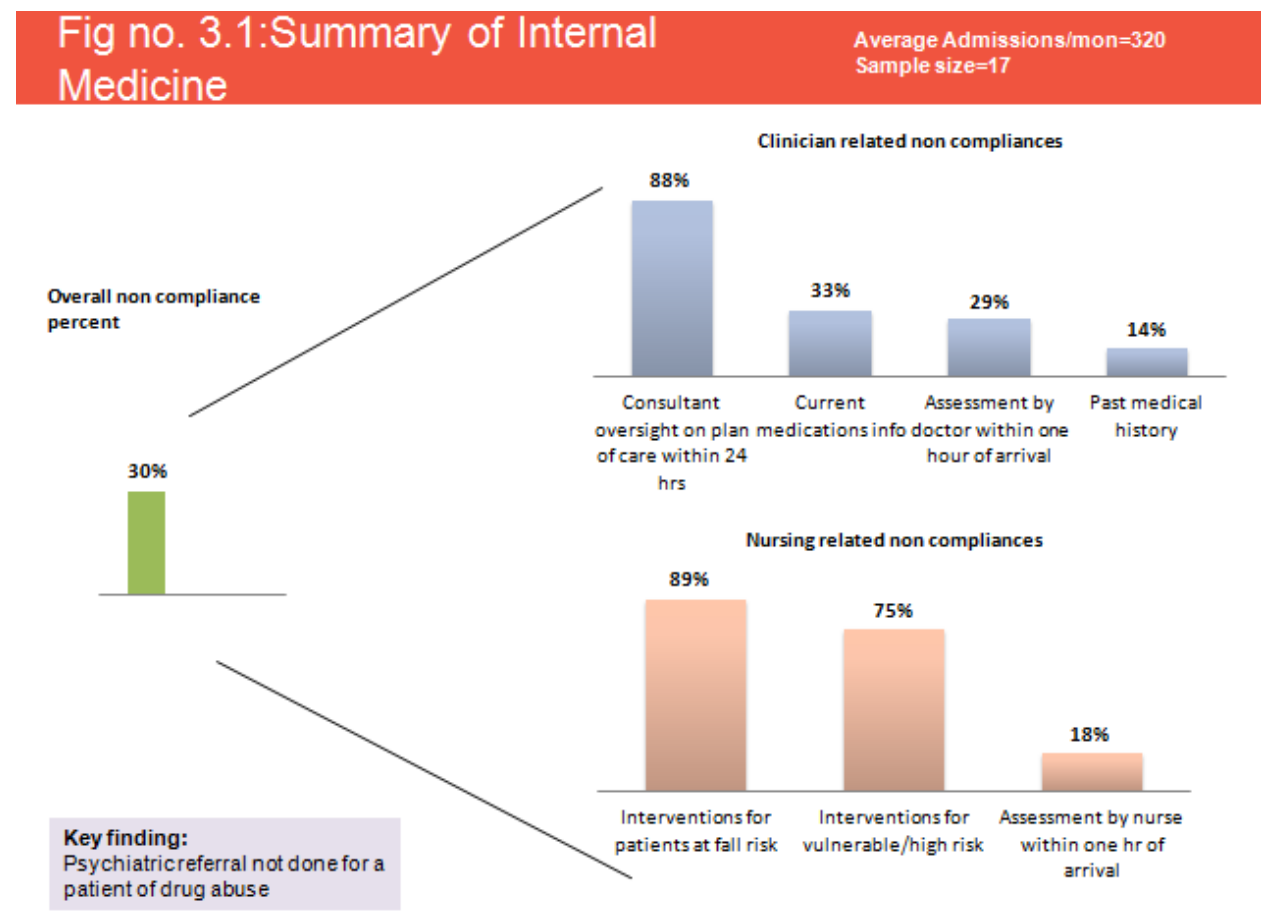


Fig 3.2 shows overall non compliance of 25% in Cardiology and its breakup into clinician and nursing non compliances.

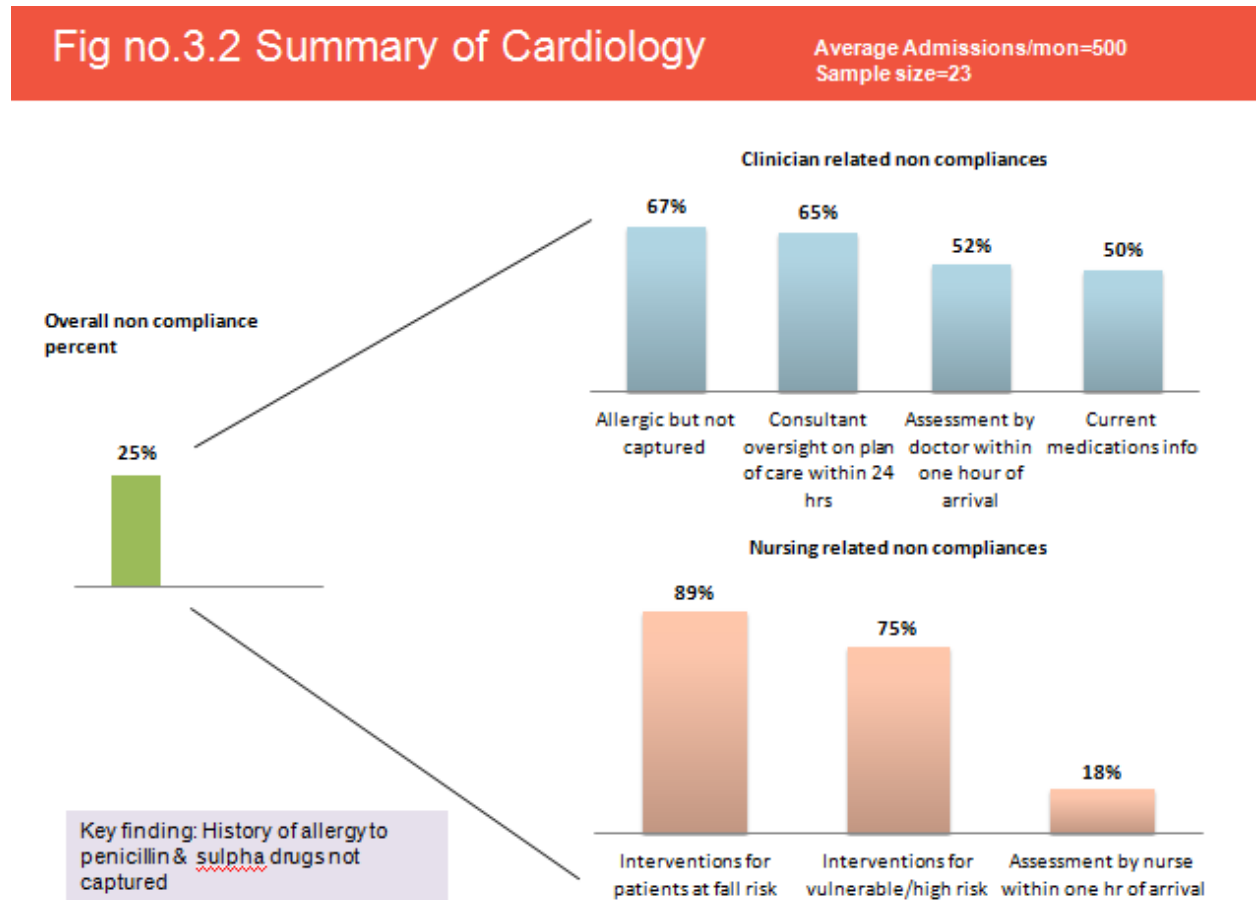


Fig 3.3 shows overall non compliance of 23% in CTVS and its breakup into clinician and nursing non compliances.

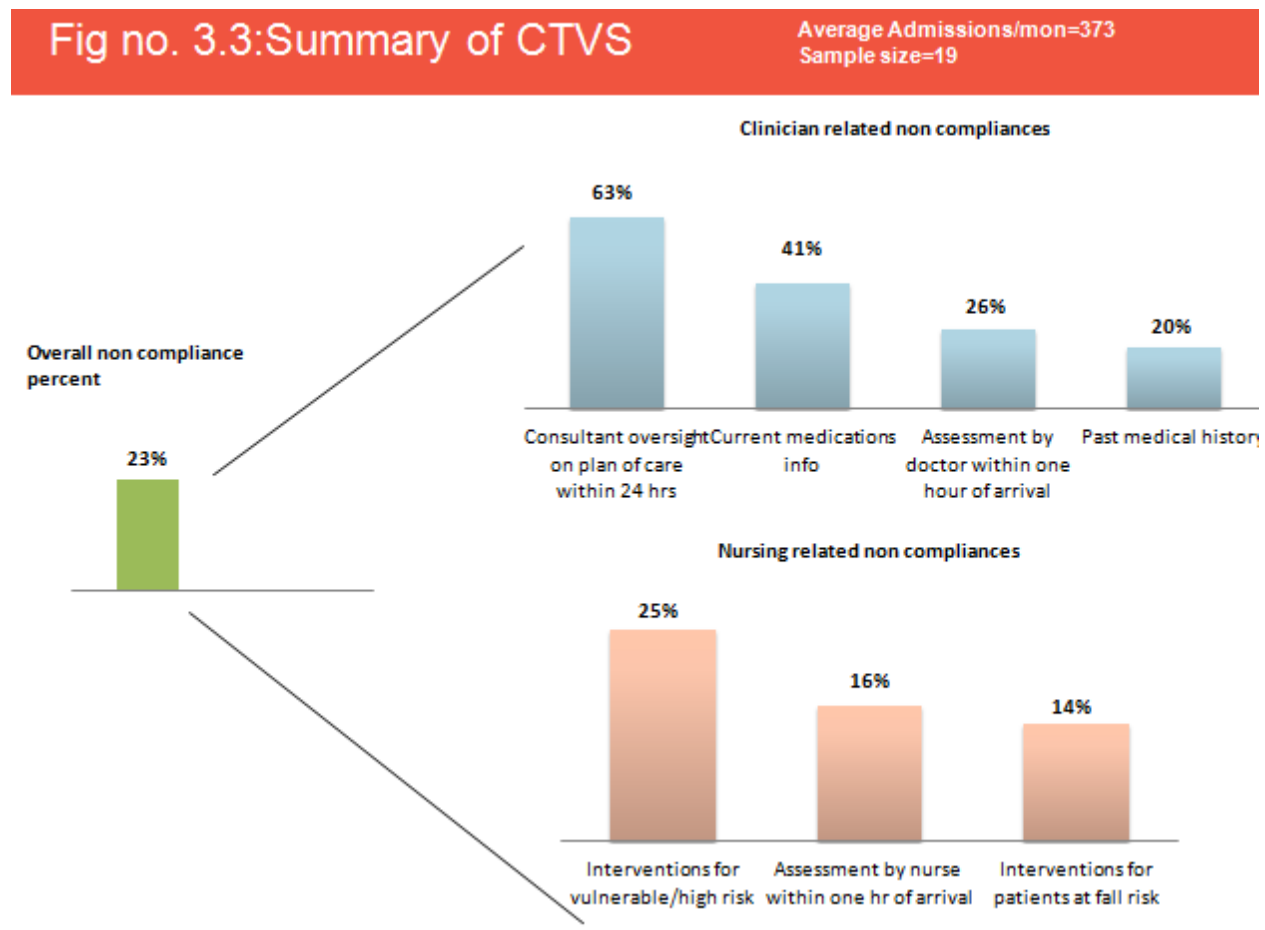
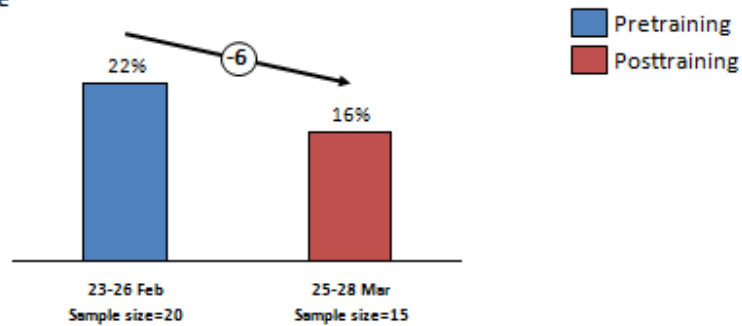


Fig 3.4 shows the impact of pilot training done in GI surgery. There was decrease in overall non compliance by 6%.

Fig no. 3.4: Impact of training on Gastro Intestinal Surgery Average Admissions/month=200

Overall non compliance percent



Clinician findings: non compliance percent

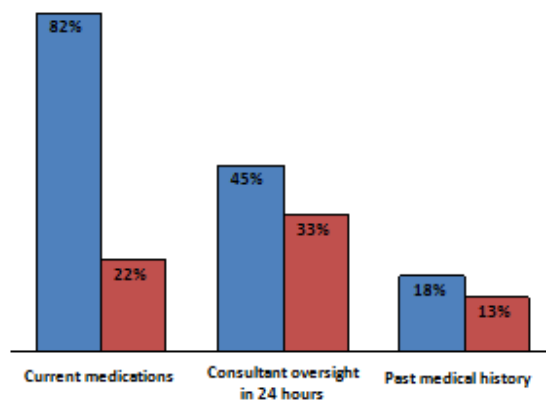


Fig 3.5 shows the impact of pilot training done in Gastroenterology. There was decrease in overall non compliance by 12%.

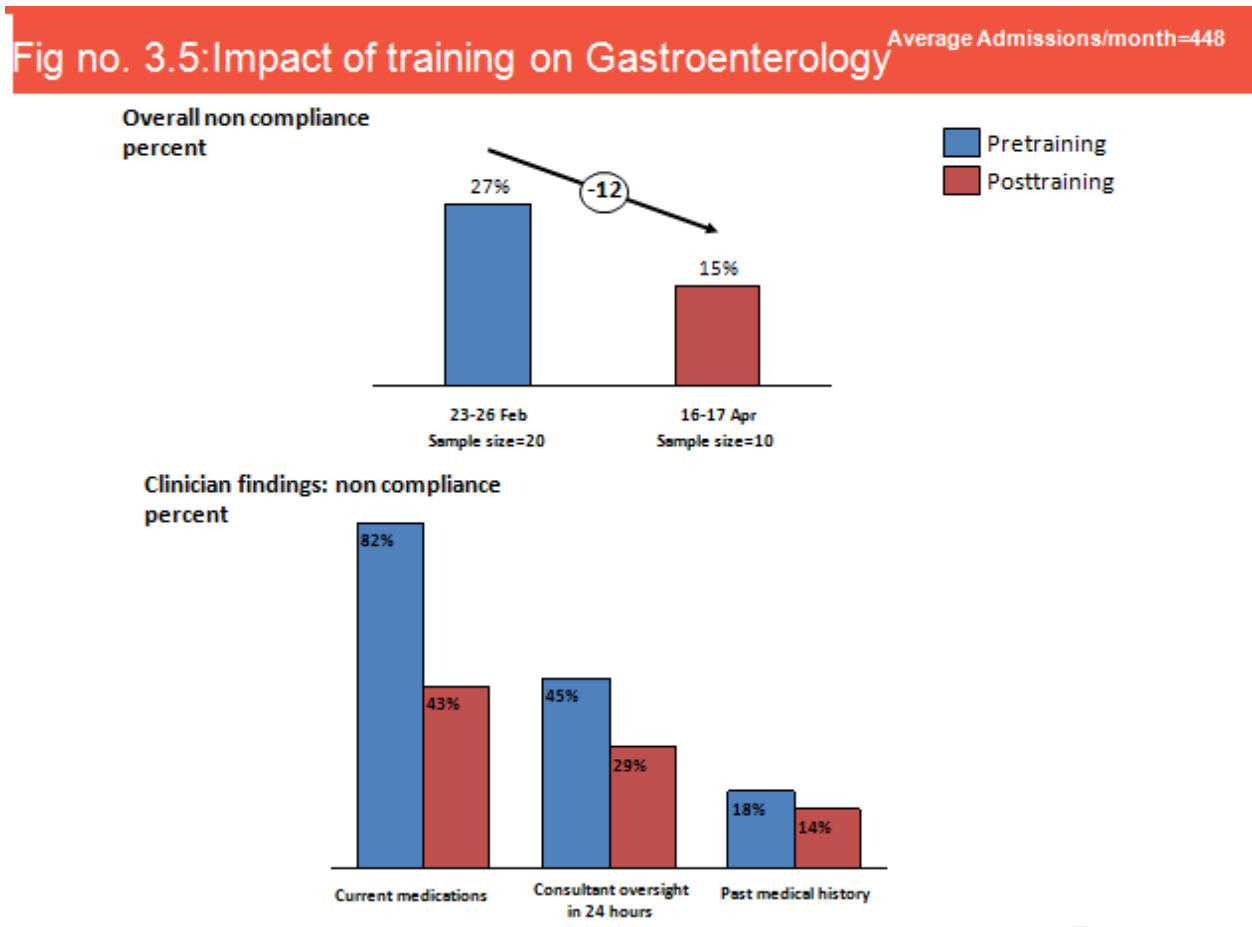


Fig 3.6 shows the findings across the entire hospital.

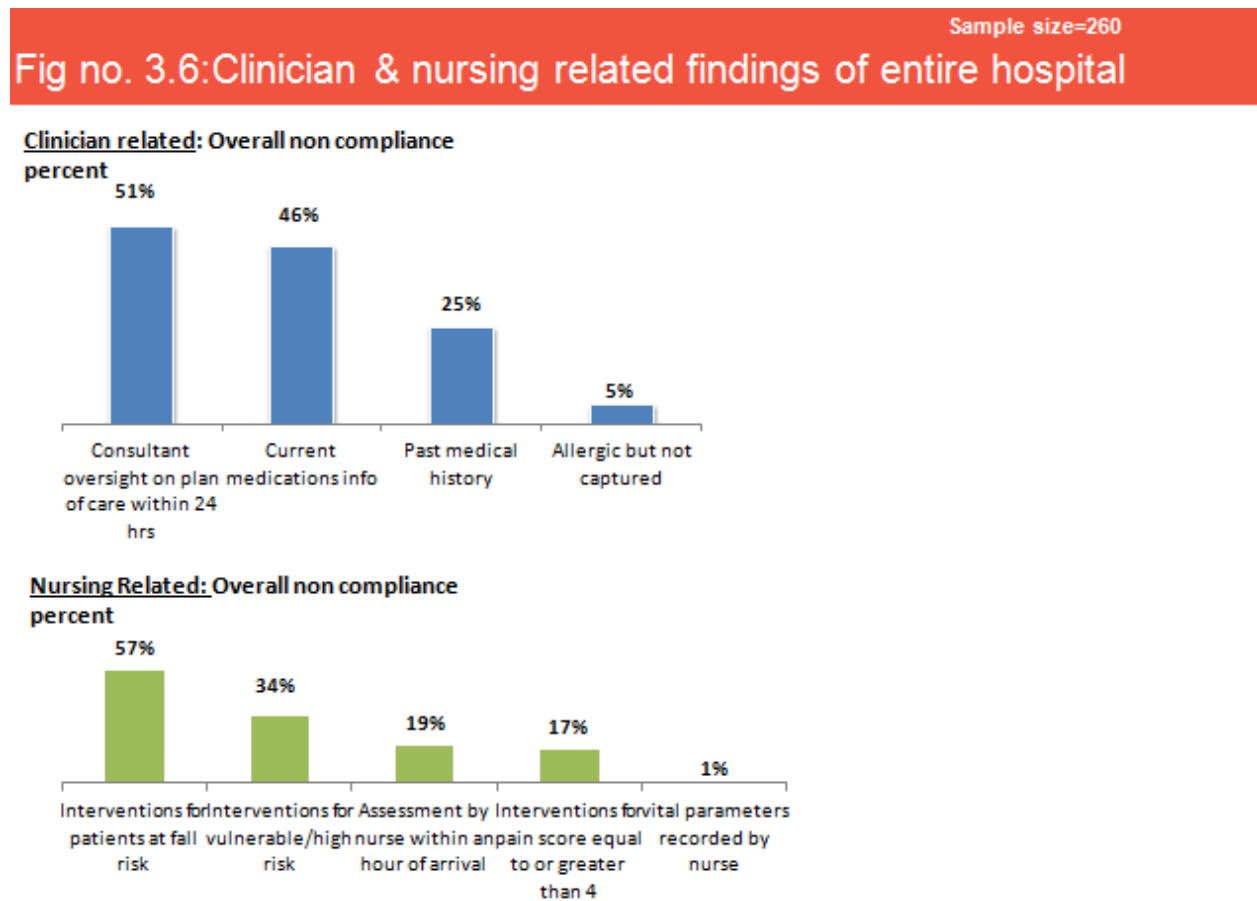


Table 3.1: Specialty wise non compliance

This table shows overall non compliance across all specialties

S.No	Specialty	No. of files audited	Overall non compliance
1	Respiratory Medicine	10	34%
2	Internal Medicine	17	30%
3	Thoracic surgery	1	28%
4	Gastroenterology	20	27%
5	Cardiology	23	25%
6	Vascular surgery	10	25%
7	ENT	10	25%
8	Plastic Surgery	10	24%
9	CTVS	19	23%
10	GI surgery	20	22%
11	Gynecology	6	22%
12	Head and neck oncology	4	22%
13	Urology	14	21%
14	Orthopedics	14	21%
15	Nephrology	11	20%
16	Medical Oncology & Hematology	20	20%
17	Liver Transplant	12	18%
18	Rheumatology	5	17%
19	Neurosurgery	14	12%
20	Interventional Radiology	1	11%
21	Neurology	10	10%
22	Breast services	4	9%
23	Radiation Oncology	5	9%
	Total sample size	260	
	Overall non compliance of hospital		21%

Summary of data analysis

A) The overall non compliance in hospital is 21%.The most important care related findings showing non compliance across the entire hospital are:

1. Consultant oversight on plan of care within 24 hours

2. Current medications information
3. Allergy history not captured
4. Past medical history

B) Quality Initial Assessment was conducted on a pilot basis for two specialties-
Gastroenterology and Gastro Intestinal Surgery

1. The training made 12% improvement in overall compliance of Gastroenterology.
2. The training made 6% improvement in overall compliance of GI Surgery.

4. CONCLUSION

The pilot on Quality Initial Assessment training was successful in improving compliances and hence could be applied across the entire hospital.

RECOMMENDATIONS

1. Training and sensitization taken across hospital
2. Adding outpatient prescription copy in the inpatient file as a system
3. Audit and focus on important 5 issues that affect care
4. Sharing weekly reports with Chairpersons
5. The department chairman may see the initial assessments of new admissions to reinforce importance of assessment
6. Non compliances can be discussed with the concerned doctors.

5. REFERENCES

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6. ANNEXES

Table 6.1. **Average monthly admissions per specialty**

<u>Speciality</u>	<u>Average month adm 2014</u>	<u>10%</u>	<u>No. of files actually audited in 2 weeks</u>
Medical Oncology & Hematology	423	42	20
Cardiology	500	50	23
Gastroenterology	448	45	20
Cardio-Thoracic Vascular Surg.	373	37	19
Urology & Andrology	302	30	14
Orthopaedics	272	27	14
GI Surgery	200	20	20
Neurosurgery	194	19	14
Neurology	122	12	10
Nephrology	134	13	11
Liver Transplant	129	13	12
Internal Medicine	320	32	17
Respiratory & Sleep Medicine	104	10	10
Ear,Nose,Throat	103	10	10
Vascular& Endovascular Surgery	98	10	10
Radiation Oncology	92	9	5
Plastic Surgery	95	10	10
Gynaecology & Obstetrics	63	6	6
Head & Neck Oncology	51	5	4
Rheumatology	48	5	5
Breast Services	36	4	4
Thoracic Surgery	11	1	1
Interventional Radiology	4	0	1
Grand Total			260

2. Audit tool

Audit Checklist for IP Initial Assessment Form - Floor

UHID No.
Specialty
Admitting Doctor's name

<u>S.No</u>	<u>Statement</u>	<u>Remarks</u>	<u>Yes/No</u>
1	The initial assessment is performed and documented by the nurse within one hour of patient's arrival in ward		
2	The vital parameters recorded by nurse		
2A	The vital parameters recorded by doctor		
2B	The vital parameters checked by doctor and nurse are in compliance		
3	Pain score equal to or greater than 4 during nursing assessment is incorporated in the nursing care plan		
4	Does the patient have any special needs?	If no, go to 5	
4A	If yes, are action specified by nurses for patients with special needs?		
5	The patients with nutritional score equal to or less than 11 are referred to dietitian by the doctor		
5A	The dietitian has done assessment for the patient with nutrition score less than or equal to 11 within 24 hours of patient's arrival		
5B	The dietitian has filled Harris Benedict Equation for patients at nutrition risk		
6	If fall risk score found moderate/high, interventions are incorporated in nursing care plan.	If NA, go to 7	
6A	If the patient has high fall risk score (45 and above), it is documented in 'High risk for fall' file with patient's details		
6B	Patient and family education is done for patients at risk of fall and documented in a separate form		
7	If the patient is high risk/vulnerable, then it's relevant category is ticked in the form	If no go to 8	
7A	If yes, FI note the category:		
7B	Vulnerable/high risk interventions are incorporated in the care plan		

<u>S.No</u>	<u>Statement</u>	<u>Remarks</u>	<u>Yes/No</u>
7C	High risk/vulnerable documented in 'vulnerable patient' register.		
7D	Blue star is put against the patient's name on the white board at nursing station.		
8	The doctor reviews the care plan and countersigns it.		
9	Psychological assessment done by nurse		
9A	Psychological assessment done by doctor		
9B	Psychological assessment done by nurse and doctor is in compliance		
9C	Patients are referred to psychiatrist if any of the findings in A/B/C/D points of psychological evaluation are positive		
10	If past medical history positive, duration is mentioned.		
11	Current medications are listed down in the table		
11A	Current medications to be continued in hospital are ticked yes / no.		
11B	Medications marked yes/written in 'current medications' are included in medication administration record		
12	Does the plan of care have measurable goals?		
13	The initial assessment is performed and documented by the doctor within an hour of patient's arrival in ward		
13A	The doctor's name is legible		
13B	History taken by dr-name		
13C	Doctor's signature present		
13D	Date mentioned by doctor		
13E	Time mentioned by doctor		
14	The consultant reviews the assessment performed by floor doctor within 24 hours of patient's arrival		
14A	Consultant's name is legible		

□

<u>S.No</u>	<u>Statement</u>	<u>Remarks</u>	<u>Yes/No</u>
14B	Name of consultant		
14C	Consultant's signature present		
14D	Date mentioned by consultant		
14E	Time mentioned by consultant		
15	The patient /attendant has put his name on form		
15A	The patient /attendant has put his signature on form (<i>Patient Interview</i>)		
16	Did the nurse play an orientation video at the time of your admission and arrival in ward?		
17	Do you have any allergy: medication/blood/food?		
17A	(Check File) In the allergy table, allergy is marked as known/not known by the doctor		
17B	If the allergy is known, it's details are recorded by doctor		
17C	Is the drug allergy reflected in the medication charts?		
17D	Is the food allergy mentioned by dietitians in their notes?		
18	(By patient observation) High risk/vulnerable patients wear a blue wrist band		
18A	Patients with a known allergy wear a red wrist band		
18B	Diabetic patients wear a yellow wrist band		