

AUDIT TO ASSESS THE COMPLIANCE OF IN-PATIENT FILES

**Internship Training
at
Paras Hospitals, Gurgaon**

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**Under the guidance of
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Jaipur
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TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Sonal Rai** student of MBA Hospital and Health Management from IIHMR University, Jaipur has undergone internship training at **Paras Hospitals, Gurgaon** from **3rd March, 2015 to 2nd May, 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 her future endeavors.



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WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Sonal Rai** has successfully completed her dissertation in the department of **Quality** from **03rd March, 2015** to **02nd May, 2015**.

During her dissertation period, she was found to be sincere and dedicated towards her assignment.

We wish her all the best for her future endeavors.

For Paras Hospitals, Gurgaon



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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled “An Audit to Assess the Compliance of In-patient Files” and submitted by Dr. Sonal Rai Enrollment No IIHMR/PGDHM/2013-15/1506 under the supervision of Dr. Suresh Joshi for award of MBA Hospital and Health Management of the university carried out during the period from 3rd March, 2015 to 2nd May, 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

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LIST OF ABBREVIATIONS

- ER- Emergency
- ICU- Intensive Care Unit
- IPD- In-Patient Department
- OPD- Out-Patient Department
- OT- Operation Theatre
- TAT-Turnaround Time

An Audit to Assess the Compliance of In-patient Files

1. Introduction

In modern healthcare organizations, the quality and coordination of care depend on the communication between different caregivers about their patients. Documentation is a communication tool for exchange of information stored in records between nurses and other caregivers [1]. Quality documentation promotes structured, consistent and effective communication between caregivers and facilitates continuity and individuality of care and safety of patients [2, 3].

The medical record is a living document that tells the story of the patient and facilitates each encounter they have with health professionals involved in their care. In addition to telling the patient's story, complete and accurate medical records will meet all legal, regulatory and auditing requirements. The old saying "If it's not documented in the medical record it was not done" has never been more timely as state and central governments continue to enact legislation to protect various healthcare consumers. Quality documentation promotes effective communication between caregivers, which facilitates continuity and individuality of care. Documentation quality, accuracy and development needs can be monitored through an auditing instrument. Audit is the process of collecting information from patient reports and other documented evidence about patient care and assessing the quality of care by the use of quality assurance program. It is a detailed review and evaluation of selected clinical records by qualified professional personnel for evaluating quality of patient care.

System of Documentation lay out in Paras Hospital, Gurgaon: Hospital uses paper-based hand written in- patient medical records with the scientific patient care process as the documentation guiding framework. After discussion with Managers of Quality department, they highlighted the issues related to documentation in the hospital. There should be 100% compliance of documentation in hospital, but there is the gap between present compliance and hospital set standard.

2. Problem Statement

Earlier audit of patient documents revealed inconsistency, incompleteness and often difficult to read as they are hand written. Most of the hospital staff employed in the hospital is enrolled with little formal training to documentation of in-patient file.

3. Review of Literature

Quality of clinical encounter notes relates to patient safety [4, 5], medical education [6-8], medico-legal issues [9, 10], and justification of reimbursement. The clinical note is the primary tool used to document care, communicate plans [11, 12], and provide guidance for follow-up treatment and care. Gaps in the quality of clinical documentation could, therefore, adversely affect patient care and healthcare outcomes. Despite the importance of documentation to clinical care, there is no agreement in the literature on a comprehensive definition of the quality of documentation within a clinical note. The audit is the tool to control the quality of the work of the medical team and is used with the objective of improving quality of provided services. One can evaluate the nursing care by means of records, which

reflect the quality of nursing care Auditing function is not only indicate the shortcomings and problems, but also pointing suggestions and solutions, is thus a highly educational character.

When identifying elements associate with quality of clinical documentation, authors commonly cite attributes such as legibility, correctness, completeness, readability, appropriateness and accuracy [13]. It is defined as the official examination of records to evaluate, monitor and improve patient care and as a method to evaluate the quality of nursing care through the records, after discharge of the patient.

There are two types of auditing: a retrospective and operational or recurrent. The auditing review is made after discharge of the patient and uses the medical records for evaluation. The operational auditing is applied as the patient is hospitalized or in outpatient care. The auditing can be classified as a form of assistance (internal and external), time (continuous and periodic), the nature (regular and special) and the limit (total and partial) [13].

There is study done by (Boulay F, et al 1997) and analysis of the 467 forms returned by 39 hospitals, showed that the quality of medical file recordings should be improved as a large amount of data or important documents were missing: reason for hospitalization (recorded on 74.1% of files), operation report (found in 83.2% of files) and discharge summary (found in 66.6% of files) [14]. And there is another study which states that general practitioner, admission documents, and delivery, anesthesia and transfusion records were almost always present. Surgery reports were found in 65 to 89% of the files. Low compliance with three criteria was observed: authorization to give health care to a minor (39 to 80% of the files), identification of the physician

who prescribed the drugs during hospitalization (6 to 32%) and discharge prescription (42 to 95%) [15].

Clinical audits would be compromised in certain hospitals by the use of medical files [14]. Widespread and systemic application of clinical audit may improve the quality of patient care and maintain the trust of the population. However, clinical audit should be effective and cost-effective. The recently published methodological guideline by the Ministry intends to promote good practice in clinical audit. The audit allows us to define the first steps of a quality improvement project for patient records [15].

4. Research Question

What is the current compliance of in-patient documentation of hospital staff involved in patient care?

5. Aim

The audit is to ensure that all clinical records are maintained to the highest standard as well as providing a benchmark to continually improve the quality and accuracy of clinical records.

6. Objectives

- To find out the compliance of in- patient documents among the staff of hospital using a self designed data collection tool.
- To compare the difference between the compliance of in-patient records and the standard compliance set by the hospital.

7. Methodology

- **Study Type:** Descriptive study was conducted to understand the activities and identify the problems.
- **Location of Study:** In-Patient Department of Paras Hospitals, Gurgaon
- **Duration of Study:** 3rd March 2015 to 2nd May 2015
- **Sample size:** 225 in- patient files

Table 1. Number of files studied for different in- patient areas

Area	Number of Files Studied
3A- Medicine ward	14
3B- Medicine ward	34
3C- Oncology ward	23
4A- Neurosurgery ward	25
4B- Surgery ward	29
4C- General ward	30
OPD	148
Emergency	77
OT	70

- **Sampling technique:** A universal coverage of all patients undergoing treatment in the hospital.
- **Inclusion criteria:** The patients whose treatment is going on not discharged were selected.

- **Exclusion criteria:** Discharged patient files and medical record files were excluded from the study.

- **Technique of data collection:**

Permission to conduct the study was taken from the Head of Quality department of hospital. All the in-patient files were checked after documentation by the concerned staff. The prescribing doctors, nurses, and other staff were largely kept unaware of the procedure, except in unavoidable circumstances, to avoid the bias in their behavior with the documentation. The data is collected from both sources i.e. **primary and secondary**.

- **Primary data** regarding the documentation involved in the in-patient file was collected for two months with the help of excel sheet. The sheet consisted points about the documents of nurses, doctors, and other staff. This was followed by calculation of compliance for each hospital category staff.
- **Secondary data** was collected from the hospital to understand the standard activities.
- **Data collection Tool:** Self designed excel sheet

Table 2: In-Patient file Consists 30 Headings

Hospital In-patient Department	Hospital Staff Category	In- Patient Study Points
OPD	OPD Admitting Staff	Admission Consent Form
	OPD Doctor	OPD Card Admission Request Form (with plan of care)

IPD	IPD Doctor	Doctor assessment within defined TAT Pain assessment Name, signed, dated, timed Physician Order Sheet- (capital, dose, time, route, frequency) & allergy
	IPD Nurse	Nursing assessment (<30min of admission) Screening for pain on admission Allergy Screening Nursing Reassessment with name, date and sign
	Dietician	Nutritional screening (<24hours of admission)
Emergency	Emergency Doctor	Doctor emergency assessment sheet
	Emergency Nurse	Nurse emergency assessment sheet
OT	OT Doctor	Consent (Procedure/ Surgery/ High Risk) Details of implants Details [Diagnosis, operation performed] Tissue sent for histopathology Condition at the end of surgery Disposition Date, Time and Sign of Doctor Post-Surgery Notes by doctor Surgical Safety Checklist Blood and Blood Products Consent

	OT Nurse	Pre-operative checklist (Surgical patient) Date, Time and Sign of Nurse Post-operative plan of care
	Anesthetist	Pre-anesthesia assessment Anesthesia Plan

- **Data Analysis:**MS Excel
- **Study of In-patient files done as follows:**

In- Patient Files Audit includes the sample size of 225 and self designed sheet includes 29 headings which are segmented under 4 main categories (OPD, IPD, Emergency, OT) and these 4 categories are further segmented into sub categories according to job role of hospital staff (OPD admitting staff, consultant doctor, emergency doctor, emergency nurse, doctors, ward nurses, dietician, OT doctors, OT nurses).

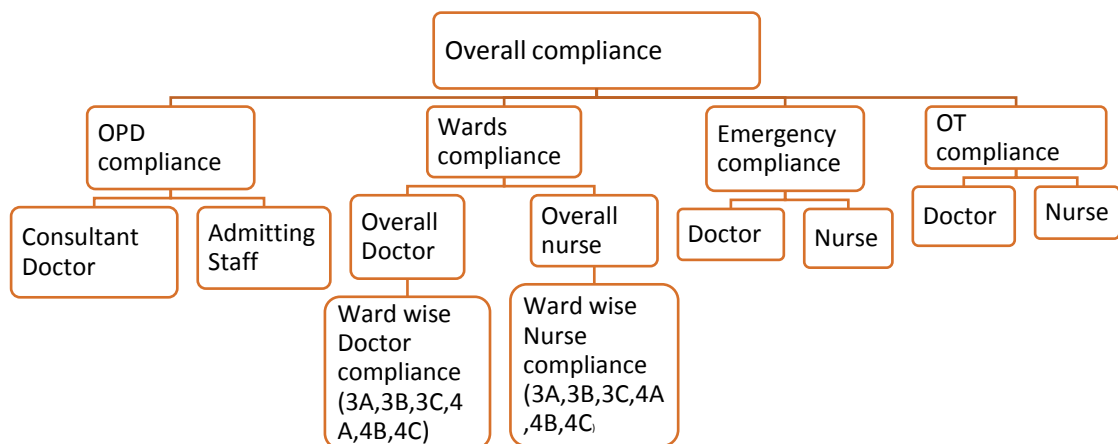


Figure 1 Study of In-patient Files done as below flow chart

8. Hospital Set Standard:

- 100% compliance of all In-patient documents

- **Formulas:**

Compliance (%) = (Sum of calculated score/ Total score of files)*100

Non-Compliance (%) = (Set Standard-Compliance) %

- **Scoring of in-patients Documents Points:**

0=not filled or document absent

5=Partial filled

10=complete filled

9. Results

9.1. Overall Patient File Audit Compliance

Overall Compliance of Patient files is 76% and Non-Compliance is 24% which is shown in figure2.

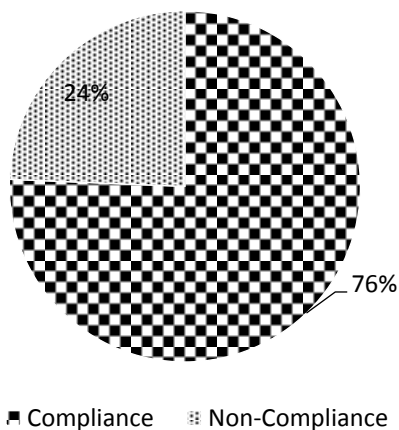


Figure 2 Proportion of inpatients documents showing full compliance of documentation standards

9.2 Compliance comparison with 4 main categories; OPD, Emergency, IPD, OT

- In below figure 3, the OPD, Emergency, IPD and OT compliance which is 90%, 47%, 81% and 71% respectively which is compared with overall compliance of Patient Audit Files which is 76%
- Emergency compliance; 47% is least and OPD compliance; 90% is maximum.

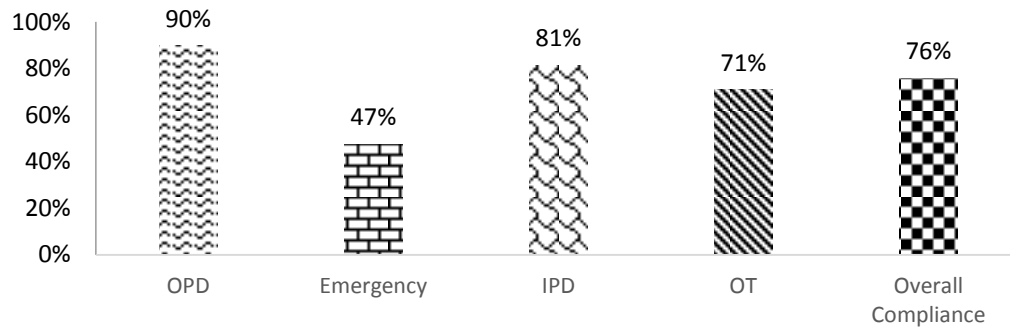


Figure 3 Comparison between Compliance of OPD, Emergency, IPD and OT against overall compliance

9.3 OPD In-patients documents compliance

- OPD includes three sub categories which includes casualty/OPD card, Admission Request form and Admission Consent form; having compliance 88%, 87% and 93% respectively as shown in figure 4.
- Compliance of these three categories is compared with Overall OPD compliance which is 90% as shown in figure 4.
- Maximum and minimum compliance of all three subcategories is Admission Consent form; 93% and Casualty/OPD card; 88% respectively as shown in figure4
- According to the staff in OPD Doctors and Admitting staff have 87% and 93% compliance respectively shown in figure 4.1.

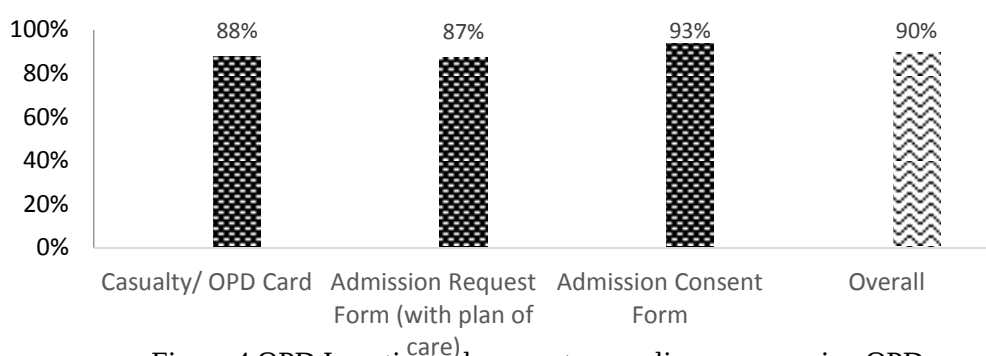


Figure 4 OPD In-patients documents compliance comparing OPD card, Admission Request Form and Admission consent Form

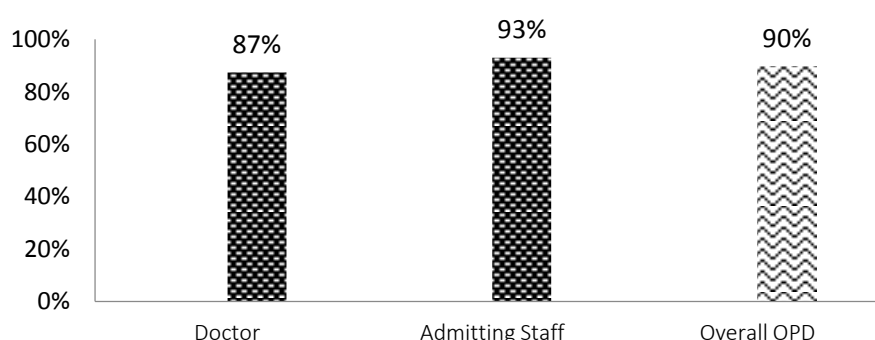


Figure 4.1 OPD In-patients documents compliance comparing Doctor and Admitting Staff

9.4 Emergency documents Compliance

- Emergency includes three sub categories which includes Doctor and Nursing; having compliance 64% and 36% respectively as shown in figure 5.
- Compliance of these 2 subcategories is compared with overall emergency compliance which is 47% as shown in figure 5.

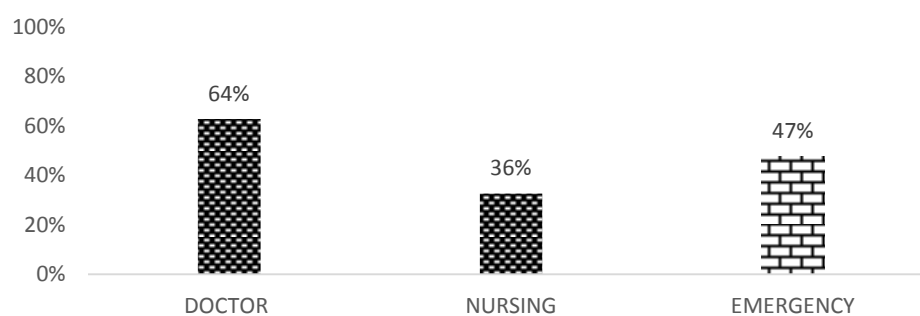


Figure 5 Emergency documents Compliance comparing documentation done by doctor, nurse and anesthetist

9.5 IPD wards documents compliance

- IPD wards includes three sub categories which includes Doctor, Nursing and Dietician; having compliance 73%, 92% and 84% respectively which is shown in figure 6.
- Compliance of these three categories is compared with Overall IPD compliance which is 81.3%, shown in figure 6.
- Maximum and minimum compliance of all three subcategories is Nursing; 93.5% and Doctor; 87.7% respectively, shown in figure 6.

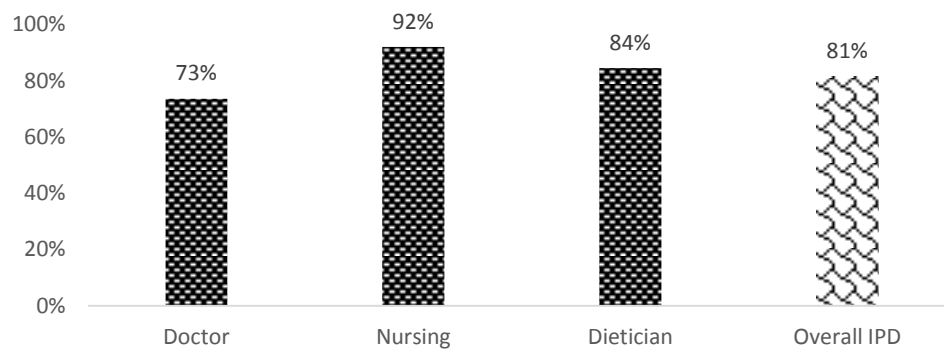


Figure 6 IPD Wards Documents Compliance comparing documentation done by doctor, nurse and Dietician

9.6 Compliance of in-patient files according to Ward Wise

- Total Six wards are there; 3A, 3B, 3C, 4A, 4B and 4C having compliance 79%, 78%, 84%, 82%, 79% and 81% respectively which is compared with overall compliance; 80% shown in green bar, figure 7.
- Maximum and minimum compliance of all the 6 wards is 3B; 78% and 3C 84% respectively, shown in figure 7.

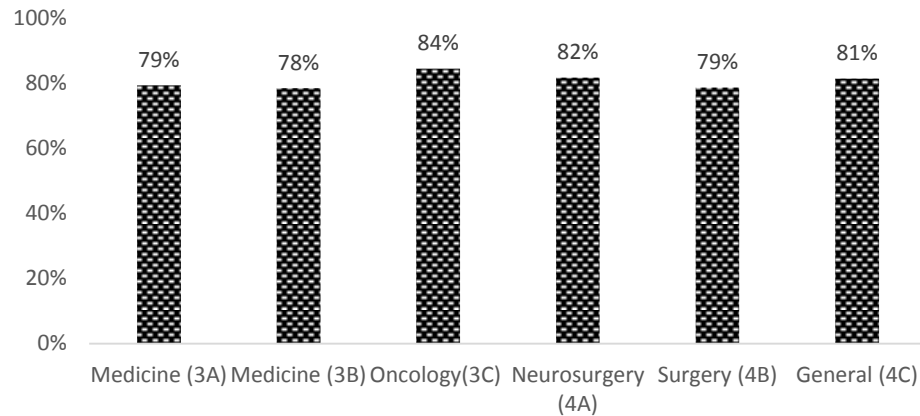


Figure7: Ward Wise, In Patient File Compliance

9.7 Doctor and Nurse In-patient documents Compliance in Wards

- In wards 3A, 3B, 3C, 4A, 4B and 4C doctors having compliance 72%, 73%, 77%, 76%, 67%, 76% respectively whereas overall doctor compliance is 74% as shown in figure 8.
- In wards 3A, 3B, 3C, 4A, 4B and 4C nurses having compliance 98%, 89%, 95%, 91%, 92% and 91% respectively whereas overall nurse compliance is 74% as shown in figure 8.
- Maximum Doctor and nurse compliance is 77% in 3C and 98% in 3A respectively as shown in figure 8.
- Minimum Doctor and nurse compliance is 77% in 4B and 8% in 3B respectively as shown in figure 8.

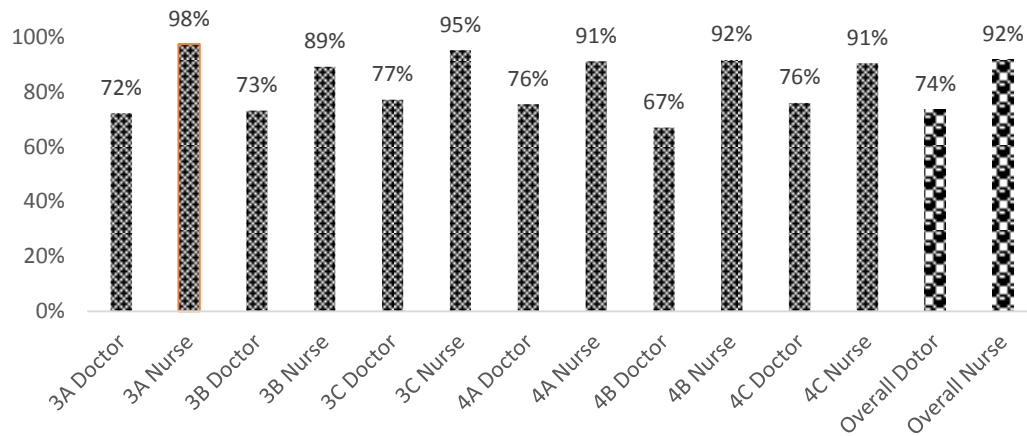


Figure 8 Doctor & Nurse In-patient Files Compliance in Wards

9.8 Compliance of all the segments under OPD, Emergency and IPD.

- Segments includes Casualty/ OPD Card, Admission Request Form (with plan of care), Admission Consent Form, Doctor, Nursing, Doctor assessment within defined Turn Around Time, Documented- Plan of care, Doctor reassessment Sheet, Pain Assessment, Name/Signed/Dated, Physician Order Sheet- (capital, dose, time, route, frequency) & Allergy, Nursing assessment (<30min of admission), Screening for pain on admission, Allergy Screening, Nursing Reassessment with name, date & sign and Nutritional screening (<24hours of admission) having compliance 88%, 87%, 94%, 63%, 33%, 69%, 73%, 94%, 37%, 94%, 75%, 92%, 96%, 88%, 92% and 84% respectively, show in Figure 9.
- Bars Highlighted in blue, yellow and grey comes under OPD, Emergency and IPD respectively.
- Minimum two are nursing; 33% compliance comes under Emergency and Pain assessment; 37% by doctor comes under IPD.
- Maximum is screening for pain on admission and Doctor Name/Sign/date which is 96% and 94% respectively, both comes under IPD.

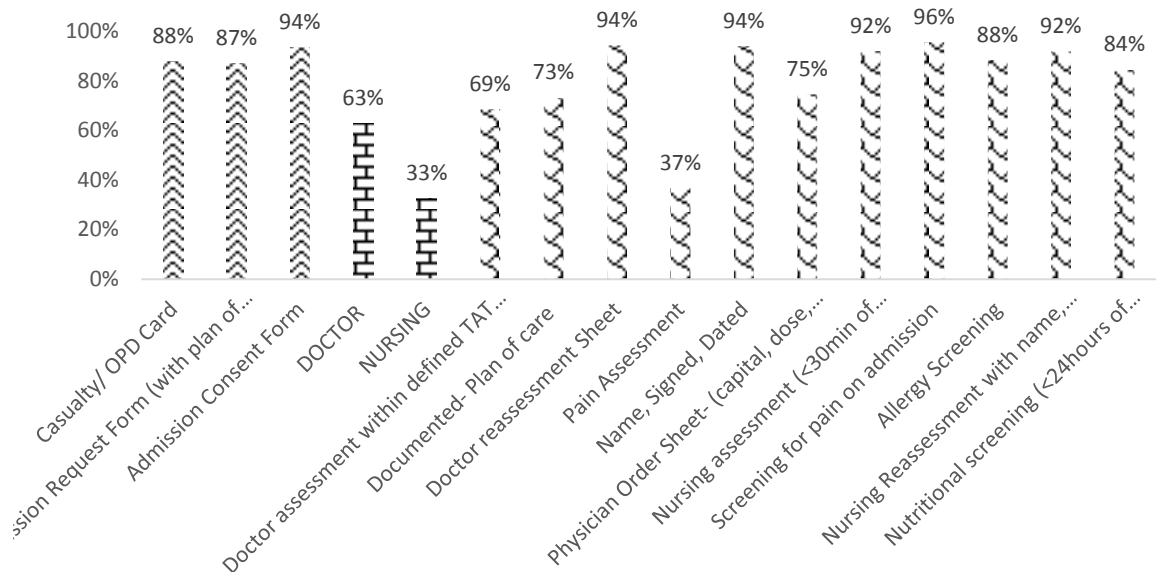


Figure 9 Comparison of all the segments under OPD, Emergency and IPD

9.9 Overall OT Compliance comparison with Doctor, Nurse and Anesthetist

- In below figure 10, the Doctor, Nurse and Anesthetist compliance which is 77%, 57% and 84% respectively is compared with overall compliance of OT which is 71%.
- Nurse compliance; 57% is least and Anesthetist compliance; 84% is maximum.

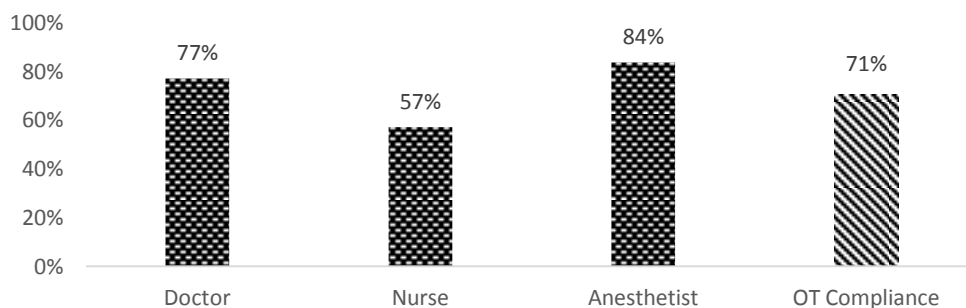


Figure 10 OT patients documents compliance comparing documentation done by doctor, nurse and anesthetist

9.10 Compliance of all the segments under OT

- Segments includes Pre-operative checklist (Surgical patient), Consent (Procedure/ Surgery/ High Risk), Details of implants, Details [Diagnosis, operation performed], Tissue sent for histopathology, Condition at the end of surgery, Disposition, Date/Time & Sign of doctor, Date Time & Sign of sister, Post-Operative Plan of care, Pre-anesthesia assessment, Anesthesia Plan, Post surgery notes by doctor, Surgical Safety Checklist and Blood and Blood Products Consent having compliance 86%, 82%, 57%, 99%, 67%, 74%, 76%, 62%, 22%, 81%, 87%, 82%, 92%, 40% and 54% respectively, show in Figure 11.
- Minimum two are date, time and signature of sister and surgical safety checklist having compliance 22% and 40% respectively.
- Maximum is Details [Diagnosis, operation performed] and Post surgery notes by doctor which is 99% and 92% respectively.

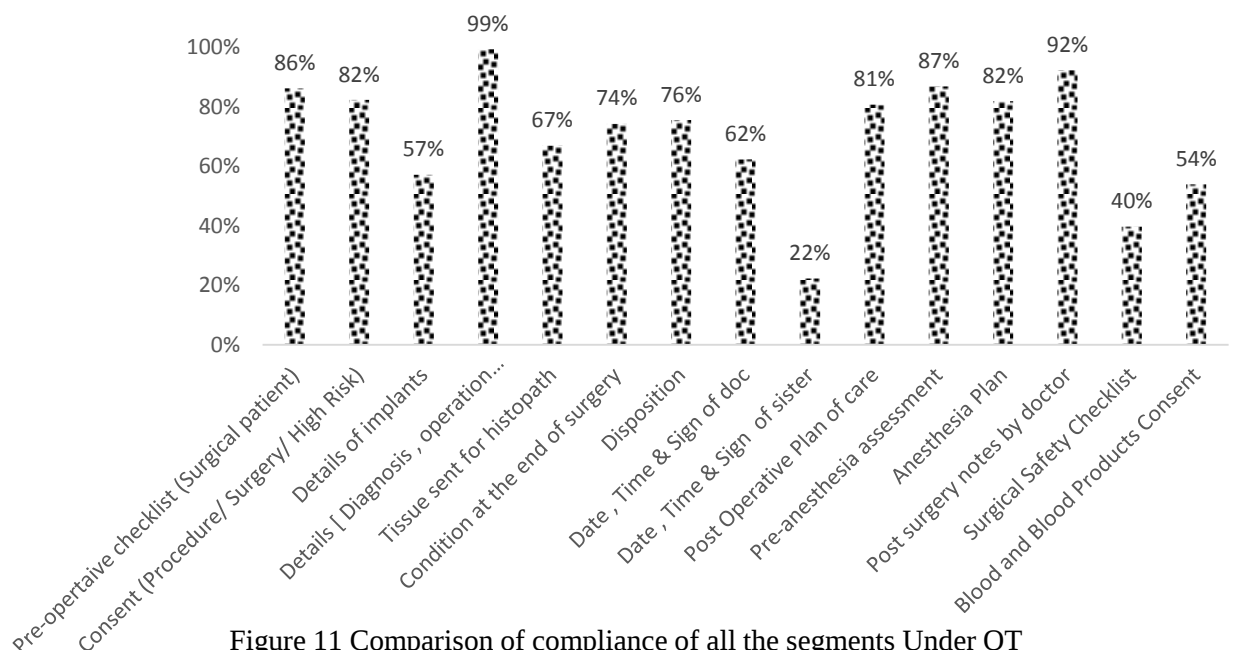


Figure 11 Comparison of compliance of all the segments Under OT

Other Observation Result:

- During the study period two documents; consent form and medication administration form format changed without training in all the areas of hospitals, which causes more documentation mistakes.

10.Findings

1. Overall compliance of the hospital is 76% and in that Department wise contribution is 90%, 47%, 81% and 71% by OPD, Emergency, IPD and OT respectively.
2. Emergency and OT is pulling down the overall compliance below 80%.
3. In Emergency, Nursing compliance; 33% is far less than doctors compliance; 63% which is also very less as compare to other departments.
4. In OT also nursing compliance; 57% is very less than Doctors compliance; 77.1% and Anesthetist compliance; 84%.
5. Under OT segments least compliance is 22% for date/time/sign of sister and Details [Diagnosis, operation performed] leads with 96% compliance.
6. Under OPD, Emergency and IPD segments least compliance is 33% for nursing comes under Emergency and screening for pain on admission under IPD leads with 96% compliance.
7. In Wards, Doctors are pulling down the overall compliance of doctor; 74% in wards and Nursing overall compliance in wards is 92%.

11.Discussion:

Monitor deficiencies and improvements. Educate practitioners who fall below accepted standards set by the practice. Make sure your compliance plan is active

along with the program and both are working and breathing documents. To overcome the challenges just like with any other goals, it should start with proper awareness and motivation. In this case, appropriate physician, nurses, other staff training and clinically oriented education should be provided. Solutions, the exact needs of the facility will be matched to the appropriate solutions. This way, physicians and nurses can document properly.

There is study done by (Boulay F, et al 1997) and analysis shows quality of medical file recordings should be improved as a large amount of data or important documents were missing: reason for hospitalization (having compliance 74% of files), operation report (found in 83% of files) and discharge summary (found in 67% of files) whereas the study in paras hospital also large amount of important data was missing; OPD documentation (having compliance 90%), emergency documentation (found in 47.5% of files), IPD documentation (found in 81% of files) and operation theatre documentation (found in 71%).

These results show that proactive monitoring and auditing are essential to test and confirm compliance with legal requirements. The auditing function is the check and balance for your documentation which also guides us the improvements areas which also leads to quality care.

12.Suggestions

1. Conduct a baseline medical record audit to identify areas that may require, corrections and make hospital staff education and training.

2. Document format would be consistent so that employees would not have to learn a new or different system every time within the same facility.
3. Practice- based learning and improvement: requires that employees be actively involved in monitoring their own clinical practices and improving the quality of care based on a systemic review of the care they provide.
4. Direct feedback such as that provided by 'report cards' on performance.
5. If other health professionals including medical staff have allocated time for audit, then nurses should accept the same privilege. Responsibility for quality is shared by individuals and organization and as nurses constitute the majority of ward staff, their involvement is necessary to represent patient care.

13.Limitations

- Staff was not supportive therefore it took time to understand the process of documentation.
- Medical documents audit cannot assess the quality of important aspects of the encounter. For example- documentation of the cardiac examination says nothing about the skill of the examiner and quality of patient instruction by the physician cannot be assessed.
- The current lack of consistency in medical documents organizational format will continue to hamper the standardization of medical audit.

14.Ethical Considerations

- Permission will be obtained from the Head admin of quality department of hospital.
- Privacy, confidentiality and anonymity will be guarded.
- Scientific objectivity will be maintained with honesty and impartiality.

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