QUALITATIVE ANALYSIS OF PATIENT DOCUMENTATION

Dissertation Submitted to

The IIHMR University, Jaipur

For the partial fulfilment for the award of the degree of

Master of Business Administration (MBA)

In

Hospital and Health Management

Management by

Dr. Ekta Shukla

Under the Supervision and Guidance of

Sunita Nigam

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Appendix D: Declaration by Student

Declaration By Student

Thereby declare that this dissertation titled…Qualitative Analysis of Patient Documentation at Apollo Hospital Noida….is the bonafide record of original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature)

Ekta Shuka

Date: 1-7-22

Appendix E: Completion Certificate

CERTIFICATE

This is to certify that Dr. Ekta Shukla in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur has successfully completed her internship at Apollo Hospitals Noida, during March 22,2022 to June 19,2022.

Preceptor/Head of the Organization

Apollo Hospitals Noida

Place:

Date:

DISSERTATION

Qualitative Analysis of Patient Documentation at Apollo Hospitals Noida

Abstract

Introduction: Medical file allows health management specialists to create and evaluate a patient's medication. Research was performed out to do a clinical audit of in-patient documentation at Apollo Hospitals Noida where the current documentation adheres to the established policy. **Methods:** Descriptive cross-sectional study was aimed in medical records of various Departments like General surgery, Obstetrics and Gynaecology, Neonatology, Orthopaedics, Oncology. Convenient sampling is used in documentation of in-patient records. Sample size was 100 case sheets. Source was the records of discharged patients available in medical record section visiting in the month of April and May. A structured checklist with 17 forms. **Results**: Findings: In this study I founded the Compliance and Non-compliance Percentage of 17 forms in total of 100 medical records. After auditing these files, I found that compliance percentage of clinical chart is highest among these parameters which is 97.88 while least compliance percentage is found in Physician Order Sheet which is 68%. And the highest Non-compliance is found in Physician Order Sheet which is 32% and the least Non-compliance is found in Clinical Chart. **Conclusions:** The present study concluded that there are some insufficiencies found in medical records especially in physician order sheet, Nutrition Assessment screening Form. The medical record has been maintained according to the NABH and JCI Accreditation. The medical records are important for:1-Recommendations. 2- Accreditation. 3-When required by the police or the court on a written deposition. 4- When required by insurance companies in accordance with the Financial Services act when the patient has waived his rights by accepting the insurance.

Key words: Qualitative Analysis, medical record, hospital, clinical audit

Acknowledgement

I would like to recognize my solemn thanks to our **Institute, Indian Institute of Health Management** Research to give me such an opportunity so that we can enhance knowledge in Hospital related distribution.

I genuinely thankful to **Mr. Raj Raina**, Unit Head, Apollo Hospitals Noida, for giving me opportunity to do the Dissertation in such an elite Hospital.

I would like to express my warm gratefulness to **Dr. Neha Minocha**, Quality and Operations Department Head, Apollo Hospitals, Noida for her support. From her busy schedule she took some time for me, helps me to know how the organization run and taught various things in order to facilitate my training. She is always there to help; without her I can't imagine to complete my Dissertation in a fluent way.

Thanks to my Institutional mentor **Sunita Nigam** at IIHMR University, Jaipur for completing this Dissertation and guide me in every step and clearing all my doubts about the Dissertation. And last but not the least thanks to my family and friends for their care and support, without them it is impossible to complete this Dissertation.

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Abbreviations

C/C	Chief Complaint
Dr.	Doctor
MRI	Magnetic Resonance Imaging
ECG	Electrocardiogram
GA	General Anaesthesia
UHID	Unique Health Identification

CHAPTER SCHEME

CHAPTER 1

1-Introduction

Medical documents (Physical, electronic) both contain information that specifies every aspect of the patient's condition. For the treatment of patients, clinicians, paramedics, and other healthcare professionals demand medical information. Medical files serve as a link between doctors, patients, and other healthcare professionals. When it is necessary or there is an issue, healthcare information provides legal protection for patients, healthcare practitioners, and hospitals. Health records also play an important role in providing financial information and establishing treatment costs, as well as supporting medical training, hospital services, and medical research.

If the quality of healthcare information is increased, the above objectives will be met. Healthcare quality is determined by the quality of collected data in every healthcare facility, and data quality is frequently studied rather than healthcare quality.

Doctors don't spend enough time creating the reports required for inpatient records, and they don't transmit them to the medical file unit either for finishing documentation whose faults are stated by defect elimination forms and are of lesser importance to doctors. As a result, a solution for eliminating faults is required so that medical data can be used to achieve the aims for which they are kept.

Health files remains furthermost essential, very genuine, and fundamental source of healthcare knowledge in the information age and skills since they are founded on medical scientific truths. There will be a significant change by scientifically maximizing health records thus according international norms and conditions, taking into account record keeping ethics and correct frameworks, applying systematic storing methods, and quickly saving, storing, and retrieving them.

Various forms, are included in a health record, as per the Indian Ministry of Health:

- Discharge Summary Sheet with a Unique patient Id and attending doctor’s signature.

- Consent form for procedure, Treatment, Anaesthesia, obstetrics, Analgesia, Sedation, High Risk Consent, High Risk Informed Consent and Request for starting Chemotherapy Risk, Benefit. The Consent forms should be completely filled with no use of abbreviations, signature of the patient, witness and doctors should be there and date should be properly written. In COVID -19 Consent Form all the details of the patient should be mentioned.
- Admission form Sheet should Have full information of patient with its address, contact number and email address. In patient history of patient. There are two parts of the form one with patient details and other with details of the billing process.
- Daily Record Nursing with information of Pain score, time, location, post intervention score, special notes taken from, fall risk measures taken. Handover signature, assigned nurse name and signature, date, time and their clock no.
- Recovery Nursing Record, Monitoring; Sign and Discharge Criteria like BP, respond to verbal stimuli, respond to painful stimuli, pain score, intervention, signature, Goal, action plan, intervention outcome, shifting notes such as time, respiration rate, Heart rate BP, SPO_2 and signature all should be filled before the patient discharges.
- Nursing Admission Assessment & Action Record includes basic information, orientation to environment, patient rights and responsibilities like privacy, confidentiality, identity of care givers, valuables, diet plan.
- Nutrition Theory Plan, Nutrition, Assessment Screening Form assessment of patient's nutritional status will be conducted by dietician within 24 hours of admitted patients.
- Patient and Family Education Documentation contains literacy or Education level, language known, ability to learn, signatures of patient, Nurse, Dietician, Doctor, Physiotherapist
- Adult in Patient and physical Record Patient includes history of present illness, presenting complaints, history of present illness, physical examination, pertinent family history.
- Apollo Fall Risk Assessment Tool (AFRAT) includes scoring of fall risk with the signature of patient and Doctor.
- Clinical Chart, vitals of the patient are recorded by the doctor.
- Physician Order Sheet includes the medicine name that is given to the patient and it should be written in capital letters with ordered date and signature.

- Surgical Safety Checklist it should include all the Sign In (Consent verified, Correct procedure verified, site marking, site marking); Time Out (Patients name, UHID, procedure, site, side, consent); Sign Out (Name of procedure confirmed, instrument, sponge and needle counts); Name and Signature of Surgeon; Name and Signature of Nurse; Name and Signature of Technician; Date; Time
- Anaesthesia Record Sheet (Pre-Operative Assessment; Post Operative Instructions; Intra Operative Monitoring; Signature)

Research Question:

What is the Compliance and Non-Compliance of in-patient medical records at Apollo Hospitals Noida and how to improve the gaps found in medical documentation?

3-Objectives

Analysis of in-patient medical records maintained at Apollo Hospitals in Noida.

• To assess if the present documentation process complies with the hospital's established policy.

•To describe the gaps in inpatient medical file and to suggest some potential improvements.

CHAPTER 2

Review of Literature

Article 1

Title-

Medical Review of Inpatient Medical Record Documentation at an Indian Multispecialty Hospital

Author name- Madhav, Saroj, Bhandaru

Source- 10.5005/jp-journals-10035-1080

Study Design-Retrospective, descriptive study

Objective- To determine whether the current documentation process complies with the hospital's established policy.

Methodology- All hospitalised patient medical records from a specific ward from the previous 12 months were thoroughly sampled at random. 40 case sheets from each department made up the 320-case sheet sample. The medical record section's discharge case files for the previous 12 months served as the primary source for the data collected, which were primary in nature.

Findings or outcome- The records from the Pediatric and Gynecology departments were deemed unacceptable. The dermatology and psychiatry departments record keeping were deemed adequate per established policy. The scheduled treatment was not prepared according to the surgery department's established protocol.

Article 2

Title- In Patient Medical records in improving Completeness Menelik II Referral Hospital, Addis Ababa, Ethiopia

Author name- Haftom Abebe, Yemane Gebremariam, and Birhanu Jikamo

Source-https://doi.org/10.1155/2017/8389414

Study Design- The study design used by Menelik II Referral Hospital of in Patient department is Pre- and postintervention study.

Objective- To raise the Menelik II Referral Hospital's inpatient medical record completion rate from 73% to 93% by the end of April 30, 2016.

Methodology- Inpatient medical record completion in Menelik II Referral Hospital was studied before and after the intervention between September 2015 and April 2016. Simple random sampling was employed. Data were gathered using a data eradication checklist, and an unconventional sample t-test with a 95% confidence interval was used to examine statistical differences between before and after intervention outcomes. A value of less than 0.05 was deemed statistically significant.

Findings or outcome- Inpatient medical record completeness significantly improved after a straightforward set of treatments that included training healthcare providers and changing the structure of the records. It is advised that the Chief Executive Officer and Quality Officer of the study hospital develop and implement intervention programmes to enhance medical record completion.

Article 3

Title- Qualitative Analysis in Improving the Medical Record Documentation in a Training Hospital

Author name- Sedighe, Nahid, Elahe

Source- https://www.ijeehs.org/text.asp?2015/1/1/22/159923

Study Design- Descriptive analytical and cross sectional was the study design.

Objective- To research how doctors in a training hospital record the status of health files.

Methodology-. Inpatient medical records from 2012 were the population, and 389 medical records were selected as samples using stratified sampling. After the data were gathered, SPSS 13 software was used to evaluate both descriptive and inferential statistics, and the results were then presented in statistical tables.

Findings or outcome- The presence of progress notes receives the highest percentage, whereas the timing of the doctor's initial visit receives the lowest percentage. The most unfinished item in the NICU, cardiovascular, psychiatric for men, surgical for women, intensive care, emergency, children, and mental for women wards was progress notes. The most deficient item in the wards of CCUII, internally for women, infants C, and internally for males, was the absence of a physician's signature on the summary sheet.

Article 4

Title- In patient Documentation for Medical Audit in a Multispecialty Hospital

Author name- Vipin Jain, Rohin Garg

Source- Pravara Med Rev 2019; 11(3) September – November 2019

Objective-To achieve the goals in analysis to analyze and improve medical record department

Methodology- The study, which lasted a full year, examined the documentation of medical audits at our own teaching hospital (Teerthanker Mahaveer Medical College, Hospital & Research Centre, Moradabad, Uttar Pradesh, India), a specialty care facility with 900 operational beds. The data so collected was through brainstorming, observation, interview, and review of workflow during the lean sessions was conducted.

Findings or outcome- In 100 entries, the care given to patients in the general surgical and medical wards did not follow the established routine. Almost all departments failed to mark the food order in the given medical records. Particularly in the general medicine department, the majority of departments lacked details for the date, name, and sign in the medical record.

CHAPTER 3

Methodology

Study Design- Descriptive Cross-Sectional Study

Setting-Apollo Hospitals, Noida (Sector 26) is a 75 bedded hospital having facilities in different medical and surgical department. It is certified by NABH and it follows best practices in different department of Orthopedics, Spinal Surgery, Renal Transplant, AHC. The doctors and team offer world's best care always puts their patients first. All necessary protocols of COVID 19 safety measures are followed here. Latest diagnostics of medical and surgeries are available for the care of the patients.

Study Population:

- **Inclusion Criteria**

  Medical records of General surgery, Obstetrics and Gynaecology, Neonatology, Orthopaedics, Oncology.
- **Exclusion Criteria**
  - Medical records of patients who are declared dead or those who are brought dead.
  - Out Patients medical records are excluded.

- **Study tools**

Indian Standard Ministry of Health inpatient documentation were involved in this study. And for these 17 types of forms were included in this study:

- Discharge Summary
- Admission form
- Nutrition Theory Plan

- Nutrition, Assessment Screening Form
- Nursing Admission Assessment & Action Record
- Clinical Chart
- Patient and Family Education Documentation
- Adult in Patient and physical Record
- Apollo Fall Risk Assessment Tool (AFRAT)
- Daily Record Nursing
- Recovery Nursing Record
- Physician Order Sheet
- Surgical Safety Checklist
- Anaesthesia Record Sheet
- Consent form for procedure, Treatment, Anaesthesia, obstetrics, Analgesia, Sedation, High Risk Consent
- High Risk Informed Consent and Request for starting Chemotherapy Risk
- COVID -19 Consent Form

Duration of study

This study is conducted in 3 months from 22 Mar 2022- 19 Jun 2022.

Sample Size

Convenient sample of all inpatient medical files visiting in the month of April and May 2022. Sample size is 100 case sheets.

The following records were evaluated for checking the completeness of the documents: Discharge Summary (Reason for admission, diagnosis & comorbidities; Physical and other findings; Discharge medication; Follow up instructions; Completeness; Signatures), Nutrition Theory Plan (Completeness) , Admission form (IP No./OP No; Patient details; All pages have patient ID; Name of Emergency; Contact & Phone Number noted in record; DOA and Time), Clinical Chart (Completeness), Patient and Family Education Documentation (Completeness), Adult in Patient and physical Record (Completeness), Nutrition, Assessment Screening Form (Completeness), Apollo Fall Risk Assessment Tool (AFRAT) [Completeness; Signature], Daily Record Nursing (Completeness), Physician Order Sheet (All

Orders written here (In Capital letters); Legibility; Orders Signed; Orders dated; Orders Timed), Recovery Nursing Record (Monitoring; Sign; Discharge Criteria), Surgical Safety Checklist (Sign In; Time Out ; Sign Out; Name and Signature of Surgeon; Name and Signature of Nurse; Name and Signature of Technician; Date; Time; Completeness), Anaesthesia Record Sheet (Pre-Operative Assessment ; Post Operative Instructions; Intra Operative Monitoring; Signature), High Risk Informed Consent and Request for starting Chemotherapy Risk, Benefit, Alternative(if any) [Use of abbreviation; Date; Time; Signatures; Witness), Nursing Admission Assessment & Action Record (Timeliness; Completeness; Legibility; Accuracy of AFRAT score), Consent form for procedure, Treatment, Anaesthesia, obstetrics, Analgesia, Sedation, High Risk consent (Completeness; Signature), COVID -19 Consent Form (Completeness).

For evaluating the comprehensiveness of documentation three scoring system is used:

Good Documentation: The documentation is considered to be good if its percentage is above 80%

Average Documentation: The documentation is considered to be average if its percentage lies between 60-80%.

Poor Documentation: The documentation is considered to be poor if its percentage is below 60%

Sampling Technique – Convenience Sampling is used for conduction of this study.

Data collection procedure

The source of the secondary data was the medical record section's discharge case files for the months of April and May. Data gathering was done using a qualitative methodology. The methods used were observation. A handful of the quality indicators were used to create a structured checklist (an audit tool).

Operations definitions-

Medical audit- This method consists of the analysis of retrospective data obtained from records.

Completeness of Medical Record - A document is completed when all the essential information which is built in this supplied file format with annexure and every access should be signatured with proper date.

Inpatient Medical Record - The authorized file of patient which encompasses actualities of the patients who are admitted in the general ward.

6-Data Analysis Plan-

Variables will be summarized using frequency and percentage distribution. The Data collected are transferred into Excel and SPSS for the statistical analysis. Pareto chart is used for Quality improvement. Below the UHID of every patient, Tick, cross and NA is used in the checklist for analysis of medical record.

Pareto Analysis

The Pareto Chart includes a line graph and a bar chart. There is only one x-axis and two y-axes in a Pareto chart.

The frequency [number of times] of each cause category is shown on the left x-axis. Data will be displayed that is categorical (nominal), ensuring that it may be categorized by a term (non-numeric data).

The total percentage of causes is represented on the right y-axis. The first bar represents the reason with the highest frequency.

A Pareto chart helps a quality assurance prepared on the areas that will have the biggest impact.

The pareto principle or the 80/20 rule can be determined using the 80 percent finish line.

The law of "The Vital Few and Trivial Many" is another name for the Pareto Principle.

Vital Few refers to the idea that many problems have a lot of relatively common causes. The sections in vital view are shown by cumulative percent sample points that are below the 80% line. To achieve a significant change, these are the top concerns that must be addressed.

Trivial Many talks about there being a lot of persistent causes, which develop into hardly any problems. The variables that are over the 80% line represent the trivial many.

They won't have a significant impact on decreasing the total issue, which is the medical error percentage, even if they are decreased or removed.

7-Ethical Consideration-

Due to retrospective study, everything was very challenging to secure the specific consent of each patient, as is needed by ethics, for the use of their information in study. However, when access to health records is necessary for the research and permission is impractical, local research ethics bodies may accept such studies. However, local research ethics committees can approve such research when access to health records is essential for the research and consent is not practical. Continuing by the principles of the Data Protection Act e.g., make sure that patient and staff information confidential and guaranteed that the data is collected and stored properly

CHAPTER 4

Results and Discussions

Results:

- In this study it was found that the Compliance, Non-compliance and Not applicability (here not applicable means the file of General Surgery, the High-Risk Informed Consent and Request for starting Chemotherapy Risk form is not applicable) of 17 forms in 100 medical records.
- After auditing these files, it was found that compliance percentage of clinical chart is highest among these parameters which is 97.88 while least compliance percentage is found in Physician Order Sheet which is 68%
- The highest Non-compliance is found in Physician Order Sheet which is 32% and the least Non-compliance is found in Clinical Chart.
- Noncompliance of physician order sheet is due to medicines prescribed by doctors were not written in Capital letters and unable to read easily.

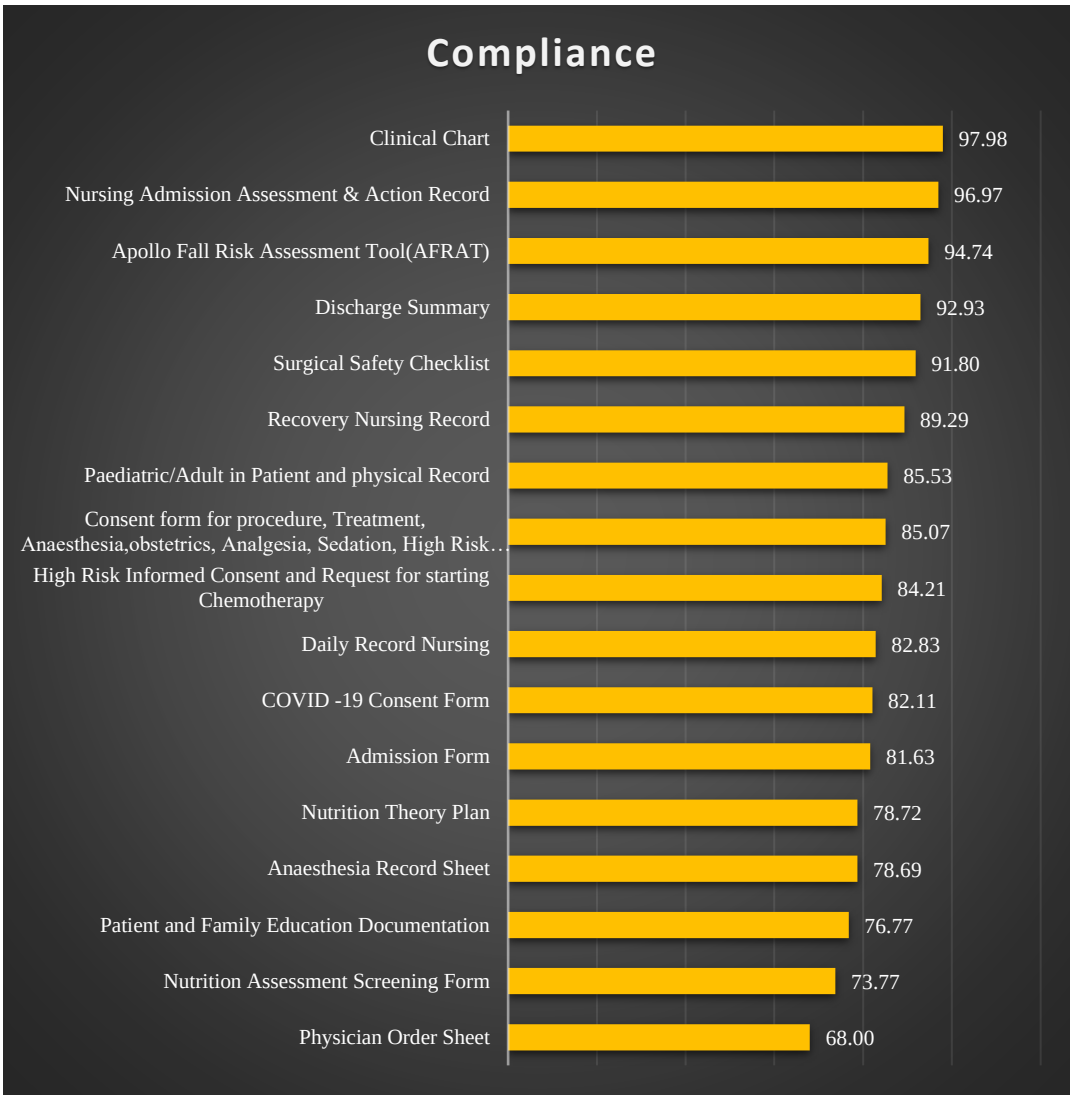

Figure 4.1 Decreasing order of Compliance Percentage of 17 forms in 100 medical records

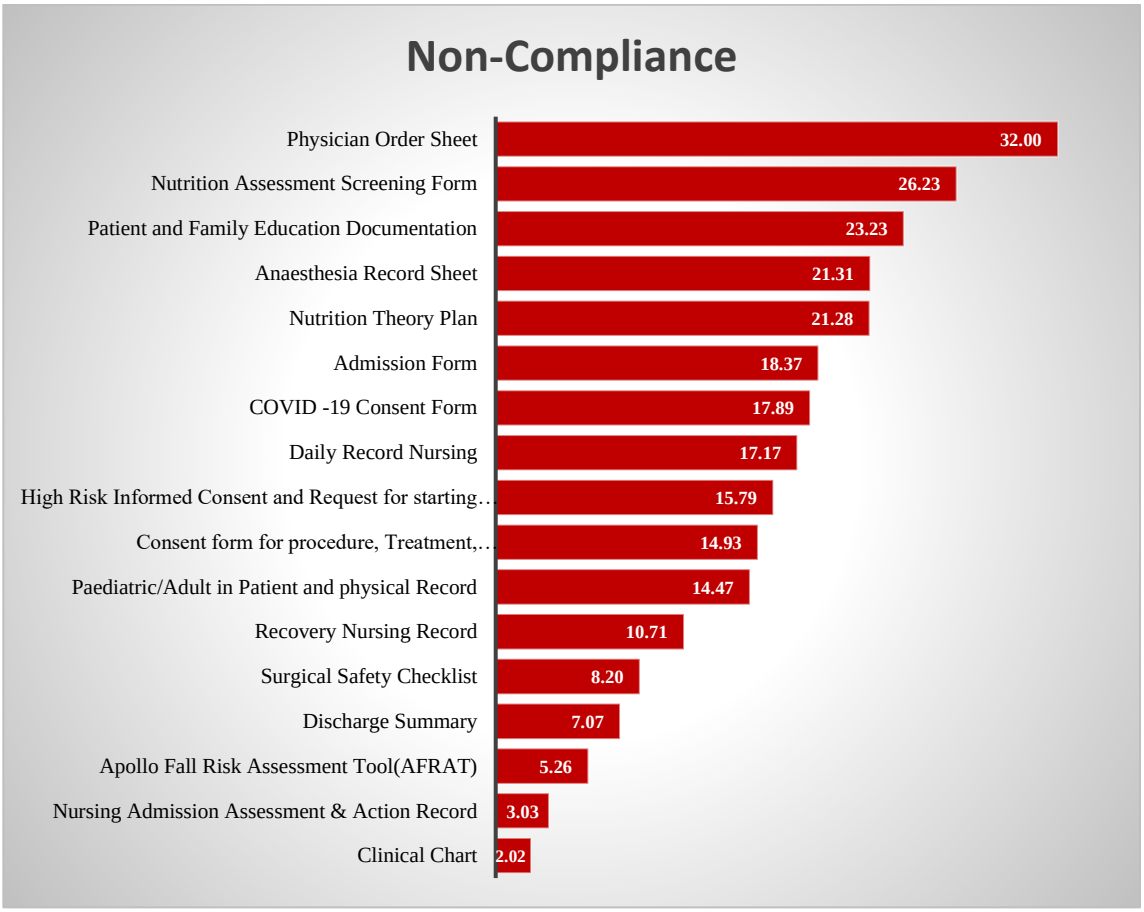

Figure 4.2 Decreasing order of Non-Compliance Percentage of 17 forms in 100 medical records

Pareto Analysis

In Pareto chart of compliance of medical records founded on the Observation during the study that from Physician Order Sheet to Paediatric is the vital view which can be checked so that the medical error can be improved.

The Trivial many in this chart is from Recovery Nursing Record to Clinical Chart. We have to focus least on this as it can hardly improve the medical documentation.

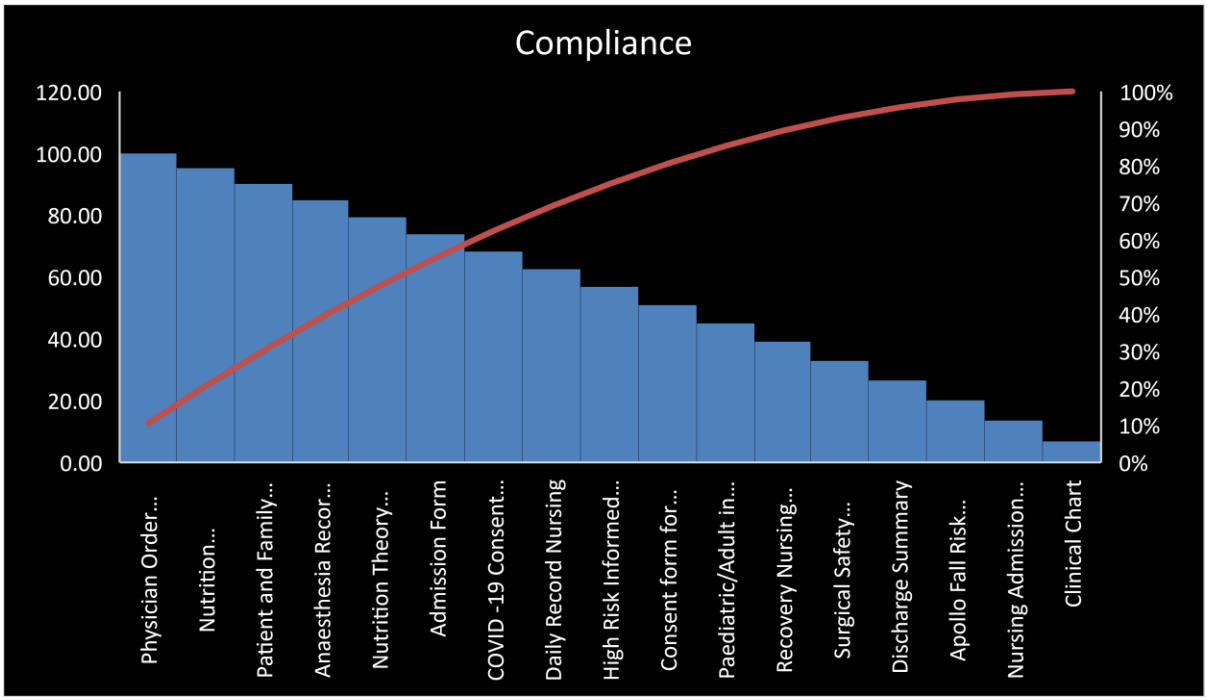

Figure 4.3 *Pareto chart of Compliance frequency*

In the pareto chart of Non-compliance from Clinical Chart to COVID-19 Consent form is the vital view and is the cause of 80% problems and need to improved.

While from Admission to Physician Order Sheet is the trivial view which cause very few problems i.e., 20% and least to be bothered about.

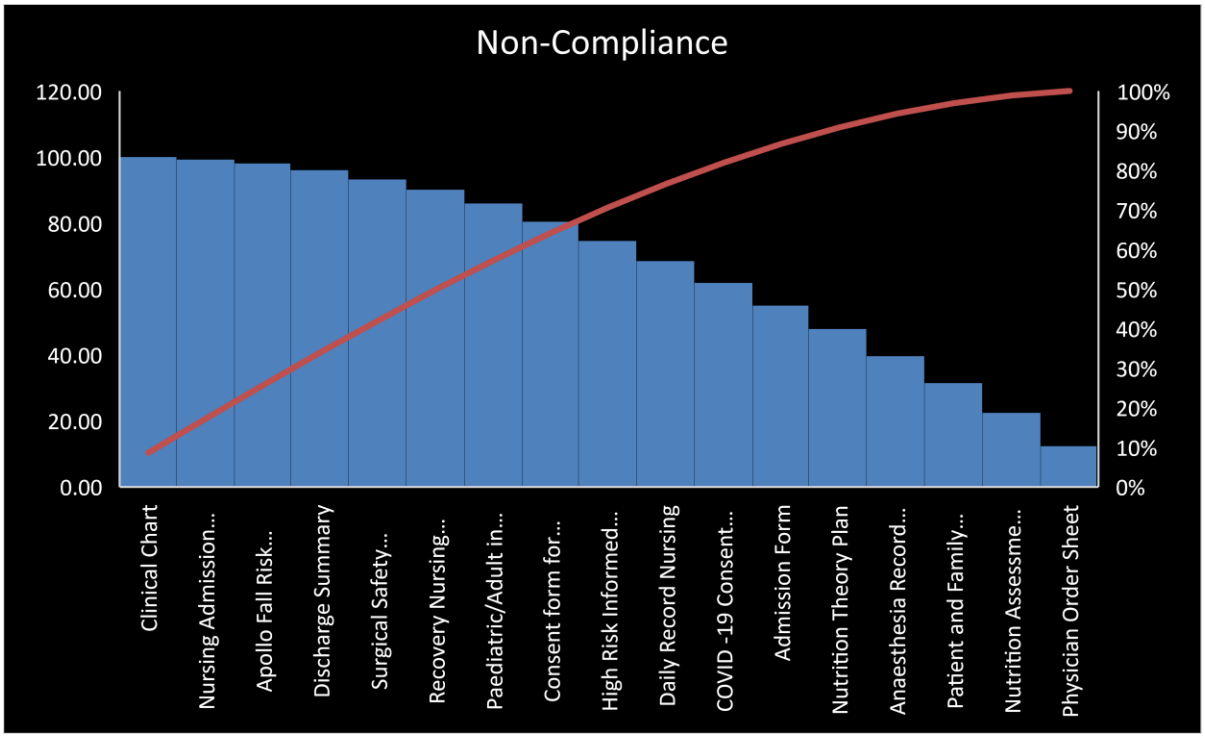

Figure 4.4 Pareto chart of Non-Compliance frequency

- In all the medical records of 100 Patients the Average Compliance rate is 84.77 and average Non-compliance is 15.23.
- Individual file the average Compliance is 85.47 and average Non-Compliance is 14.53

Average Compliance	Average Non-Compliance
84.77	15.23

Table 4.1 Average Compliance and Non-Compliance of 100 Medical records

Average Compliance	Average Non-Compliance
85.47	14.53

Table 4.2 Average Compliance and Non-Compliance in individual file

- The Compliance of Discharge Summary Sheet is 92 while that of Admission form is 80, whereas the noncompliance of discharge summary is 7 and for Admission form is 18.
- While the discharged summary form which is not applicable in the file is 1 and that of Admission form is 2.
- The main reason for non-compliance of discharge summary is signature of the consultant is missing and that for Admission form is patient's details are not filled properly, in some forms the address is missing, while some have missed the details about the insurance.

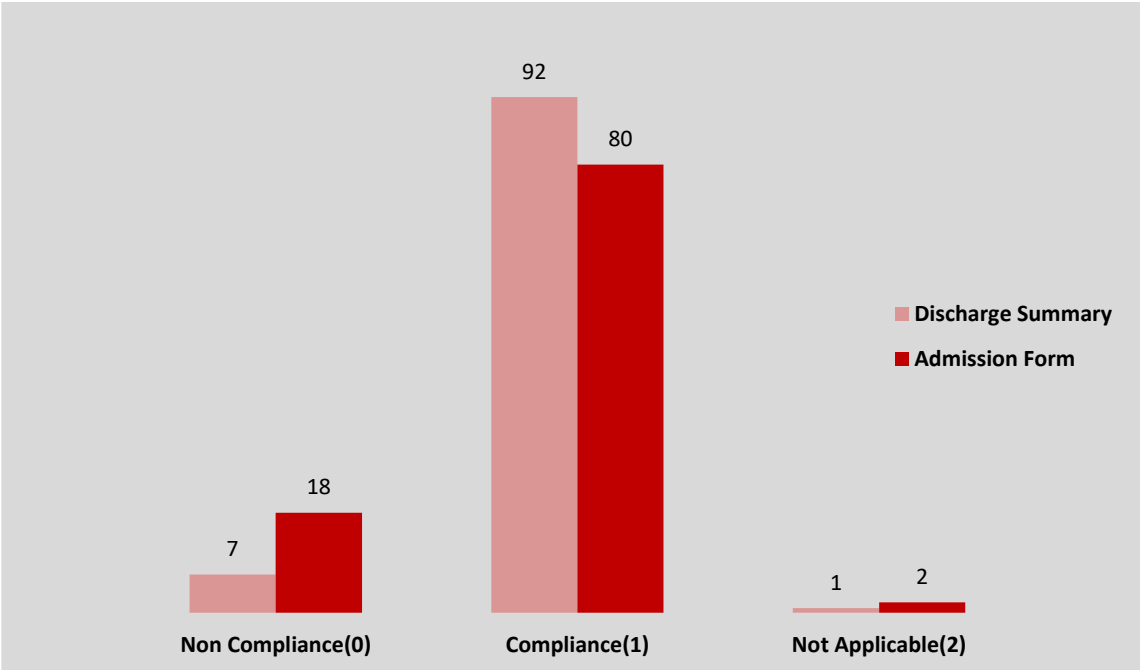

Figure 4.5 Compliance and Non-Compliance and Non applicability of Discharge Summary and Admission Form

- Compliance for Nutrition, Assessment Screening Form is 45 while that of Nutrition Theory Plan is 37.
- Non-compliance for Nutrition, Assessment Screening Form is 16 while that of Nutrition Theory Plan is 10.
- The major reason of non-compliance in Nutrition Assessment screening form is signature of doctors, nurses, physiotherapist, Dietician are missing in some forms while in Nutrition theory plan the diet is mentioning but its signature are missing.

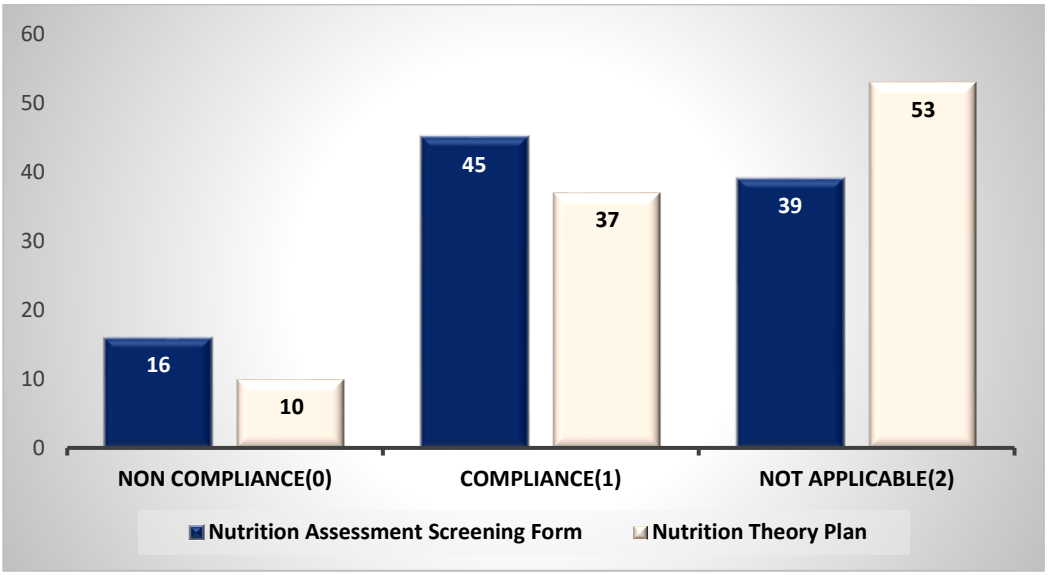

Figure 4.6 Compliance and Non-Compliance and Non applicability of Nutrition Assessment Screening Form and Nutrition Theory Plan

In all 100 medical records,

- The Compliance of consents form High Risk Informed Consent and Request for starting Chemotherapy Risk, Benefit is 16, Consent form for procedure, Treatment, Anaesthesia, obstetrics Analgesia, Sedation is 57, COVID -19 Consent Form is 78.
- While Non-Compliance of High-Risk Informed Consent and Request for starting Chemotherapy Risk, Benefit is 3, Consent form for procedure, Treatment, Anaesthesia, obstetrics Analgesia, Sedation is 10, COVID -19 Consent Form is 17.
- In High-Risk Informed Consent and Request for starting Chemotherapy Risk, Benefit is the form not applicable is 81, and that for Consent form for procedure, Treatment, Anaesthesia, obstetrics Analgesia, Sedation is 33, and 5 COVID -19 Consent Form are not available.

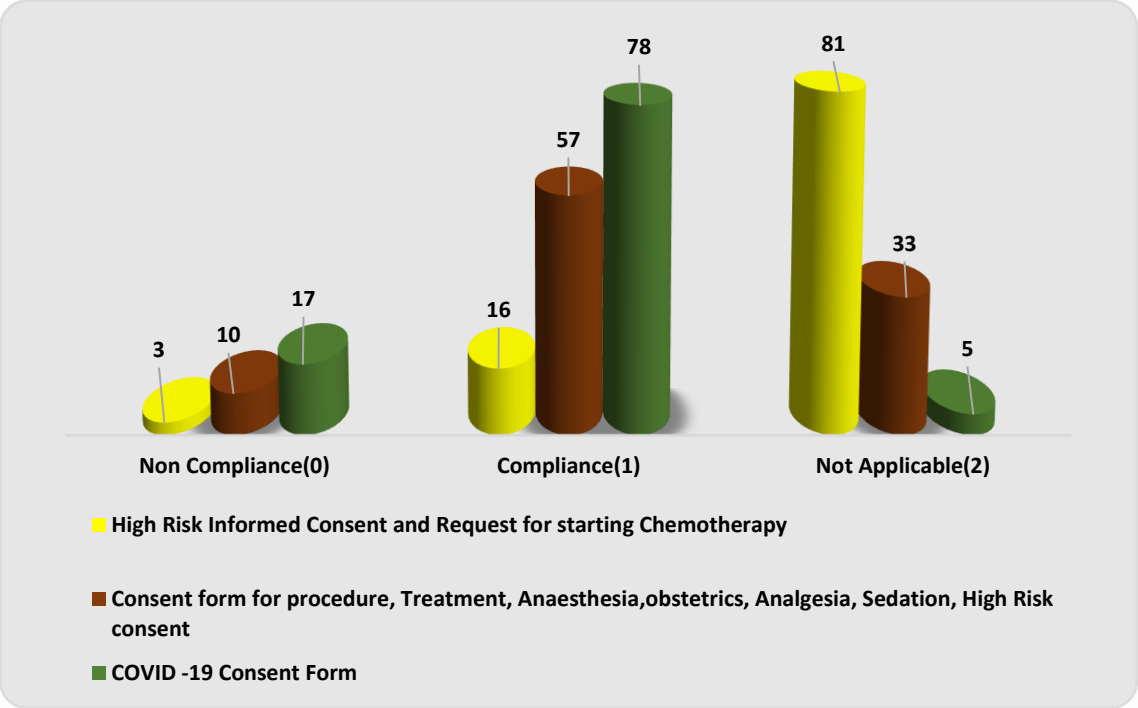

Figure 4.7 Compliance and Non- Compliance and Non applicability of High-Risk Informed Consent and Request for starting Chemotherapy Risk, Benefit, Consent form for procedure, Treatment, Anaesthesia, Obstetrics, Analgesia, Sedation, High Risk Consent,Covid-19 Consent Form

- In all 100 medical records, there are 90 medical records of Apollo Fall risk Assessment Tool (AFRAT) where the compliance is found and in 5 medical records the non-compliance found and in 5 medical records this form is not applicable (here fall implies that an individual comes to floor or decreased level accidentally).
- Noncompliance mainly found in the Signature of the Patient and the doctors

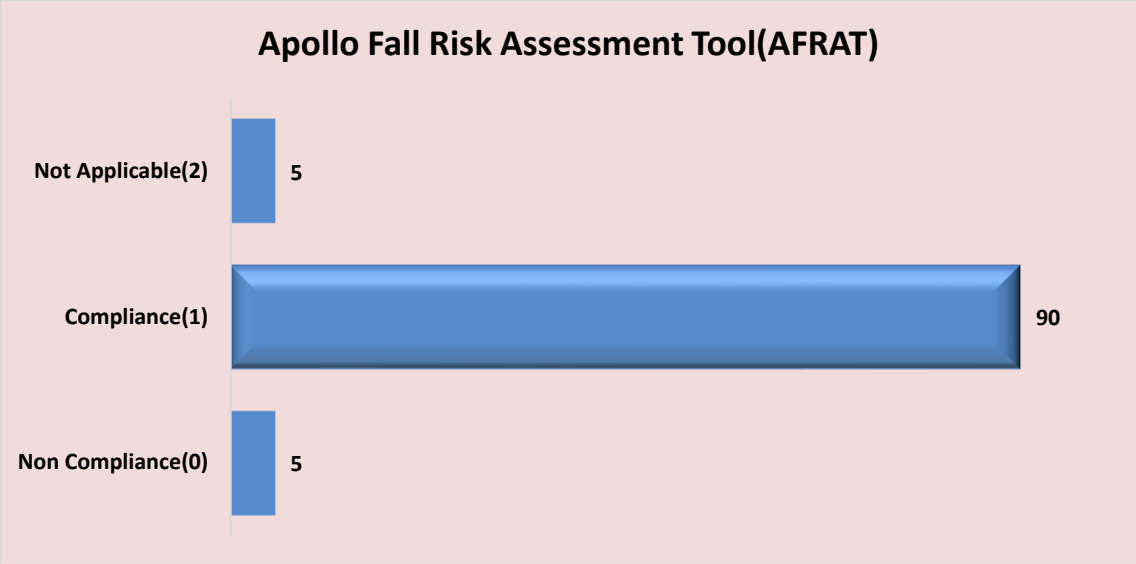

Figure 4.8 Compliance and Non-Compliance and Non applicability of Apollo Fall risk Assessment Tool (AFRAT)

- Compliance for Surgical Safety Checklist is 56 for Anaesthesia Record Sheet is 48 and that for Physician Order Sheets, is 68
- Non-Compliance for Surgical Safety Checklist is 5 for Anaesthesia Record Sheet is 13 and that for Physician Order Sheets, is 32.
- Forms not applicable for Surgical Safety Checklist is 39 for Anaesthesia Record Sheet is 39.

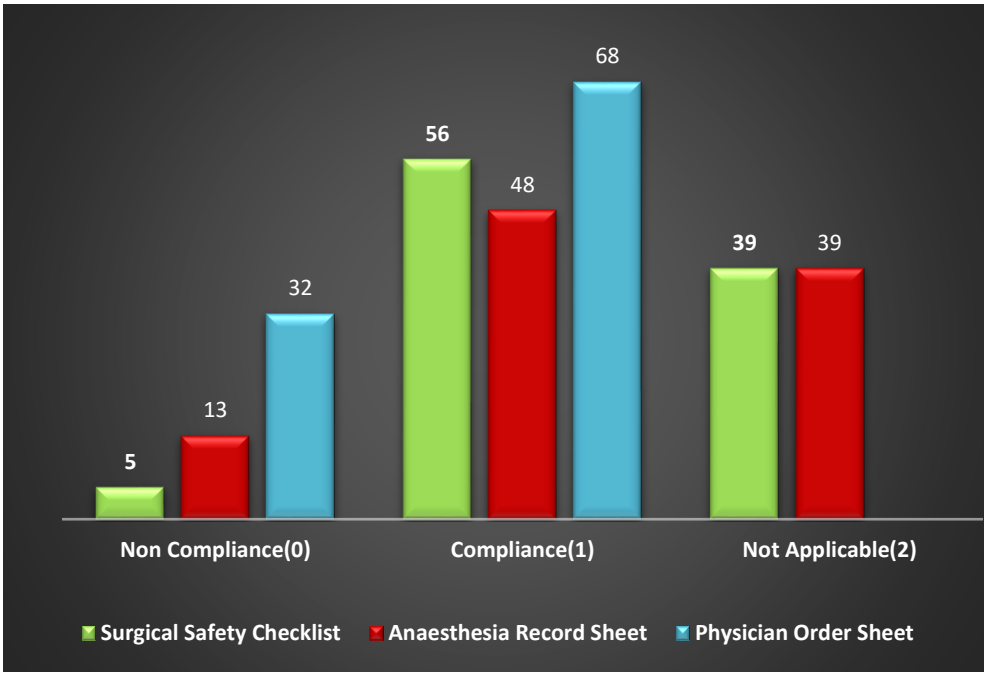

Figure 4.9 Compliance and Non-Compliance and Non applicability of Surgical Safety Checklist, Anesthesia Record Sheet, Physician Order Sheet

- In Daily Record Nursing, compliance is 82, while in Nursing Admission Assessment & Action Record and Recovery Nursing Record it is 96 and 50.
- Non-compliance for Daily Record Nursing, compliance is 17, while in Nursing Admission Assessment & Action Record and Recovery Nursing Record it is 3 and 6.

- Daily Record Nursing Form, Nursing Admission Assessment & Action Record form is not applicable only in one medical record. While in 44 medical records Recovery Nursing record form is not applicable.

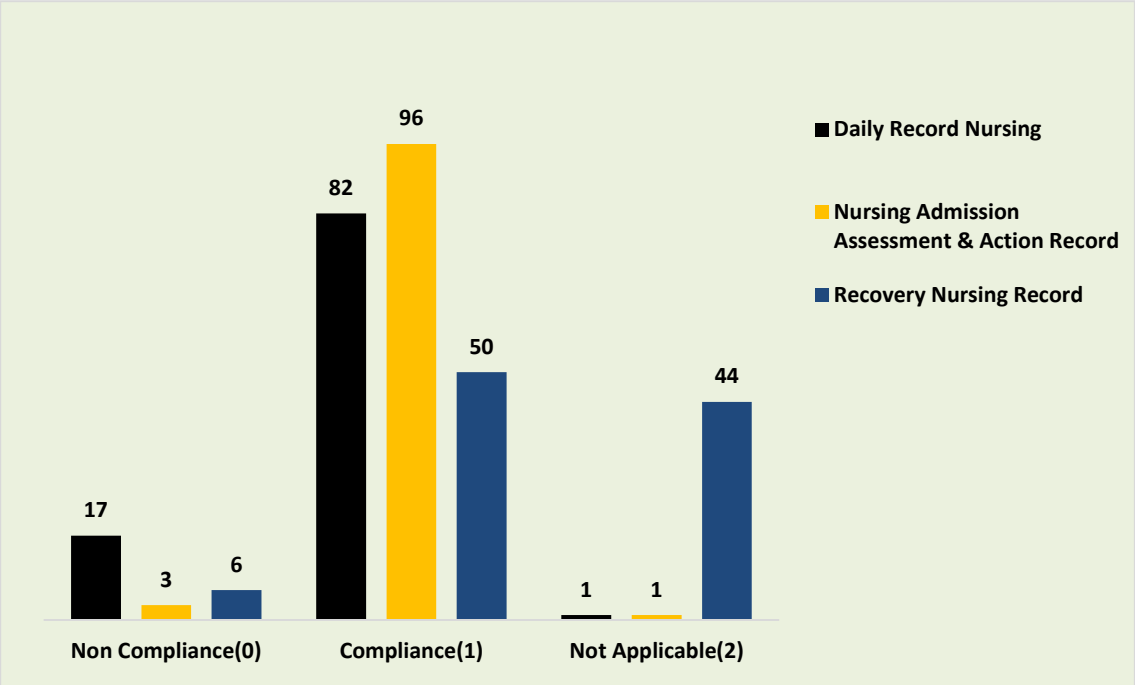

Figure 4.10 Non-Compliance, Compliance and Non applicability of Daily Record Nursing, Nursing Admission Assessment & Action Record, Recovery Nursing Record

- Out of 100 medical files the Compliance in Paediatric/Adult in Patient and physical Record, Patient and Family Education Documentation, Clinical Chart is 65,76 and 97.
- The non-compliance in Paediatric/Adult in Patient is 11 for physical Record, Patient and Family Education Documentation it is 23 and for Clinical Chart it is 2.

- Out of 100 medical records in 24 records, the Paediatric/Adult in Patient and physical Record form is not applicable in Patient and Family Education Documentation, Clinical Chart form is not applicable only in 1 file.

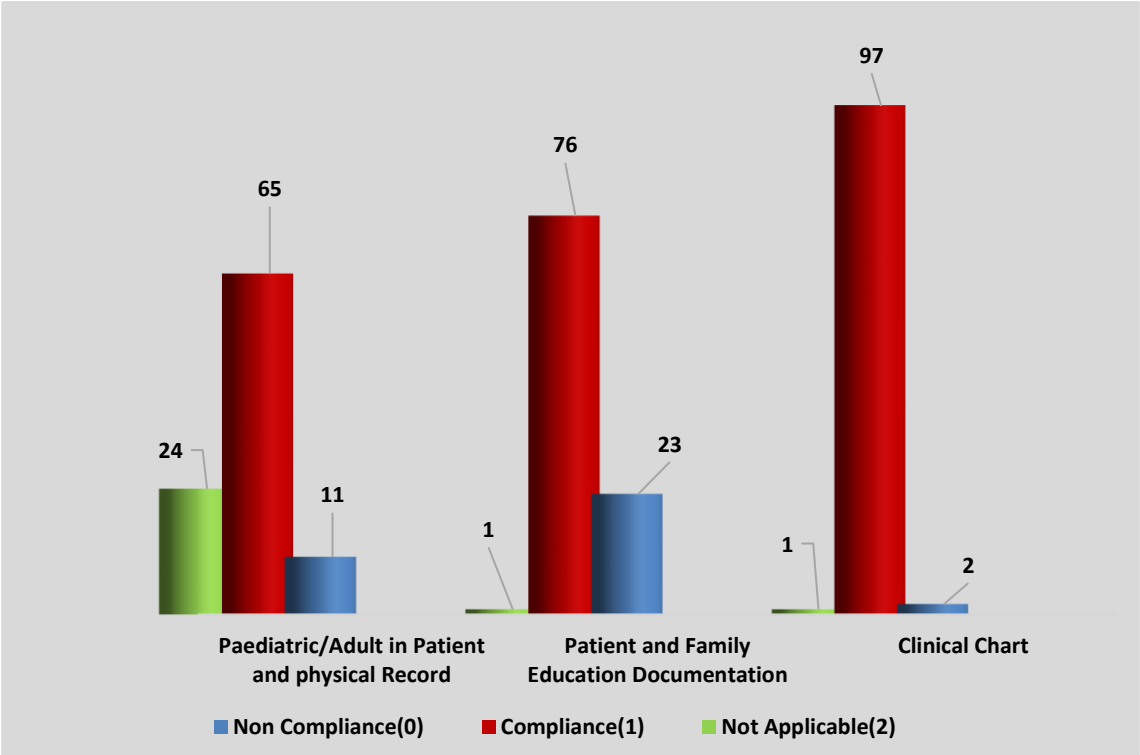

Figure 4.11 Compliance, Non-Compliance and Non applicability of Pediatric/Adult in patient and Physical Record, Patient and Family Education Documentation and Clinical Chart

Good Documentation:

- Some of the documents like Discharge Summary, Admission form, clinical chart, Daily record nursing, Recovery record, Nursing admission, COVID 19, Surgical safety checklist, Apollo fall risk assessment, High Risk Informed

Consent and Request for starting Chemotherapy, Consent form for procedure, Treatment, Anaesthesia, obstetrics, Analgesia, Sedation, High Risk, Pediatric/Adult in Patient and physical Record are come under Good Documentation.

- Among this Clinical chart documentation is filled highest followed by Nursing Admission Assessment & Action Record admission, Apollo fall risk assessment discharge summary.

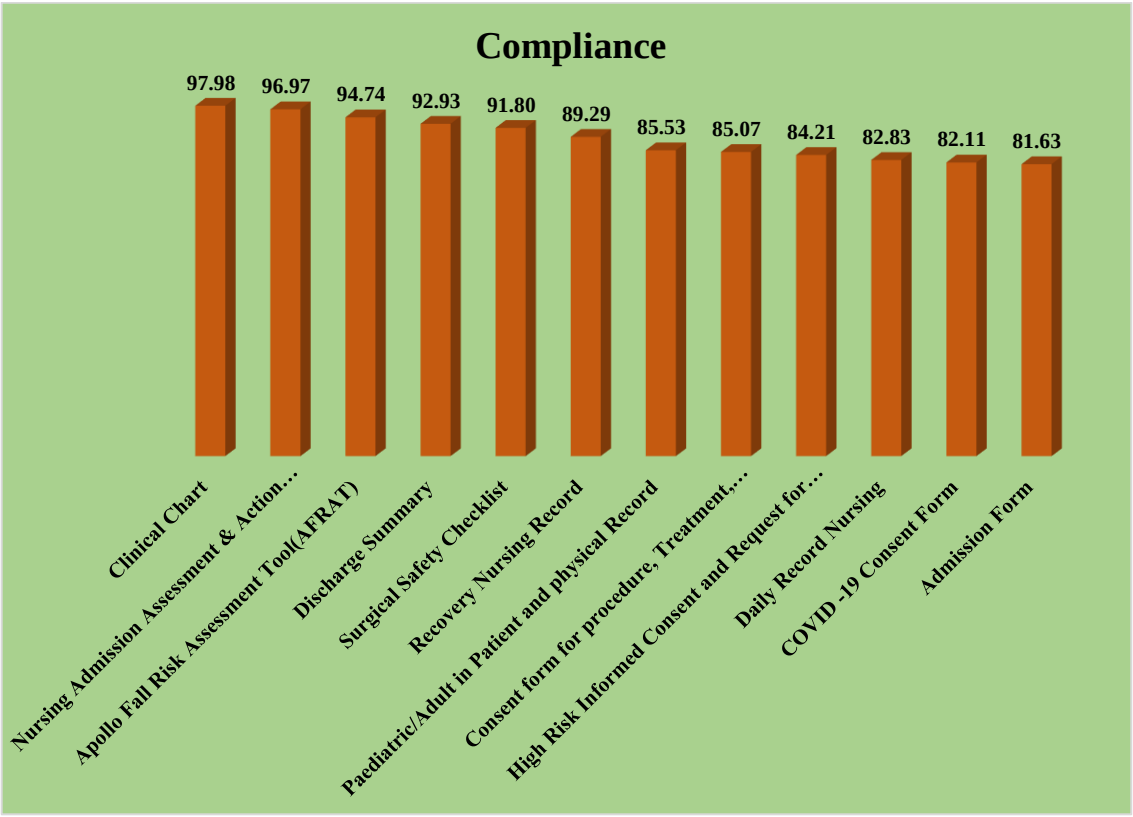

Figure 4.12 Compliance of forms which are above 80%

Average Documentation:

- Documents like Nutrition theory Plan, patient and family education documentation, Nutrition Assessment Screening Form, Physician Order Sheet,

Anaesthesia Record Sheet are considered as average documentation as their percentage lies between 60 to 80.

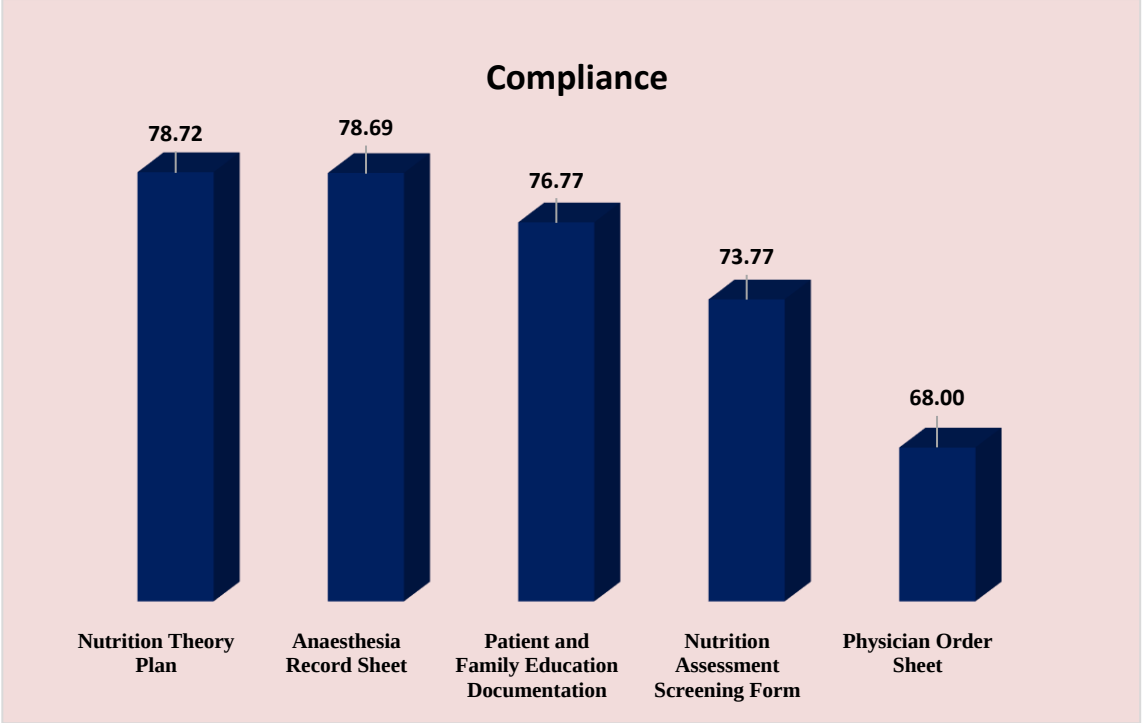

Figure 4.13 Compliance of forms which lies between 60-80%

Discussion:

Majority of the medical records in this study are come under the category of good documents. This study is similar to the study Improving Completeness of Inpatient Medical Records in Menelik II Referral Hospital, Addis Ababa, Ethiopia where discharge summary was involved for 107 which comprises of 96.4% and completed for 93 which comprises 83.8%. In our study the discharge summary form is having compliance rate of 92.93%.

In a Similar study of Analysis of Health Record Documentation Process as Per the National Standards of Accreditation with Special Importance on Tertiary Care Hospital Nutritional assessment form and notes 8.3% (full Compliance)66.3% (Partial compliance) 25.4%(Non-Compliance), Surgical Safety Checklist 95% (full Compliance)5% (Partial compliance) 0%(Non-Compliance). In our study Nutrition Assessment Screening Form the compliance percentage is 73.77% and non-compliance percentage is 26.23%. while that of surgical checklist 91.8% is the compliance and 8.2% is the non-compliance.

Medical records are important as it has the ability of healthcare practitioners to prove that a patient is receiving acceptable care focuses on having a thorough record, in ways that are compatible with license and certification criteria.

So, its duty of Hospital and their administrative staff to complete all the documents of medical in-patient records.

It is crucial that the patient's name, the date, and the doctor's signature appear legibly on the prescription for medication. If the patient abuses an incorrect prescription, the doctor could go into problems.

The doctor is in charge of everything related to this process, including the referral paperwork, records of discharge, medical certificates, forms of consent, treatment plans, post-operative notes, and medication records.

Conclusion:

The present study concluded that there are some insufficiencies found in medical records especially in physician order sheet, Nutrition Assessment screening Form.

The medical record has been maintained according to the NABH and JCI Accreditation.

The medical records are important for:

1-Recommendations 2- Accreditation 3-when required by the police or the court on a written deposition 4- when required by insurance companies in accordance with the Financial Services act when the patient has waived his rights by accepting the insurance.

It is crucial that the patient's name, the date, and the doctor's signature should be written properly on the prescription for medication. If the patient abuses an undated prescription, the doctor could get into problems.

These documents could be consulted for research needs.

The first and foremost things is to see that the hospital give importance in establishing and organizing the medical records for scientific maintaining of patient’s records.

The medical staff should adopt minimum standards for their medical records, and acquire and each and every member of the staff has to build their standard and keep records up to the mark and audit its work time to time.

However, certain forms have accurate information, indicating that medical clinical staff have the competence but not the will to provide high-quality clinical documentation. A clinical documentation improvement programme must be implemented, and staff members must be encouraged to provide high-quality clinical documentation.

The Hardest Part of the audit is implementing the changes which improves the bad results. Discussion should be done by all team members so that appropriate changes are made and according to it the solutions are framed. These changes depend on special conditions of audit and more often includes the training of staff and should start the new guidelines

CHAPTER 5

Recommendations

- Root cause Analysis should be done at every department.
- Sensitizing the staff (whether it is clerical or clinical) so that the documents should be filled correctly
- Weekly the documents should be checked by the consultants.
- Rewards should be given to the best department for those who fills their records in a correct way.
- Quarterly audit of medical records should be done by the Hospital.
- Incomplete file has to be put with different coloured stickers along with a comment.
- Next day it has to be ensured that that incomplete medical record has to be completely filled as per the policies set by the hospital.
- The medical files should be separated into sections so that it would be very easy for every department in completing it.
- All record in the medical file needs to be clear, timed (using the 24-hour clock), and dated. Those should be made as soon as reasonable after the event to be recorded (such as a change in clinical status, a ward round, an investigation, etc.) and before the appropriate staff member leaves the building. If there is a gap, the event's time, the delay, and the delay's cause should all be noted.
- Avoid using abbreviations since they could be unclear. GA for example, might stand for General Anaesthesia. On the other hand, it is allowed to employ abbreviations when doing so would make the full phrase more readily understood by the general public and the abbreviation is widely used in society (e.g., HIV, a.m., p.m. etc). Additionally, it's crucial to refrain from adding pointless comments to the patient report. Any derogatory, intimate, or amusing remarks could harm your trustworthiness. Keep in mind that patients have the right to view their records, and it may be challenging to justify a flippant comment found in a patient's files.

CHAPTER 6

References

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Annexure

Checklist prepared for in patient Documentation

Discharge Summary
Reason for admission, diagnosis & comorbidities
Physical and other findings
Discharge medication
Follow up instructions
Completeness
Signatures
Nutrition Theory Plan
Completeness
Admission forms
IP No./OP No
Patient details
All pages have patient ID
Name of Emergency Contact & Phone Number noted in record
DOA and Time
Clinical Chart
Completeness
Patient /Family Education Documentation
Completeness
Paediatric/Adult in Patient and physical Record
Completeness

In the Checklist Scaling was done by ✓,✗ and NA for analysis.

Nutrition Assessment Screening Form
Completeness
Apollo Fall Risk Assessment Tool (AFRAT)
Completeness
Signature
Daily Record Nursing
Completeness
Physician Order Sheet
All Orders written here (In Capital letters)
Legibility
Orders Signed
Orders dated
Orders Timed
Recovery Nursing Record
Monitoring
Sign
Discharge Criteria
Surgical Safety Checklist
Sign In
Time Out
Sign Out
Name and Signature of Surgeon
Name and Signature of Nurse
Name and Signature of Technician
Date
Time
Completeness

Anaesthesia Record Sheet
Pre-Operative Assessment
Post Operative Instructions
Intra Operative Monitoring
Signature
High Risk Informed Consent and Request for starting Chemotherapy
Risk, Benefit, Alternative (if any)
Use of abbreviation
Date
Signatures
Witness
Nursing Admission Assessment
Timeliness
Completeness
Legibility
Accuracy of AFRAT score
Consent form for procedure, Treatment, Anaesthesia, obstetrics, Analgesia, Sedation, High Risk consent
Completeness
Signature
COVID -19 Consent Form
Completeness

	APD2.0000181800	APD2.0000102197	APD2.0000182031	APD2.0000165545	APD2.0000182016	APD2.0000178392
Discharge Summary						
Reason for admission, diagnosis & comorbidities	✓	✓	✓	✓	✓	✓
Physical and other findings	✓	✓	✓	✓	✓	✓
Discharge medication	✓	✓	✓	✓	✓	✓
Follow up instructions	✓	✓	✓	✓	✓	✓
Completeness	✓	✓	✓	✓	✓	✓
Signatures	✓	✓	✓	✓	✓	✓

	APD2.0000183168	APD2.0000183090	APD2.0000182133	APD2.0000183080	APD2.0000182859	APD1.0010433042
Nutrition Theory Plan						
Completeness	✓	✓	×	×	✓	✓

	APD2.0000025006	APD2.0000183296	APD2.0000001998	APD2.0000146165	APD1.0011420136	APD2.0000183561
Admission forms						
IP No./OP No	✓	✓	✓	✓	✓	✓
Patient details	×	✓	✓	✓	✓	✓
All pages have patient ID	✓	✓	✓	✓	✓	✓
Name of Emergency Contact & Phone Number noted in record	✓	✓	✓	✓	✓	✓
DOA and Time	✓	✓	✓	✓	✓	✓

	APD2.0000183316	APD2.0000183286	APD2.0000010981	APD2.0000127534	APD2.0000183275	APD2.0000183248
Clinical Chart						
Completeness	✓	✓	✓	✓	✓	✓

	APD2.0000183463	APD2.0000183467	APD2.0000183225	APD2.0000183484	APD1.0010569088	APD2.0000176591
Patient /Family Education Documentation						
Completeness	×	✓	✓	✓	✓	✓

	APD2.0000183272	APD2.0000183173	APD2.0000183211	APD2.0000175120	APD2.0000183223	APD2.0000137745
Paediatric/Adult in Patient and physical Record						
Completeness	✓	NA	✓	✓	✓	✓

	APD2.0000182759	APD2.0000101963	APD2.0000001901	APD2.0000180102	APD2.0000183259	APD2.0000182329
Nutrition Assessment Screening Form						
Completeness	✓	NA	✓	×	✓	✓

	APD2.0000182133	APD2.0000183080	APD2.0000182859	APD1.0010433042	APD2.0000180790	APD2.0000181046
Apollo Fall Risk Assessment Tool (AFRAT)						
Completeness	✓	✓	✓	✓	✓	✓
Signature	✓	✓	✓	✓	✓	✓

	APD2.0000181800	APD2.0000102197	APD1.0011382843	APD2.0000165545	APD2.0000182016	APD2.0000178392
Daily Record Nursing						
Completeness	✓	✓	✓	✓	✓	✓

	APD2.0000008784	APD2.0000182355	APD2.0000133714	APD2.0000183353	APD2.000018349	APD2.0000181700
Physician Order Sheet						
All Orders written here (In Capital letters)	✓	×	✓	×	✓	✓
Legibility	✓	✓	✓	✓	✓	✓
Orders Signed	✓	✓	✓	✓	✓	✓
Orders dated	✓	✓	✓	✓	✓	✓
Orders Timed	✓	✓	✓	✓	✓	✓

	APD2.0000133714	APD2.0000183353	APD2.000018349	APD2.0000181700	APD2.0000183286	APD2.0000010981
Recovery Nursing Record						
Monitoring	✓	✓	✓	✓	✓	✓
Sign	✓	✓	✓	✓	✓	✓
Discharge Criteria	✓	✓	✓	✓	✓	✓

	APD2.0000077758	APD2.0000176133	APD2.0000176578	APD2.0000182068	APD2.0000182069	APD1.0010087715
Surgical Safety Checklist						
Sign In	✓	✓	✓	✓	✓	✓
Time Out	✓	✓	✓	✓	✓	✓
Sign Out	✓	✓	✓	✓	✓	✓
Name and Signature of Surgeon	✓	✓	✓	✓	✓	✓
Name and Signature of Nurse	✓	✓	✓	✓	✓	✓
Name and Signature of Technician	✓	✓	✓	✓	✓	✓
Date	✓	✓	✓	✓	✓	✓
Time	✓	✓	✓	✓	✓	✓
Completeness	✓	✓	✓	✓	✓	✓

	APD1.0010689498	APD2.0000183511	APD2.0000055763	APD2.0000148162	APD2.0000183248	APD1.0011411081
Anaesthesia Record Sheet						
Pre-Operative Assessment	✓	✓	NA	✓	✓	✓
Post Operative Instructions	✓	✓	NA	✓	✓	✓
Intra Operative Monitoring	✓	✓	NA	✓	✓	✓
Signature	✓	✓	NA	✓	✓	✓

	APD2.00004101 0	APD2.00000652 23	APD2.00001399 22	APD2.00001712 82	APD2.00000141 32	APD1.00111435 51
High Risk Informed Consent and Request for starting Chemotherapy						
Risk, Benefit, Alternative (if any)	NA	✓	✓	✓	✓	✓
Use of abbreviation	NA	✓	✓	✓	✓	✓
Date	NA	✓	✓	✓	✓	✓
Signatures	NA	✓	✓	✓	✓	✓
Witness	NA	✓	✓	✓	✓	✓

	APD2.00001738 92	APD2.00000153 22	APD2.00001831 26	APD2.00001809 49	APD2.00001831 68	APD2.00001831 090
Nursing Admission Assessment						
Timeliness	✓	✓	✓	✓	✓	✓
Completeness	✓	✓	✓	✓	✓	✓
Legibility	✓	✓	✓	✓	✓	✓
Accuracy of AFRAT score	✓	✓	✓	✓	✓	✓

	APD2.0000182859	APD1.0010433042	APD2.0000180790	APD2.0000181046	APD2.0000008784	APD2.0000182355
Consent form for procedure, Treatment, Anaesthesia, obstetrics, Analgesia, Sedation, High Risk consent						
Completeness	✓	✓	✓	✓	NA	✓
Signature	✓	✓	✓	✓	NA	✓

	APD2.0000182103	APD1.0010525692	APD1.0010028657	APD2.0000159611	APD2.0000179756	APD2.000041010
COVID -19 Consent Form						
Completeness	✓	✓	×	✓	✓	✓