DISSERTATION

2022

AT

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UNDER THE GUIDANCE
OF
SUNITA NIGAM

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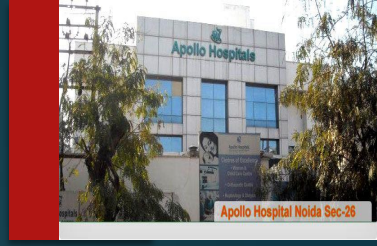
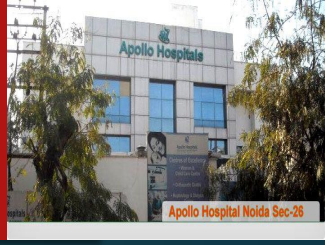
About Organization



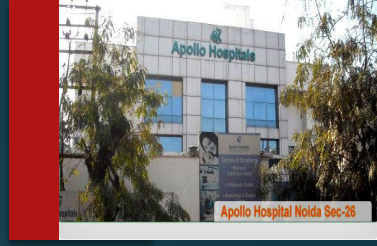
Introduction

- Apollo Hospitals, Noida established in 2006. It is a 75 bedded Secondary care facility providing services in various medical and surgical disciplines.
- Hospital provides specialty care in the department of mother and child care, orthopedics, joint Replacement & Spinal Surgery, Kidney Transplantation & Renal Diseases, Oncology, General, and Laparoscopic & Bariatric Surgery & Preventive Health Check.
- The Hospital brings together some of the most talented medical professionals and has a dedicated team of clinicians to provide highest standards of patient care.
- Certified by NABL & NABH



Objectives of Internship:

- To study the organization structure.
- To know how the various departments of organization works.



Key Learnings from Internship

- Weekly PPT of Voice of Customer at Apollo
- Weekly Noida Attribute wise report
- Daily make cases on voice of customer
- Daily make MIS report on Med Mantra at Apollo
- Monthly updating the AOP data on Apollo Light House.
- Minutes of Meeting
- Make Report on AOP (Annual Operation Plan)
- Average length of stay in hospitals
- MIS closure.
- Stock summary for housekeeping stocks
- CRT Data
- Stock summary for Sodexo India Services India PVT.

Key Activities/ Projects Undertaken Other than Dissertation

- Downtime Mock drill Audit
- Participated in Fire Mock drill.

QUALITATIVE ANALYSIS OF PATIENT DOCUMENTATION

Apollo Hospitals Noida

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?

Introduction

- Medical documents 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.
- 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.

❑ 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.

❑ Study Design-

- Descriptive Cross-Sectional Study

❑ 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.

❑ 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 records visiting in the month of April and May 2022. Sample size is 100 case sheets.

❑ 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).

Results:

- In this study it was found that the Compliance, Non-compliance and Not applicability of 17 forms in 100 medical records.

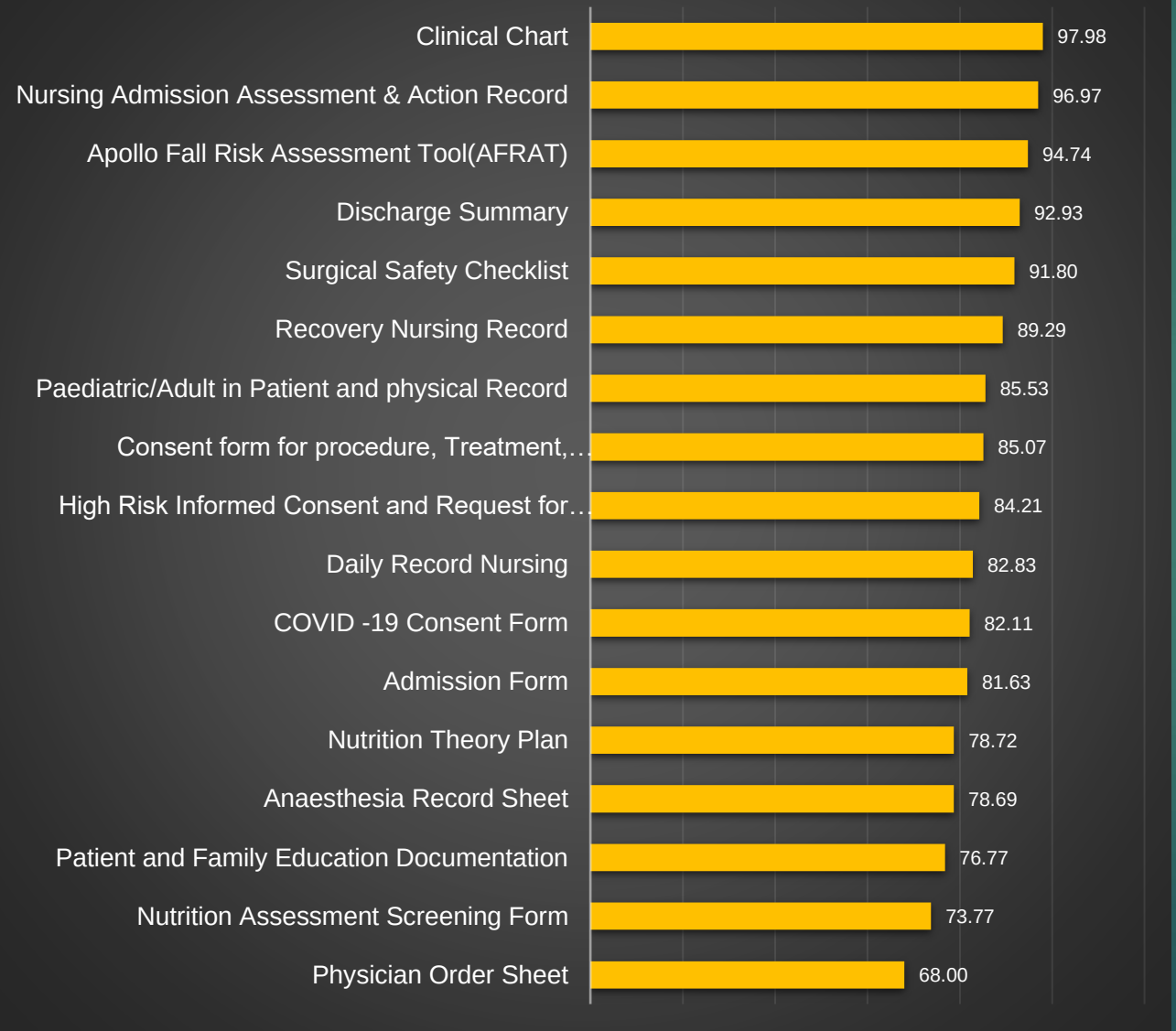
- After auditing these files, it was found that compliance percentage of clinical chart is highest among these parameters which is 97.88 while least compliance percentage is found in Physician Order Sheet which is 68%

- The highest Non-compliance is found in Physician Order Sheet which is 32% and the least Non-compliance is found in Clinical Chart.

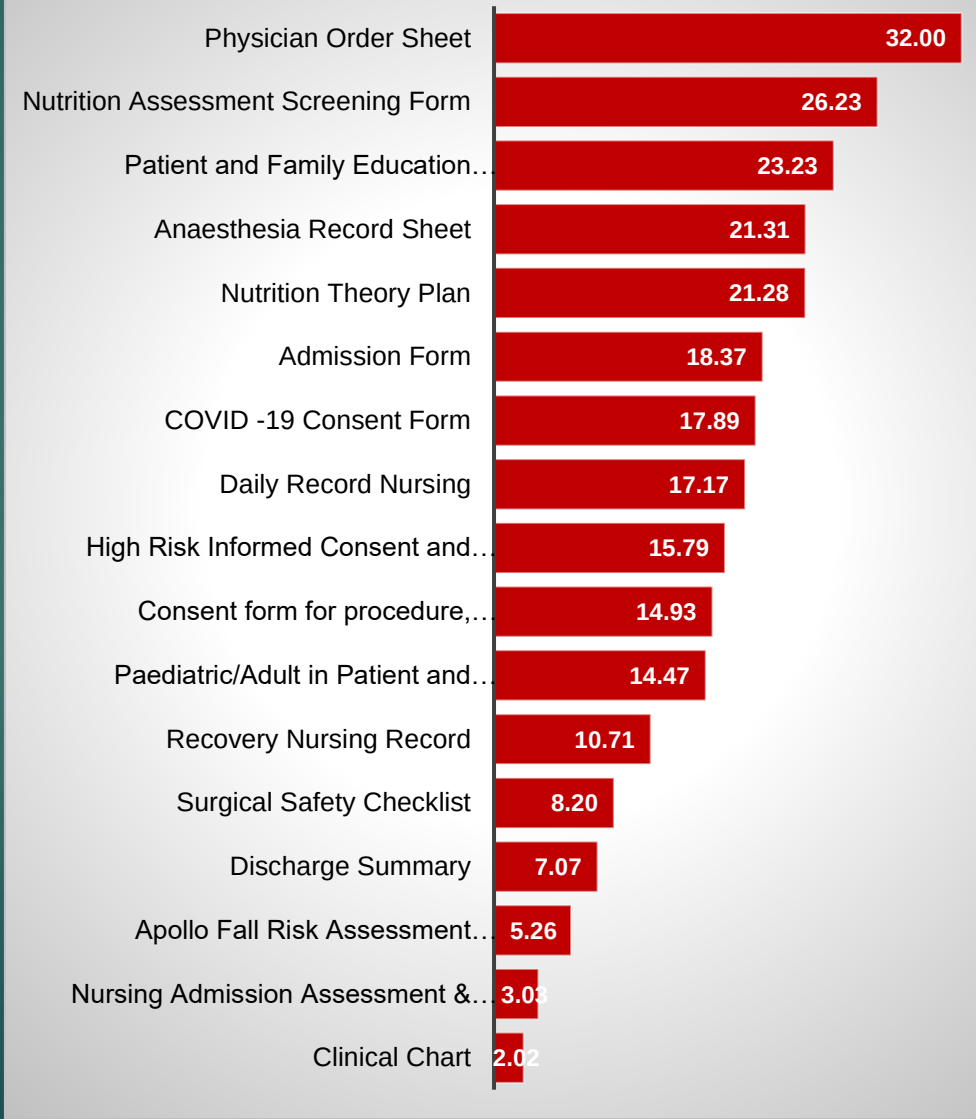
- Noncompliance of physician order sheet is due to medicines prescribed by doctors were not written in Capital letters and unable to read easily.

Average Compliance	Average Non-Compliance
84.77	15.23

Compliance



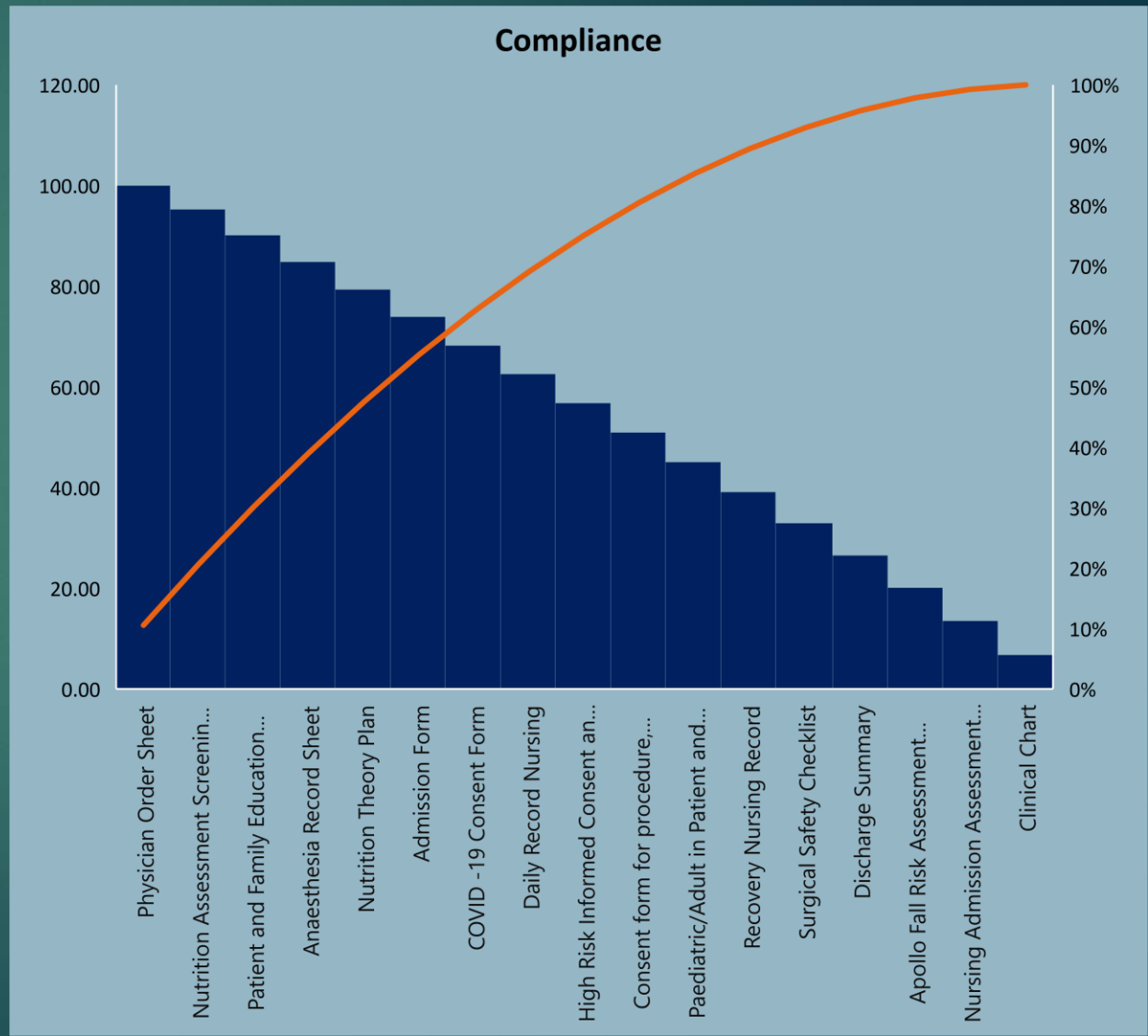
Non-Compliance



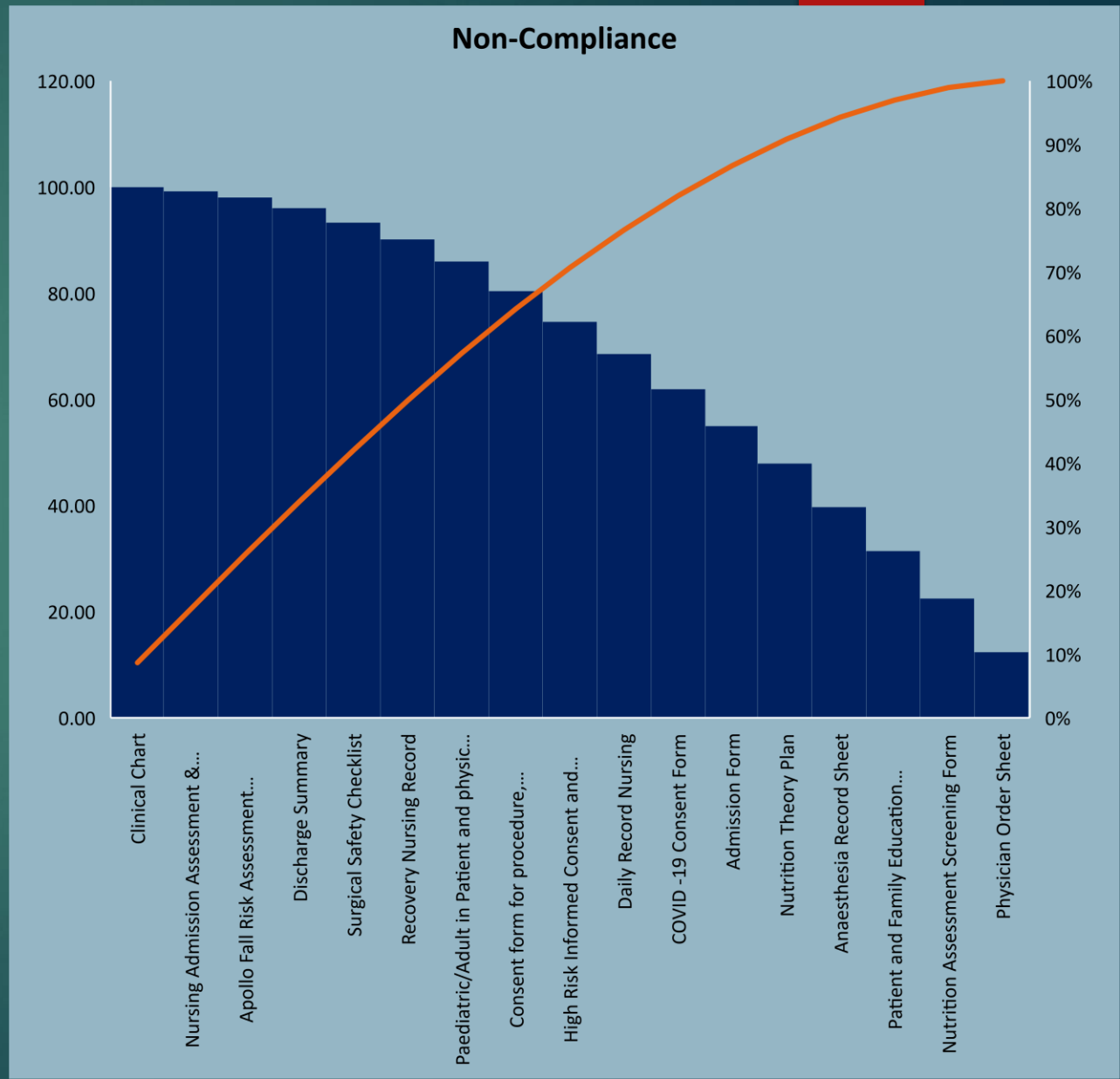
Pareto Analysis

- In Pareto chart of compliance of medical records founded on the Observation during the study that from Physician Order Sheet to Pediatric/Adult in Patient and physical Record 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.



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



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.

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.

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.

Recommendations

- Root cause Analysis should be done at every department.
- Sensitizing the staff
- 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. 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.

- 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.

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