“EVALUATING THE ACCURACY AND COMPLETION OF MEDICATION HISTORIES IN VARIOUS INPATIENT DEPARTMENTS”: A STUDY AT FORTIS ESCORTS HOSPITAL, JAIPUR

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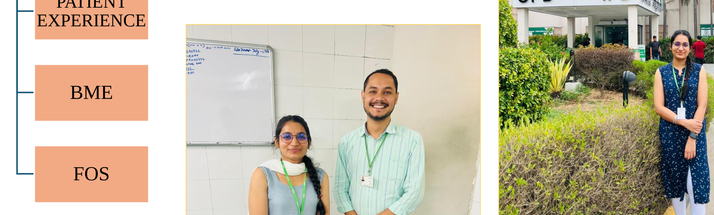
ABOUT FORTIS ESCORTS HOSPITAL, JAIPUR

Fortis Escorts Hospital, located in Malviya Nagar, Jaipur, is a leading multi-specialty tertiary care hospital established in 2007. As part of the Fortis Healthcare network, it offers a wide range of advanced medical services across various specialties, including Cardiology, Orthopaedics, Neurology, Oncology, Gastroenterology, Paediatrics, Urology, and Gynaecology. Accredited by the National Accreditation Board for Hospitals & Healthcare Providers (NABH), Fortis Escorts Jaipur adheres to high standards of healthcare services. The hospital is also involved in community health initiatives, providing free health camps, awareness programs, and preventive health check-ups.

***Vision** : To create a world-class integrated healthcare delivery system in India, entailing the finest medical skills combined with compassionate patient care.*

***Mission**: To be a globally respected healthcare organization known for Clinical Excellence and Distinctive Patient Care.*

ORGANISATION STRUCTURE



LEARNINGS DURING INTERNSHIP:

- **File Management Techniques:** Effective practices for managing medical records in the department.
- **Departmental Workflow:** Understanding workflow and file handling in hospital departments.
- **Audit Procedures:** Procedures for auditing Medico Legal Cases (MLC), Discharge, and Death records.
- **IPD File Audits:** Auditing closed IPD files, including death records, over multiple years.
- **NABH Compliance:** Knowledge of NABH standards and compliance requirements.
- **Open and Closed Audits:** Experience in conducting audits for various IPD departments.
- **Interdepartmental Collaboration:** Collaborating across departments for comprehensive audits.
- **Error Audits and Data Analysis:** Identifying and analyzing prescription and medication errors.
- **Data Collection and Analysis:** Collecting data for quality improvement projects and error audits.

THEORETICAL LEARNING

- File arrangement specifications for the Medical Records Department (MRD).
- Layout and organization of the Outpatient Department (OPD)
- Separate entrances for Emergency and OPD areas.
- File flow processes across hospital departments and MRD.
- NABH audit procedures and requirements.
- Standards for auditing medication and prescription errors.
- Hospital coding systems.

PRACTICAL EXPOSURE:

- Observed and verified file arrangements in the MRD.
- Confirmed OPD layout through direct observation.
- Noted the separation of Emergency and OPD entrances.
- Witnessed file flow in various departments and MRD.
- Participated in the NABH audit process.
- Conducted medication and prescription error audits.
- Reviewed hospital coding systems in practice.

RECOMMENDATIONS

- Implement **targeted training programs** to emphasize the importance of documenting all aspects of patient history, especially **current medications**.
- Develop and enforce **standardized checklists and protocols** to ensure all necessary patient information is consistently documented.
- **Enhance patient interview** techniques to better capture comprehensive medication details and past medical histories.
- **Leverage EHR** systems to prompt and assist healthcare providers in documenting all required patient information, particularly focusing on areas with lower compliance rates.
- Perform **audits of documentation** practices periodically and provide constructive feedback to healthcare providers to reinforce compliance with documentation standards.
- **Involve patients in the documentation** process by encouraging them to provide accurate and detailed information about their medical history, current medications, and allergies.
- **Interdisciplinary communication** between nursing staff and doctor.

OBJECTIVE

- Evaluate how accurately medication histories are recorded across different inpatient departments to identify discrepancies and ensure correct medication use.
- Determine the completeness of medication records to support comprehensive patient care and minimize the risk of adverse drug events.

RESULT

Sample and data description:

The data collected for the project is primary.

Sample size of the data is 126.

- **Score of 10**: Awarded when the entire assessment is completed within **15 mins in Triage**, **20 mins in ICU** & **30 mins in the ward** and is countersigned by the admitting consultant within 24 hours. This is categorized as **COMPLIANCE**.
- **Score of 5**: Given when any detail from the above requirements is missing. This is classified as **PARTIAL COMPLIANCE**.
- **Score of 0**: Assigned when the assessment form is completely unfilled. This is identified as **NON-COMPLIANCE**.

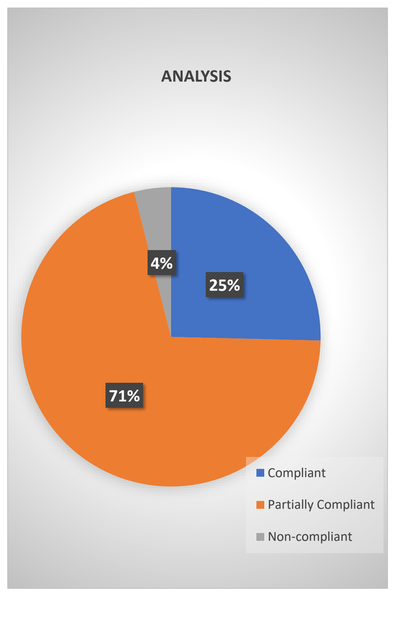
Additionally, the analysis extended to compare the compliance levels of various components within the history sheet, such as the history of present illness, past medical history, drug allergies (if any), and current medications. The analysis revealed that in 116 assessment sheets, the history of present illness was fully completed. Past medical history was fully documented in 113 sheets, drug allergy information was recorded in 116 sheets, and current medication details were provided in only 34 sheets.

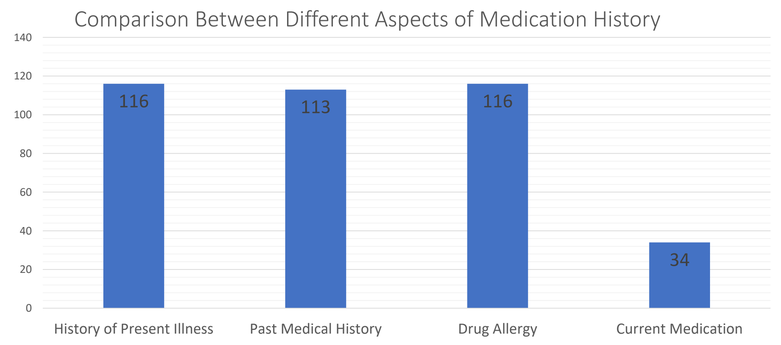
METHODOLOGY

- **Type and study design:** Descriptive study is conducted at the nursing stations on each floor of the inpatient departments (IPDs). It involves assessing the inpatient physical and history sheets, which are required to be completed within **20 mins in ICU and within 30 mins in Wards** of the patient’s admission.
- **Data collection method:** Primary data was collected by observation.
- **Target Population:** All patient getting admitted in the hospital either for surgical or medical management.
- **Sampling technique:** Systematic random sampling.
- **Sampling size:** 126 patients that were admitted from May13,2024 to June10,2024. Primary data was collected to analyze the completion of the inpatient physical and history sheet.

ANALYSIS

After analysis of the data, it was found that out of all the 126 admitted patients, 32 admissions i.e. 25.93% were compliant, 89 doctor’s initial assessment sheets were partially compliant i.e. 70.63% and rest 5 i.e. 3.96% were not compliant.





OPPORTUNITIES

- Targeted Training Programs.
- Enhanced use of EHR.
- Patient interaction.
- Periodic Audits.

STRENGTHS

- Accredited Standards like NABH,NABL,ISO.
- Experienced staff
- Advanced Technology

WEAKNESS

- Inconsistent Documentation.
- Negligence and Oversight by Doctors and Nurses.
- Limited Patient interaction.

THREATS

- Adverse Drug Events.
- Regulatory Non-Compliance.
- High Workload and Burnout.
- Patient Satisfaction and Trust.

ABOUT THE PROJECT

INTRODUCTION

Accurate medication histories are vital for safe hospital care, detailing current and past medications to guide treatment decisions and prevent interactions. Challenges like patient recall, multiple prescribers, and EHRs affect accuracy. Despite technology, incomplete interviews and documentation errors lead to adverse drug events, prolonging stays and increasing costs. Evaluating accuracy across departments helps improve medication documentation for better patient safety

CHALLENGES FACED DURING INTERNSHIP:

- Navigating and understanding the complex workflows and file management systems of diverse hospital departments.
- Maintaining precision and accuracy in auditing various records while ensuring strict adherence to protocols.
- Grasping and implementing the detailed and demanding requirements of NABH compliance standards.
- Accurately identifying prescription and medication errors and conducting thorough data analysis for quality improvement projects.