

**A STUDY ON
MEDICAL RECORD
DOCUMENTATION
IN COMPLIANCE
WITH NABH 5TH
EDITION
GUIDELINES**

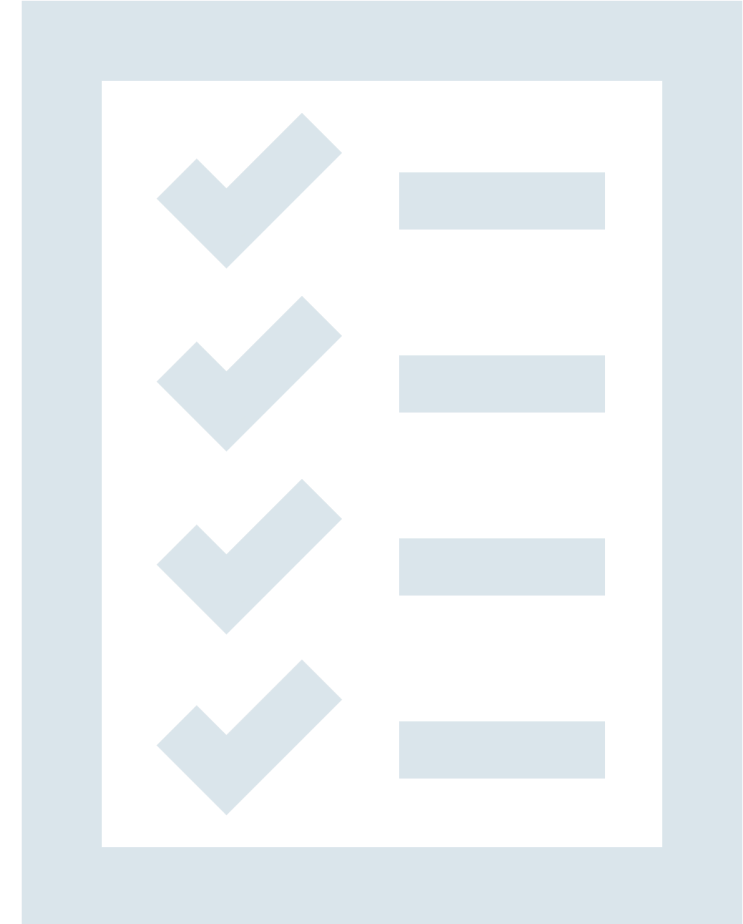
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INTRODUCTION



- Medical records include various forms and documents, such as patient assessments, investigations, drug administrations, consent forms, and pre and post-operative management details.
- Essential for planning and evaluating patient treatment, ensuring continuity of care, and providing a detailed past medical history for healthcare providers.
- Documentation standardizes actions across different departments and functional units, enhancing the overall efficiency and consistency of healthcare delivery.
- Medical records are crucial for ensuring patients receive the best possible care by supporting informed decision-making and patient safety.
- NABH guidelines provide a framework for best practices in medical record documentation, helping healthcare organizations maintain high standards of quality and safety in patient care.

LITERATURE REVIEW

Authors (Year)	Study Location	Sample Size	Sampling Techniques	Salient features
Pizziferri, L., Kittler, A. F., Volk, L. A., et al. (2005)	USA	3805	Random Sampling	Investigated the impact of an EHR on the time efficiency of physicians and quality of clinical documentation.
Thakkar, M., & Davis, D. C. (2006)	USA	Not specified	Not specified	Explored the role of health information technology in improving the quality of medical documentation and patient outcomes.
Agarwal, R., Kalita, J., & Misra, U. K. (2010)	India	Not specified	Not specified	Evaluated the use of computer-based patient record systems in improving documentation accuracy and completeness.
Jamoom, E., Patel, V., Furukawa, M. F., & King, J. (2012)	USA	3180	Stratified random sampling	Analyzed the adoption of EHR systems and their impact on clinical documentation and patient care quality
Hebda, T., Czar, P., & Mascara, C. (2013)	USA	Not specified	Not specified	Reviewed the critical role of nursing informatics in enhancing medical record documentation and ensuring compliance with healthcare standards.

METHODOLOGY

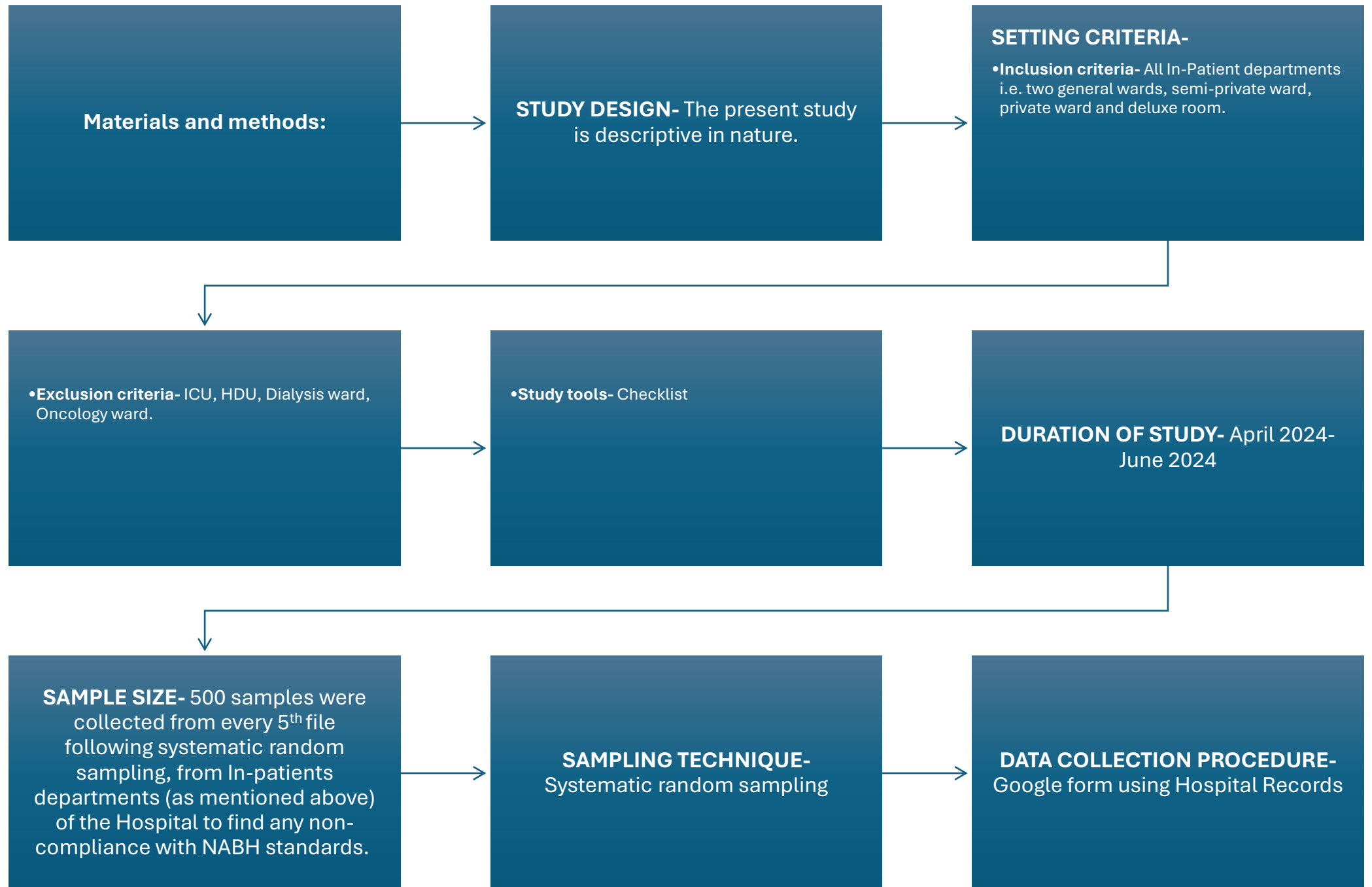


Research question:

- What are the current practices and levels of compliance with NABH 5th edition guidelines in medical record documentation within Apollo Hospitals, Bilaspur
- Whether the quality of MRD as per NABH guidelines?
- What are the gaps or deficiencies in the current documentation practices?

Objectives:

- Evaluate the existing medical record documentation practices to determine the level of compliance with NABH 5th edition guidelines.
- Assess the quality of MRD in case of accuracy, integrality, timeliness, and relevance, as per NABH standards.
- Identify any gaps or deficiencies in the current documentation practices that may exist in relation to NABH guidelines.
- To spotlight key findings and recommend actionable solutions, to enhance compliance with NABH guidelines and optimize medical record documentation practices.



RESULTS

A total of 500 samples were collected from 50 patients were taken in the study using 10 various assessment forms for each patient through Google form using hospital records, ensuring anonymity and confidentiality. For record maintenance, UHID Number was recorded with date. The samples were collected from all IPD wards departments i.e. two general wards, semi-private ward, private ward and deluxe room.

These forms serve as a tool for internal audits and quality improvement initiatives, helping the hospital to identify areas where education practices can be enhanced.

The forms that were taken for compliance:

- Patient & Family Education Documentation
- Nutrition Assessment Screening (For Adult Patients)
- Nursing Admission Assessment & Action
- Initial Assessment (Accident & Emergency)
- Plan of Care
- Informed Consent Form
- Pre-Operative Checklist
- Safe Surgery Checklist
- Pre-Operative Anaesthetic Assessment
- Nursing Caps Risk Assessment Record



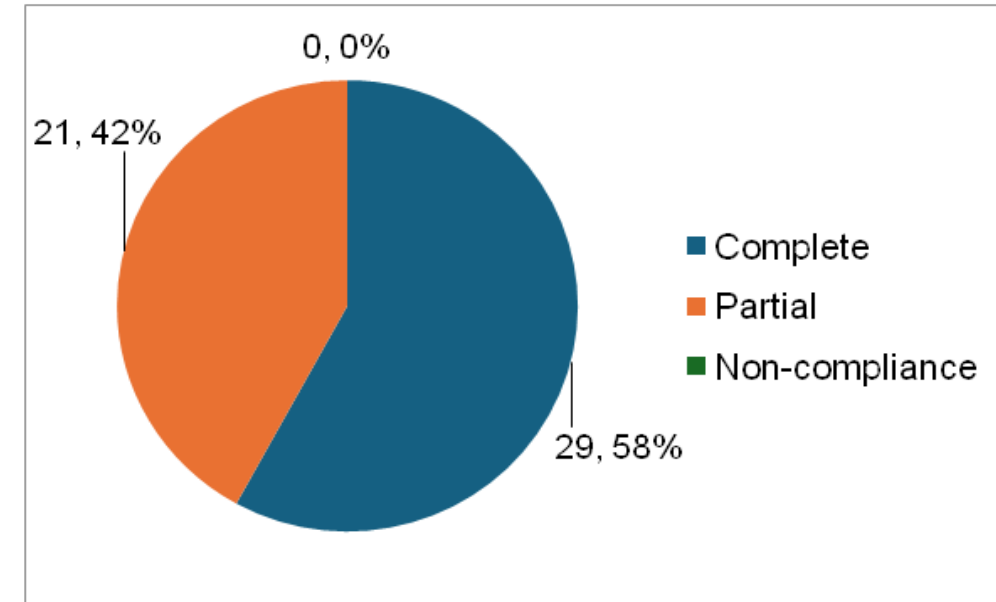
1. Patient & Family Education Documentation

A Patient & Family Education Documentation form is an essential tool in hospitals, designed to systematically record educational interactions between healthcare providers, patients, and their families. This form ensures that patients and their families receive consistent, accurate, and personalized information about medical conditions, treatments, medications, and lifestyle changes. It typically includes sections for patient demographics, educational needs, topics covered, teaching methods, patient understanding, and the date and time of sessions.

The result regarding the completion rate of patient and family education documentation is explained through analysis:

It highlights a significant portion of patient and family education documentation that is Complete (29.58%) and partially complete (21.42%).

Graph 1- Patient & Family Education Documentation (n=50)



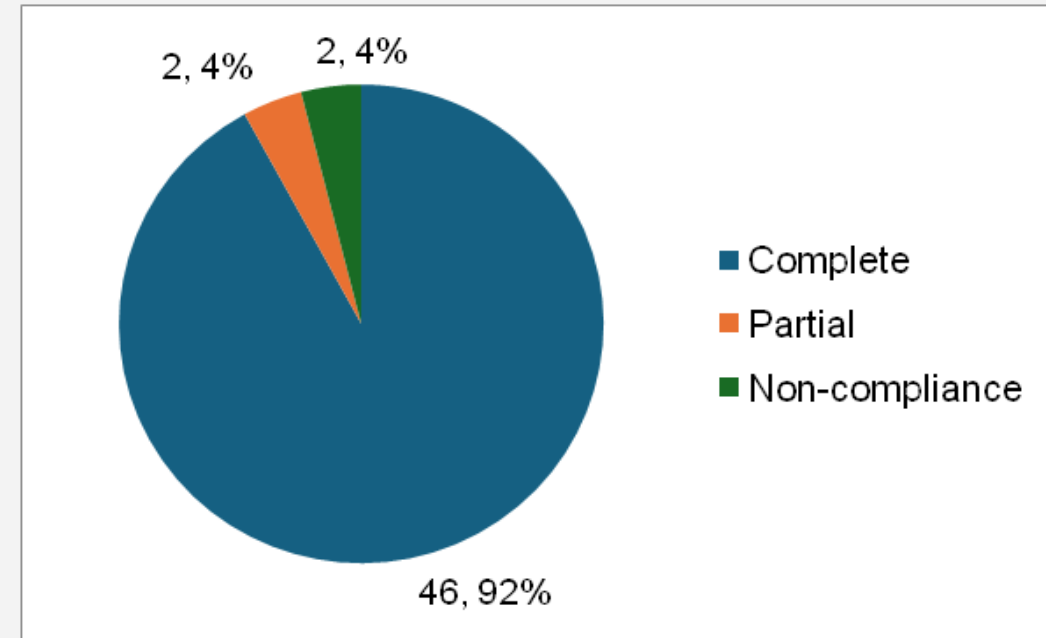
2. Nutrition Assessment Screening (For Adults)

A Nutrition Assessment Screening form for adults in hospitals evaluates a patient's nutritional status upon admission, identifying those at risk of malnutrition. It includes sections on demographics, medical history, dietary intake, weight changes, and physical exam findings like BMI. The form helps healthcare providers assess nutritional risk and develop personalized care plans.

Additionally, it was found that the completion rate of Nutrition Assessment Screening (Adults). Here's a breakdown for the analysis:

The significant portion of nutrition assessment screening (adults) is complete (92%), partially complete (4%) and non-compliance (0%)

Graph 2- Nutrition Assessment Screening (Adults)
(n=50)



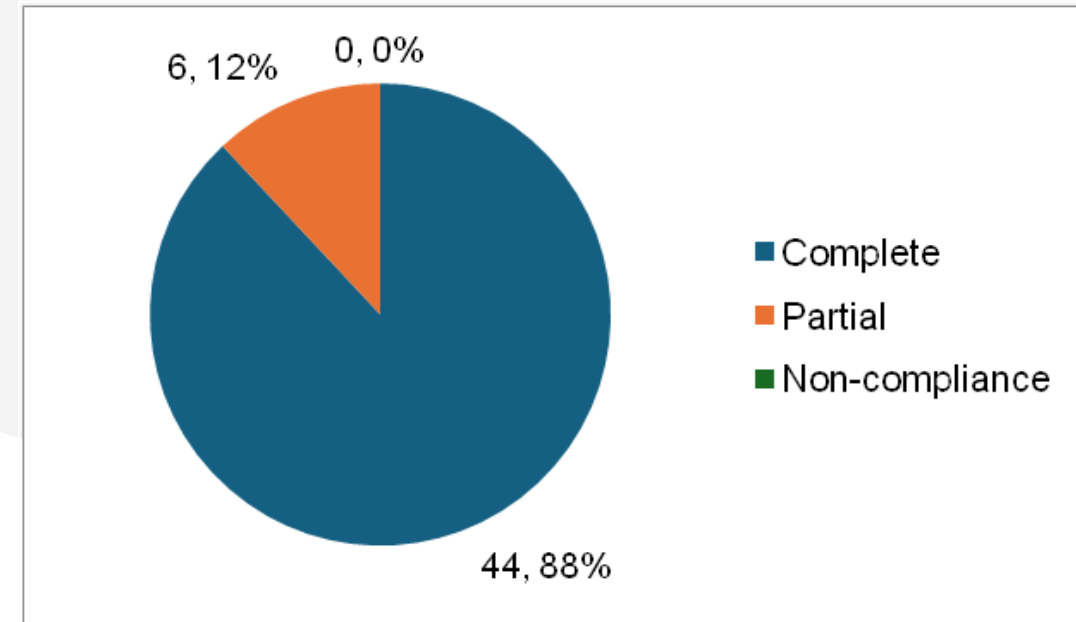
3. Nursing Admission Assessment & Action

A Nursing Admission Assessment & Action form in hospitals is used to gather comprehensive information about a patient upon admission. It includes sections on time of arrival, patient attendant, language understandable, medical history, current medications, allergies, vital signs, and physical assessment. This form helps nurses identify immediate care needs and plan appropriate interventions.

Further this study suggests that the completion rate of Nursing Admission Assessment & Action. Here's a breakdown for your dissertation analysis:

This highlights that a significant portion of nursing admission assessment & action is complete (88%), partially complete (12%) and non-compliance (0%)

Graph 3- Nursing Admission Assessment & Action (n=50)



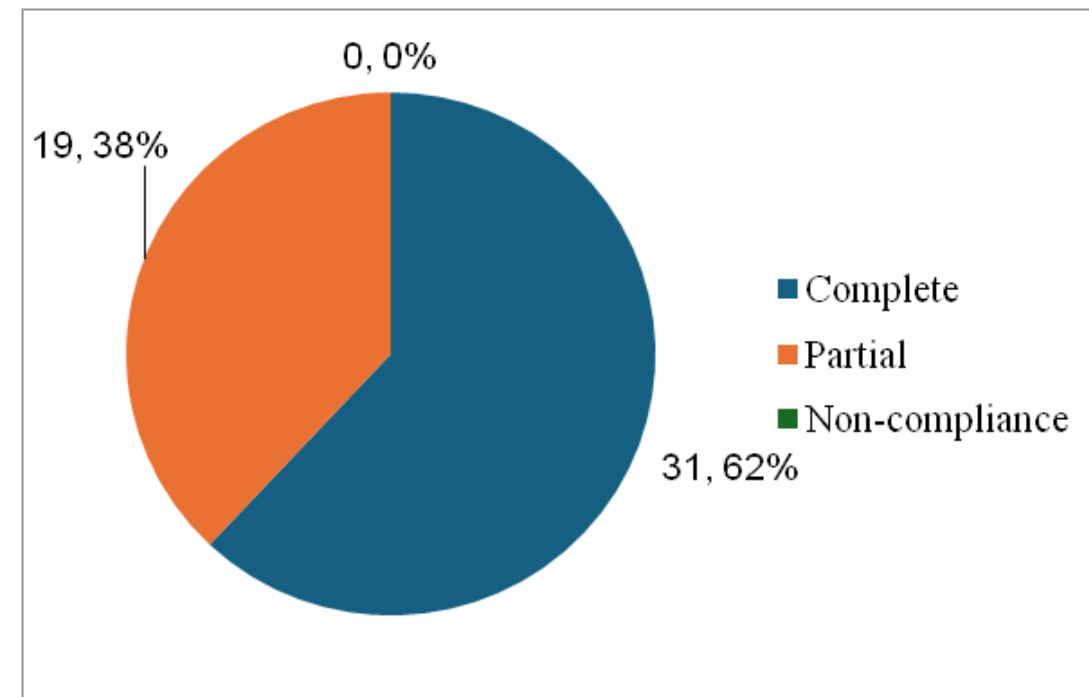
4. Initial Assessment (Accident & Emergency)

The Initial Assessment (Accident & Emergency) form in hospitals collects critical information about patients upon arrival in the emergency department. It includes sections for patient demographics, the reason for visit, medical history, vital signs, pain assessment, and immediate observations. This form enables healthcare providers to quickly evaluate the patient's condition, prioritize care, and initiate appropriate interventions. It ensures efficient communication among the emergency team and supports rapid decision-making.

The above figure shows the completion rate of Nursing Admission Assessment & Action. Here's a breakdown for your dissertation analysis:

This indicates that a significant portion of nursing admission assessment & action is complete (88%), partially complete (12%) and non-compliance (0%)

Graph 3- Nursing Admission Assessment & Action (n=50)



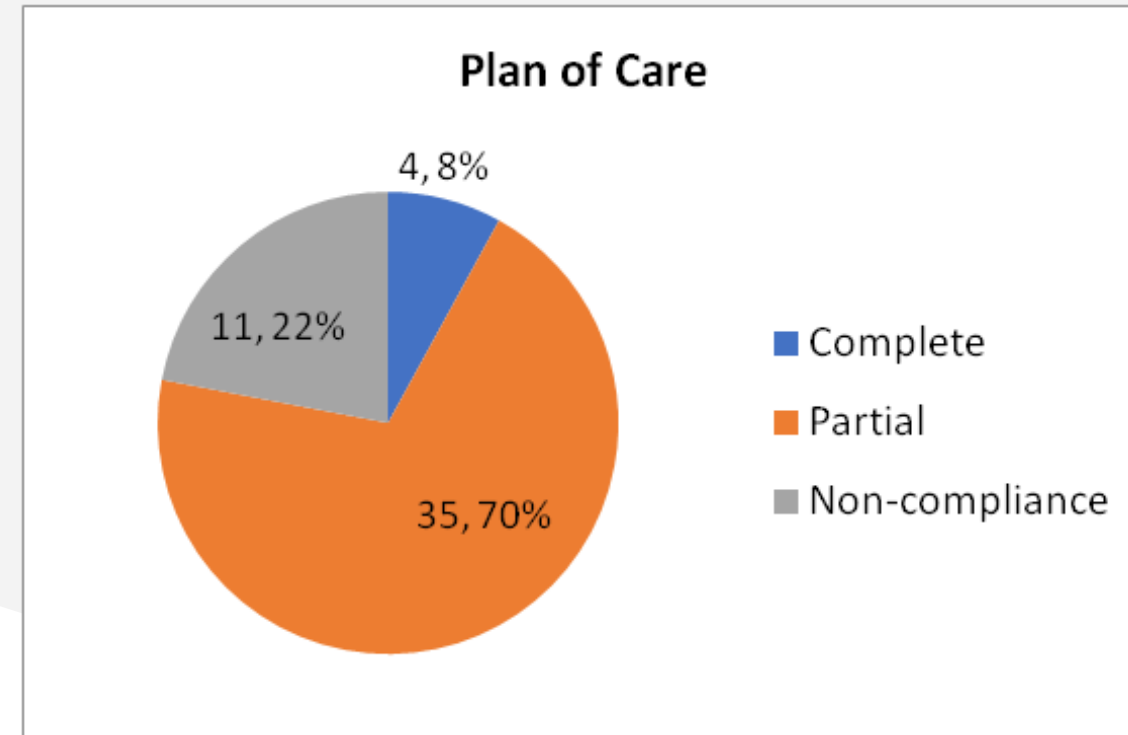
5. Plan of Care

A Plan of Care form in hospitals outlines a comprehensive, individualized plan for a patient's treatment and recovery. It includes sections for patient information, diagnosis, treatment goals, interventions, and progress notes. This form helps healthcare providers coordinate and document planned interventions, monitor patient progress, and adjust care strategies as needed. It ensures continuity and consistency in patient care by facilitating communication among the healthcare team.

The result regarding the completion rate of Plan of Care through breakdown for the analysis:

This shows that significant portion of plan of care is complete (8%), partially complete (70%) and non-compliance (22%)

Graph 5- Plan of Care (n=50)



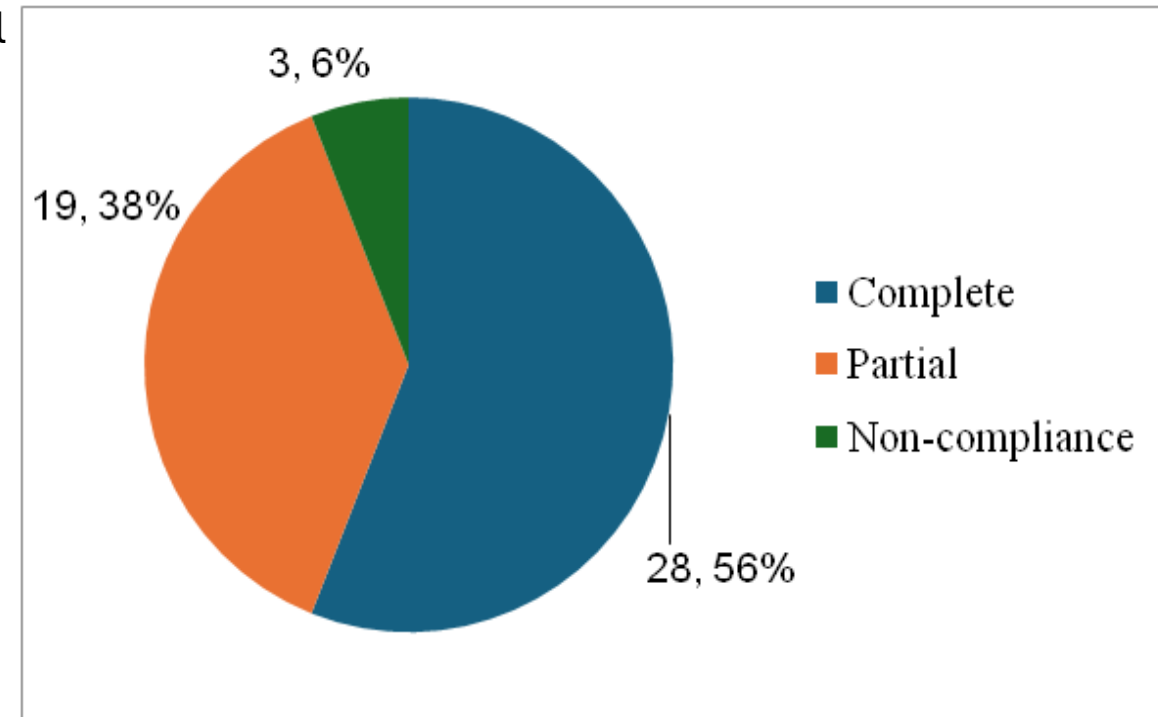
6. Informed Consent Form

An informed consent form in hospitals is a crucial document that ensures patients understand and agree to the proposed medical treatments or procedures. It includes sections for patient information, details of the procedure, potential risks, benefits, alternatives, and the right to refuse treatment. By signing this form, patients acknowledge that they have been adequately informed and voluntarily consent to the procedure.

The completion rate of Informed Consent Form which can be explained through the analysis:

This highlights a significant portion of Informed consent form is complete (56%), partially complete (38%) and non-compliance (6%)

Graph 6- Informed Consent (n=50)



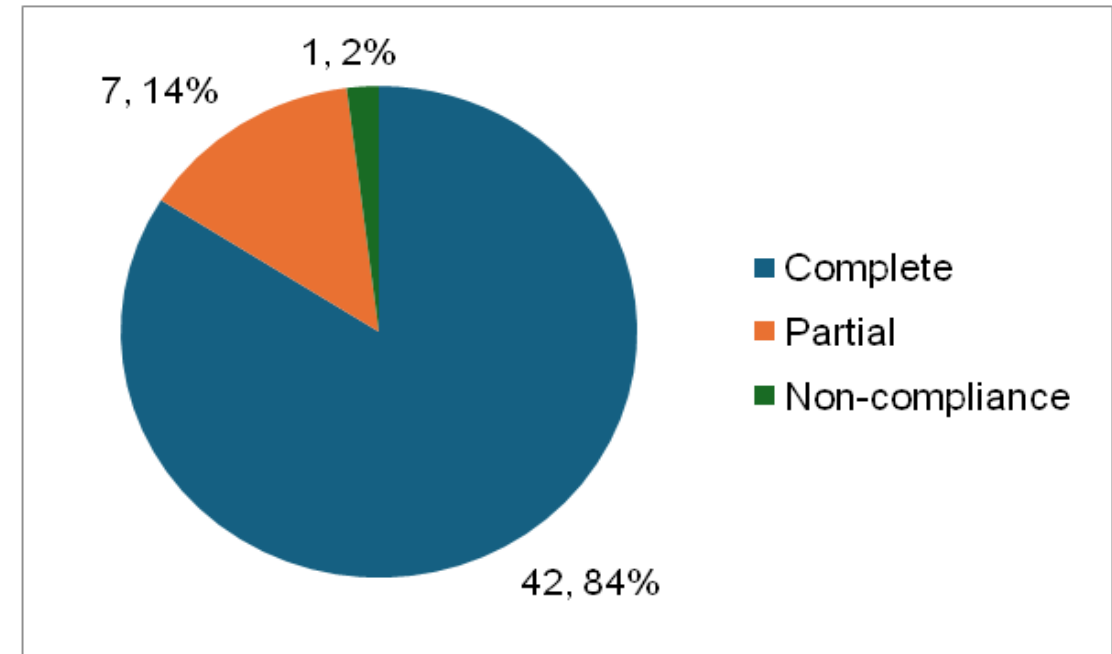
7. Pre-Operative Checklist

A Pre-Operative Checklist form in hospitals ensures that all necessary preparations are completed before surgery. It includes sections for patient identification, confirmation of the surgical procedure, medical history review, allergy checks, vital signs, and verification of informed consent, also personal valuable items. The form also covers pre-surgery instructions, such as any diagnostic test, Laboratory or Haematology test.

The graph suggests the completion rate of Informed Consent Form. Here's a breakdown for your dissertation analysis:

The highlighted shows that a significant portion of Informed consent form is complete (84%), partially complete (14%) and non- compliance (2%)

Graph 7- Pre-Operative Checklist (n=50)



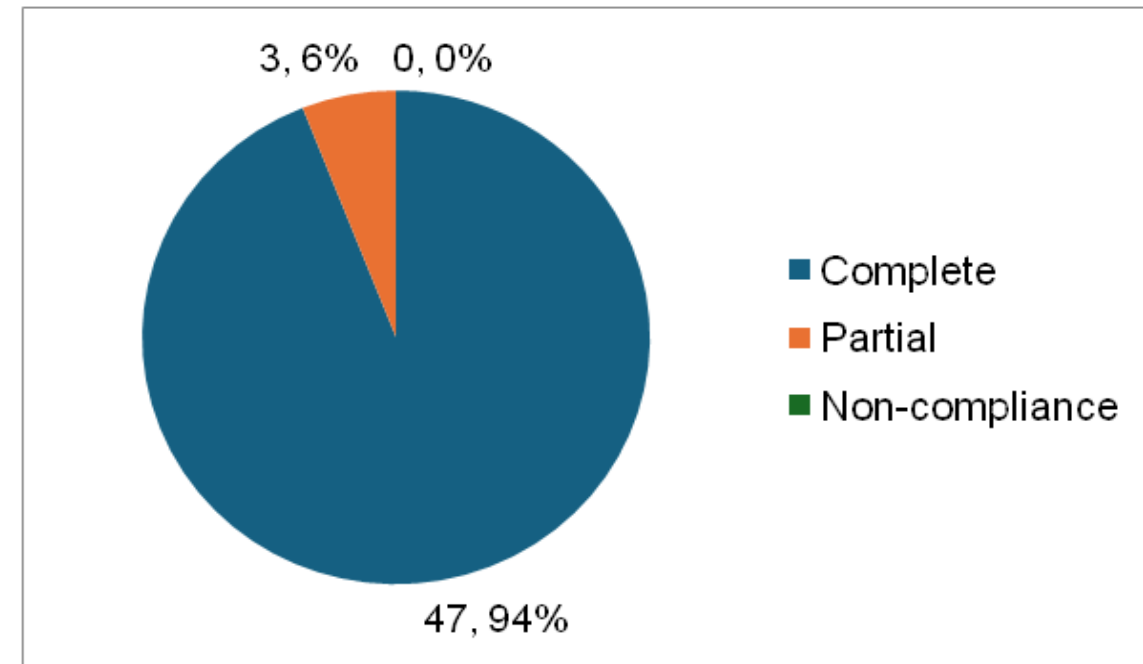
8. Safe Surgery Checklist

A Safe Surgery Checklist form in hospitals is designed to enhance surgical safety and reduce the risk of errors. It includes sections for pre-operative verification of patient identity, surgical site, and procedure, as well as a review of critical steps and anticipated challenges. The checklist ensures that essential items, such as surgical instruments and medications, are available and functioning. It promotes team communication by confirming roles and responsibilities and conducting time-outs for final verification before incision.

The above figure shows the completion rate of Safe Surgery Checklist. Here's a breakdown for the dissertation analysis:

A significant portion of safe surgery checklist is complete (94%), partially complete (6%) and non-compliance (0%)

Graph 8- Safe Surgery Checklist (n=50)



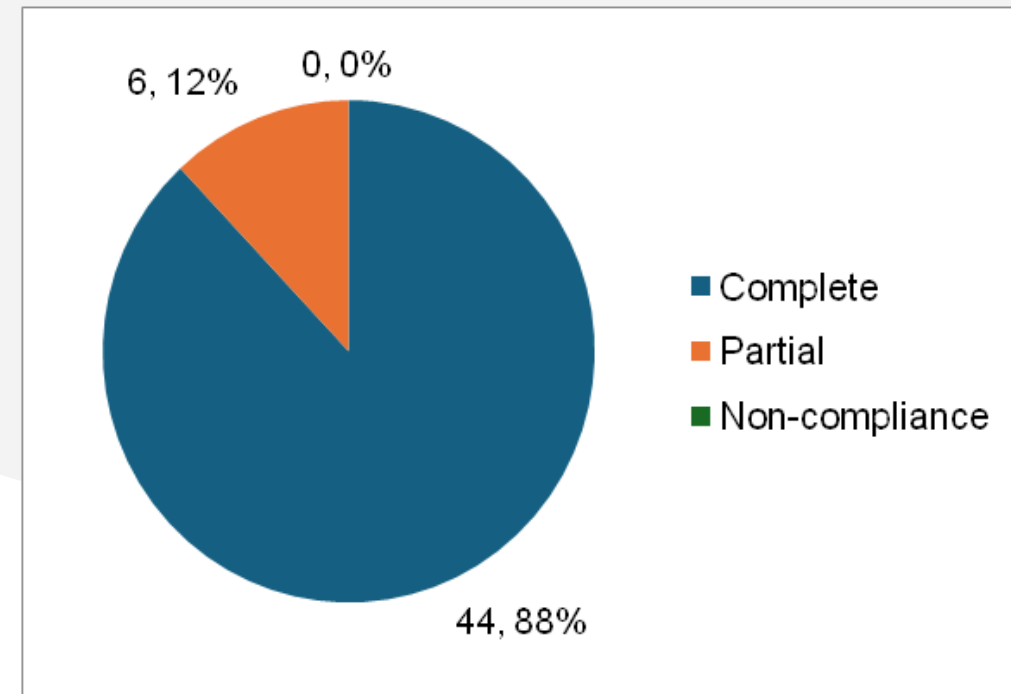
9. Pre-Operative Anesthetic Assessment

A Pre-Anaesthetic Assessment form in hospitals is used to evaluate a patient's medical status before administering anesthesia. It includes sections for patient demographics, medical and surgical history, current medications, allergies, and vital signs. This form assesses risk factors, such as heart or lung conditions, that could affect anesthesia.

The graph suggests the completion rate of Safe Surgery Checklist. Here's a breakdown for the analysis:

The significant portion of safe surgery checklist is complete (88%), partially complete (12%) and non-compliance (0%)

Graph 9- Pre-Operative Anesthetic Assessment (n=50)



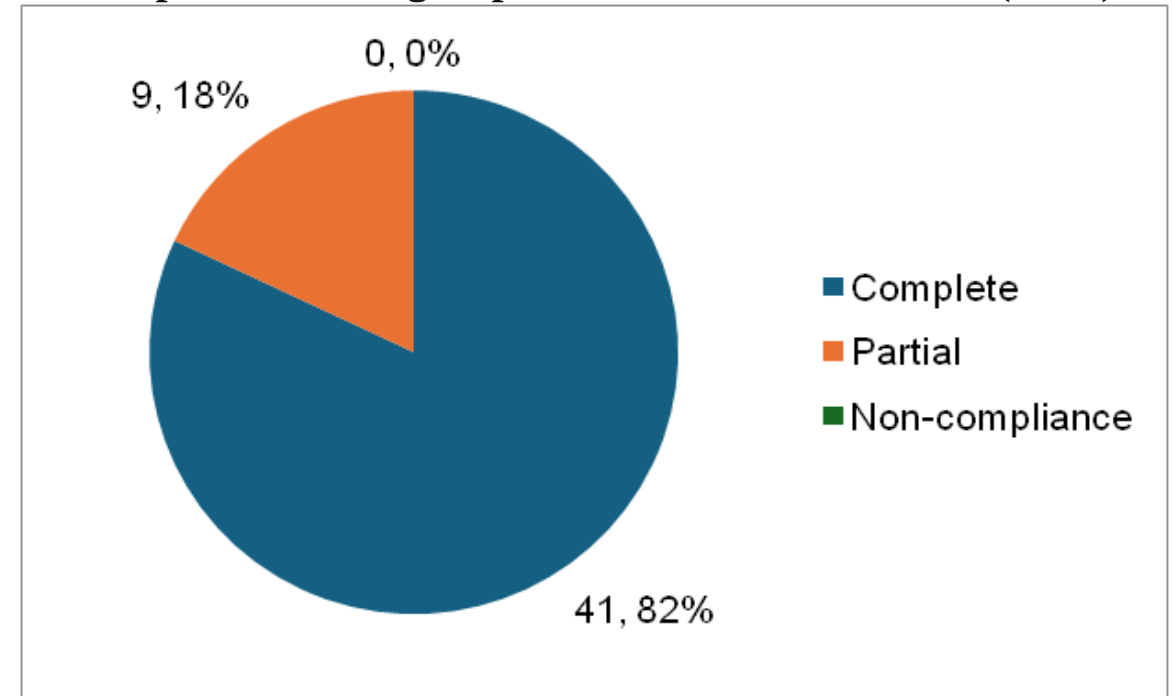
10. Nursing Caps Risk Assessment Record

A Nursing CAPS (Critical Assessment and Patient Safety) Risk Assessment Record form in hospitals evaluates patients' potential risks to ensure their safety. It includes sections for patient identification, risk factors such as fall risk, pressure ulcers, and infection, and assessments of mobility, cognitive function, and skin integrity.

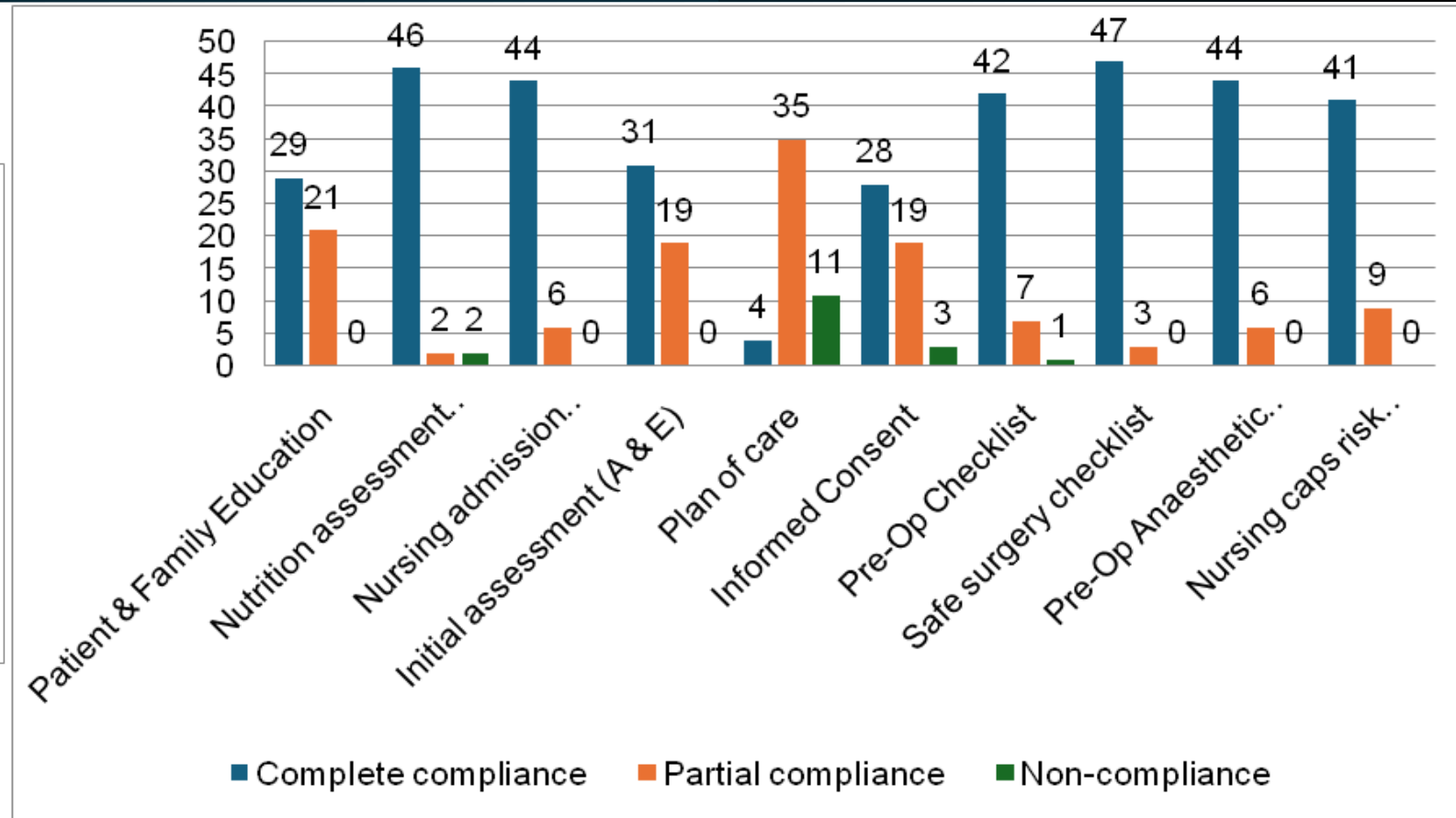
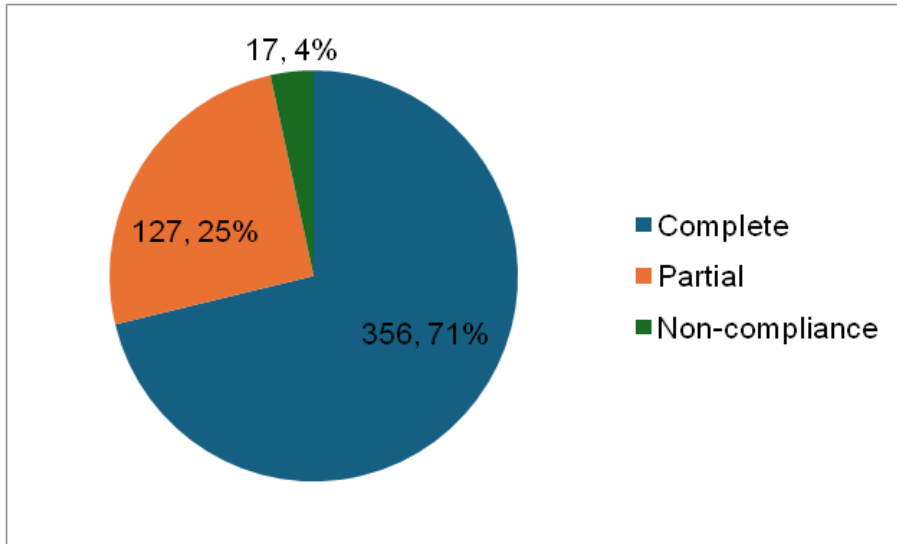
The pie chart depicts the completion rate of Safe Surgery Checklist. Here's a breakdown for the analysis:

A significant portion of safe surgery checklist is complete (82%), partially complete (18%) and non-compliance (0%)

Graph 10- Nursing Caps Risk Assessment Record (n=50)



Total compliance



Out of 500 samples, it is found that 356 samples were complete compliance, 127 samples were partial compliance and 17 were non-compliance. The pie chart shows three slices labeled Non-compliance (4%), Partial compliance (25%), and Complete compliance (71%).

CONCLUSION

Based on the study examining medical record documentation in compliance with NABH 5th Edition Guidelines, several key conclusions were drawn.

Overload

Overload patients and families, leading to incomplete sections or skipping entire parts.

Neglect

Unintentionally neglect to complete certain sections of the documentation due to forgetfulness or time pressure.

Rushed

Feel rushed during consultations, leaving insufficient time to fully complete the documentation with patients and families.



RECOMMENDATIONS



CONDUCT REGULAR TRAINING SESSIONS FOR HEALTHCARE PROVIDERS ON NABH GUIDELINES AND THE IMPORTANCE OF ACCURATE MEDICAL RECORD DOCUMENTATION TO KEEP STAFF UPDATED ON ANY CHANGES OR UPDATES TO NABH GUIDELINES.



IMPLEMENT EMR SYSTEMS WITH AUTOMATED ALERTS AND REMINDERS FOR INCOMPLETE OR MISSING DOCUMENTATION, ENSURING TIMELY COMPLETION OF RECORDS THAT INCORPORATE NABH GUIDELINES INTO THEIR TEMPLATES, FACILITATING EASIER COMPLIANCE AND REDUCING MANUAL ERRORS.



BY CONDUCTING REGULAR AUDITS, IDENTIFY COMMON AREAS OF NON-COMPLIANCE AND ADDRESS THEM PROMPTLY.



EDUCATE PATIENTS ABOUT THE IMPORTANCE OF ACCURATE MEDICAL RECORDS AND ENCOURAGE THEM TO PROVIDE COMPLETE AND ACCURATE INFORMATION.



THANK YOU