

Summer Training

At

**Bhagwan Mahaveer Cancer Hospital and Research Centre
(BMCHRC)**

From 10th May, 2021 to 2nd July, 2021

A Report on

**Adherence of the active patient files to the NABH guidelines before and
after intervention and gauging their improvements in BMCHRC.**

By

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Bhagwan Mahaveer
Cancer Hospital & Research Centre
(Managed By K. G. Kothari Memorial Trust)

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Date: July 3rd , 2021

To whomsoever it may concern

This is to certify that the student **Rushi S Joshi**, MBA Hospital and Healthcare Administration student from **IIHMR University, Jaipur** has completed his internship program from **10th May 2021 to 2nd July 2021**.

During the tenure of his internship he has assisted the hospital operation team in NABH preparation as per 5th edition guidelines.

He has done his work satisfactorily during internship period.

We wish him all the best for his future endeavors.

Bhattacharya

Tapti Bhattacharya

Head HR & Training

Tapti Bhattacharya
Head-HR & Training
BMCHRC, JAIPUR



ACKNOWLEDGEMENT

This internship was a great learning curve for me, being in such a prestigious institution has its perks, with exposure being the keyword. Exposure to knowledge, test of our mettle and skills and opportunity to imbibe new and amazing thing and also being able to forge lifelong friendships.

I'd like to thank my college, IIHMR University for the opportunity to intern in a great organisation. I would also like to extend my gratitude to BMCHRC for the insightful and opportunity ridden internship. Further, I would like to extend my gratitude to Dr. Subha Pathania (Medical Superintendent) for having the faith in the students of IIHMR and giving them an opportunity to prove themselves. A very big thank you goes to the Quality Assurance Dept. under whom I spent the most amount of time, Dr. Sonal Rai (Senior Quality Executive) for the humility with which she guided me, helped me do better work and make me gain knowledge, skills. Also, a thank you to Vansh Chaudhary (Quality Executive) for his help and being a friend all the while. Lastly, I would like to thank my fellow interns who made the process fun, exciting and enriching. A special thank you to Dr. Akshita Sharma and Dr. Munir Susham for helping me in need and being there all the while as a great friend.

I hope this captivating experience will enable me to further ahead and help people.

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ACRONYMS/ ABBREVIATIONS

BMCHRC	Bhagwan Mahaveer Cancer Hospital and Research Centre
CSSD	Central Sterilization and Supply Department
Dept	Department
MS	Medical Superintendent
NABH	National Accreditation Board for Hospitals
OPD	Out Patient Files
IPD	In-Patient Files
HOD	Head of Dept.
POST OP.	Post Operation
MO	Medical Officer
SICU	Surgical Intensive Care Unit
MICU	Medical Intensive Care Unit

OBSERVATIONAL LEARNING

BRIEF DESCRIPTION OF THE ORGANISATION



Bhagwan Mahaveer Cancer Hospital and Research Centre, Jaipur (BMCHRC), a NABH accredited institution, was established in the year 1997 as a cancer speciality hospital offering cancer prevention, treatment, education, and research centre. Started with just 50 beds at the initial stage, it grew into a super-speciality, 300-bedded hospital with leading-edge infrastructure housing several wards, laboratories, utility services and specialities after 23 years. Today, BMCHRC has its own Surgical Oncology, Medical Oncology, Radiation Oncology, Radiology, Nuclear Medicine, Pathology departments, and a huge Blood Bank. It is a not-for-profit super specialty cancer hospital.

BMCHRC offers several services to fulfil its aims of providing comprehensive cancer care to the patients. The services offered at the institute include:

SCOPE OF SERVICES

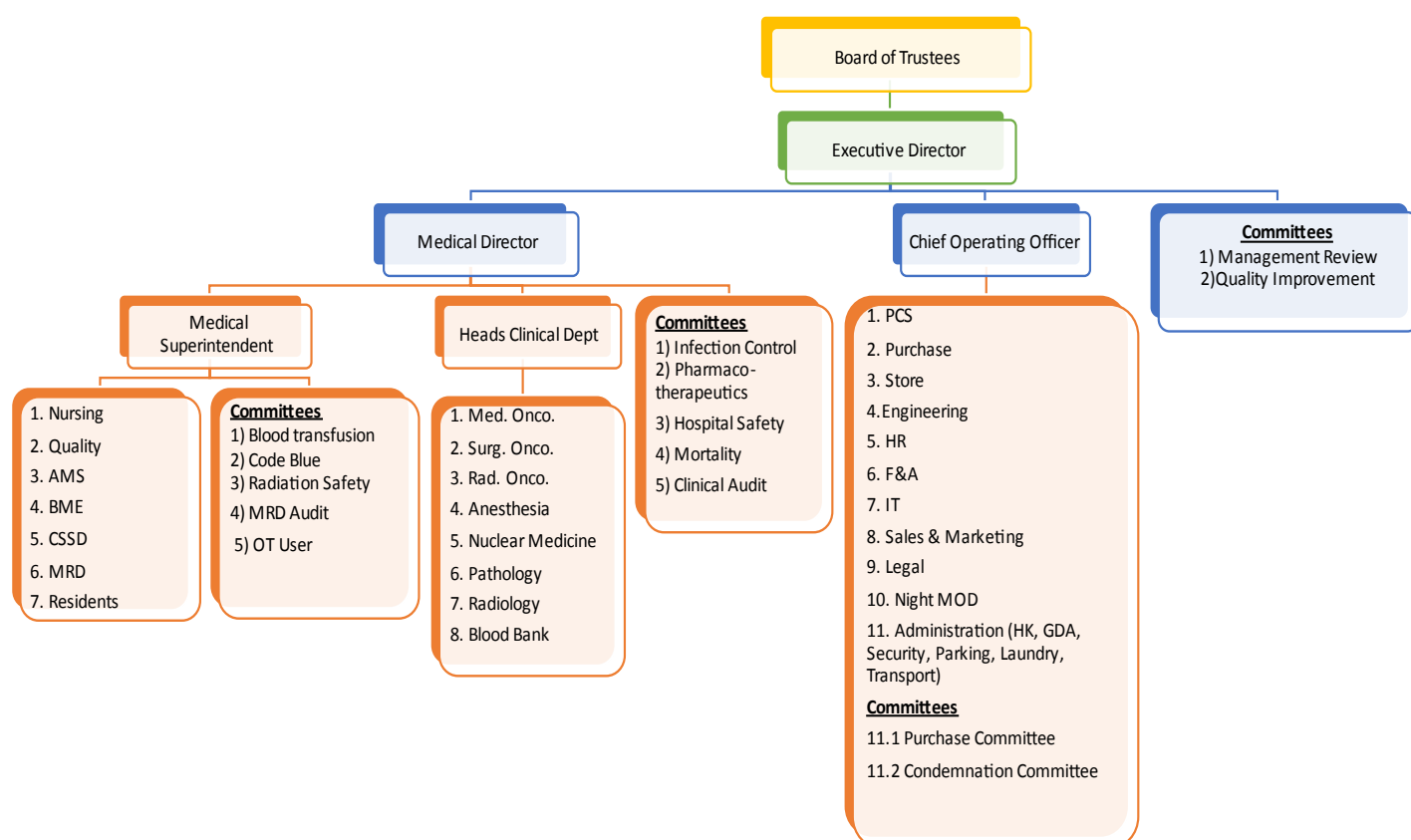
CLINICAL SERVICES	Medical Oncology • Solid Tumor • Hemato Lymphoid • Paediatric Oncology • Day Care	Radiation Oncology • Linear Accelerator (IMRT, IGRT, 3DCRT, RapidArc, SRS, SRT) • Brachy Therapy • PET-CT planning • Intra Operative Radio Therapy
	Surgical Oncology • Head & Neck	Nuclear Medicine • Radio Iodine Therapy

	• Breast • Genito Urinary • Gynecology • Gastrointestinal Tract • Thorax & Esophagus • Soft Tissues • Neuro Oncology • Ortho Oncology • Plastic & Reconstructive Surgery	• Samarium Therapy
	Anesthesiology	General Medicine
LABORATORY SERVICES	• Hematology • Biochemistry • Histopathology (Frozen Section & IHC) • Cytopathology • Microbiology and Serology • Molecular Pathology • Clinical Pathology • Flow Cytometry	
DIAGNOSTIC SERVICES	• PET-CT • Gamma Camera • Sentinel Node Imaging Biopsy • CT-Scan • MRI • Mammography • Ultrasound • X-Ray • 2D Echo • OPG Dental • Bone Marrow Biopsy/Aspiration	
SUPPORT SERVICES	• Palliative Care • Physiotherapy • Dietetics Services • Mortuary • Tele-consultation	
24*7 SERVICES	• Emergency Services • Blood Bank • Laboratory • Radiology • Pharmacy • Ambulance (outsourced)	

SERVICES NOT AVAILABLE IN BMCHRC

- Organ Transplant
- BMT
- ANC Ultrasound
- Pediatric Intensive Care Unit
- Neonatal Intensive Care Unit
- Burns

ORGANOGRAM OF THE BMCHRC



SPECIFIC OBJECTIVES

- To provide “Affordable Care with Human Touch” to all sections of the society irrespective of economic considerations.
- To make Bhagwan Mahaveer Cancer Hospital and Research Centre (BMCHRC) a comprehensive world-class cancer treatment facility with cutting edge technology.

MODE OF DATA COLLECTION

- **Quality dept.-** CAPI (Computer assisted personal interviewing) through google forms.

- **Medical Admin-** Manual noting of time while measuring TAT time and/or use of google forms.
- **Operation Theatre** – Checking of input of times of stages of surgery by manual noting and anti-biotic and surgical checklist audit was conducted via google forms.

GENERAL FINDINGS ON LEARNINGS

Department wise observations (Major critical factors) and learnings

QUALITY ASSURANCE DEPARTMENT

- A considerable amount of time (4 weeks) was spent in the quality assurance dept. as organisation's initial posting was done here.
- Deployment was done a month before the NABH accreditation.
- Responsibility given included that of being the **internal auditors** for the various patient files which included Active patient file audit, Patient Safety Audit, Closed file or discharge file audit and Prescription audit.
- The files were audited based on questionnaires which were made based on NABH guidelines.
- The NABH accreditation which took place was of the 5th NABH edition, which is for four years now, with surveillance every two years.
- The quality assurance of the hospital is involved in the maintenance of the standards and improving them in all aspects of the hospitals.
- The active file audit and patient safety audit is done by inspecting the admitted patient's files and checking for adherence.
- The discharge file audit and prescription audit is done by inspecting the files from the MRD departments and checking their adherence to the NABH gudelines.
- The files are checked, adherence computed, improvements suggested, and the files are re-audited in some time for gauging their improvements.
- Root-cause analysis or Fish-bone analysis was done for various parameters in the organisation; interviews were done with the hospital staffs for the following parameters:
 1. Turn-Around Time for OPD patients
 2. Waiting time (TAT) for various diagnostics(Ultrasound, MRI, CT, X-ray, Mammography)

3. Operation Theatre cancellation of surgeries/ rescheduling of surgeries
 4. Unplanned return to OT
 5. Return to emergency within 72 hours
- Filing of the various incidents in the incident report file which includes incidents for every accident in all floors and personnel.
 - Collecting data from Infection control committee about HAI (Hospital Associated Infection) which includes:
 1. **CAUTI** (Catheter associated Urinary tract infection)
 2. **VAP** (Ventilator associated Pneumonia)
 3. **CLABSI** (Central line associated blood stream infection)
 4. **Surgical Site infection**
 5. **Needle stick injury**
 - Keeping a check on the patient-nurse ratio by checking the formula used by the floor personals and their method of indicating the nursing superintendent about the needs. The ratio is as follows (Nurse: Patients)
 1. For ventilator patients - 1:1
 2. ICU patients – 2:1
 3. In wards – 4:1
 - Keeping Corrective Action, Preventive Action (**CAPA**) register for the various departments like civil dept., electrical dept. etc for the needs that came across.
 - Mock interviews for all the departments of the hospital for the NABH accreditation.
 - With March being an unusual month where there were five instances of unplanned return to OT, the analysis for it was done by correlating the incident report files, surgeries conducted in OT and a conclusion was reached that 91% of the surgeries that had an unplanned return to OT were of the free flap surgeries kind and the research was given supporting the same.
 - NABH was conducted and the hospital was accredited with **95% compliance**.

MEDICAL ADMINISTRATION DEPARTMENT

- Second deployment was in the medical administration under the medical superintendent of the hospital for a week.
- Initial task here was creation of the Clinical Pathway for oral cancer and breast cancer, the non-existence of which was a giveaway and feedback of the recently concluded NABH accreditation.
- Clinical Pathway which is the set documented protocol for the treatments for certain diseases; hence the initial phase had the clinical pathway for oral cancer and breast cancer.
- The draft for the same was prepared in association with the quality dept. and the draft was taken to various doctors of the surgical oncology, medical oncology and radiation oncology for checking of the draft.
- The required changes were then made and a final report consisting of the Clinical Pathways for the Oral and Breast cancer was prepared and submitted to the NABH.
- The various training programs for the prepared clinical pathway according to the NCCN guidelines were given to the various doctors and technicians/ technologists by the MS.
- To further reduce the TAT of the patients, the hospital process of registration to the doctor's desk was understood, patient followed, time noted, the various processes including registration for various kinds of patients like Jan Arogya Yojana patients, ECHS patients, govt. employees' patients etc. to the process of initial assessment and panel selection by the doctors and AMS (Assistant Medical Superintendent) respectively. The process was tabulated, a root cause analysis was made and submitted to the MS.

OPERATION THEATRE

- The next deployment was in the Operation Theatre.
- The zonings of the OT were understood thereof, Protective zone, clean zone, Sterile zone and Dirty Zone.
- The scheduling and noting of various times of the surgeries like-
- Patient Wheel-in time
 - b) Anaesthesia intubation time
 - c) Incision time (Time-out time)
 - d) Closure time (Sign-out time)

- The times were noted and were audited with the times mentioned by the staff in the intra-operative record and other records.
- Questionnaire for an Anti-Biotic audit was prepared as mentioning of the antibiotic name and administration time of the same is to be done according to the NABH feedback in the concluded NABH accreditation and the patient files in the Surgical-ICU were audited.
- Similarly, a questionnaire for a Surgical Safety checklist audit was prepared, as this was also a feedback that was to be followed for the completion of the surgical safety checklist which also included the newly added antibiotic adherence, and the SICU patient files were audited for it.

Furthermore, various other departments were visited for understanding their functioning like:

Blood Bank

- a) The various equipment's and their functioning were explained by the HOD.
- b) The equipment containing the isotope to deactivate the blood (lymphocytes) of Graft versus Host disease was seen. The process is photopheresis.
- c) The haemolysis of blood was seen.
- d) The machine which separates for e.g. Only platelets from a donor from his donated blood and transfuses the rest to him was seen.
- e) The storage of blood and its components and their separation process was seen.
- f) The process of matching of the stored blood with the required blood from the wards/OT was seen.

CSSD

- a) The three areas were understood- decontamination, clean and sterile.
- b) The ultrasonic (multienzyme solutions and sound waves clean) or thermal wash (90 degrees) for the instruments initially.
- c) Packing in the clean zone according to the list and sticker for confirmation of sterilization is stuck and double wrapping is done.
- d) Autoclave sterilization at 134 degrees and at 2.1 kg pressure.

- e) In tests for sterilization, the leak test, Bowie-dick test for checking air inside the autoclave, and biological indicator test for gauging penetration of sterilization wherein a vial of bacteria with food is kept in the autoclave, after which it's incubated along with a sample for checking if there's a growth of the bacteria after being in the autoclave.
- f) Storage of the sterile items in the sterile room was understood and seen.
- g) Separates storage for linen and cloth items exists for avoiding the mixing of the instrument with any cloth fibres.

IT Dept

- a) CPOE (computerized physician order entry) as a concept was understood.
- b) Dicom technology in the diagnostics dept. for archiving the scans with the memory of 7TB which is replenished every two years was understood.
- c) Picture Archiving and Communication System (PACS) technology in the radiology dept was understood.
- d) The importance of IT dept in maintenance of servers, appointment software's etc were understood.

Electrical and Fire Safety Dept.

- a) The importance of jockey for maintaining pressure, hydrant technology to ensure reach of water and sprinkler technology in every room whose seal is broken automatically at 68 degrees.
- b) The existence of 2 Lakh+ 40 thousand litres of water stored, and the intricate technology involves in it.
- c) The transformer and the breaker circuit for converting DC to AC at 440 volts were understood along with the generators in place (900KV + 500KV + 500KV) were observed.
- d) The system in place that accurately lets the dept know of the address of fire was seen.

Central Supply Store

- a) The method of forecasting needs based on past years and the process of how each dept. files their need indent was understood.

- b) The ABC analysis and FIFO method of warehousing was understood.
- c) The GRN (Goods Received Number) generating process was understood.
- d) The software that keeps track of the indents, warehouse numbers was understood.
- e) Storage of different kinds of items was seen in the storage area.

LIMITATIONS AND SUGGESTIONS

- ◆ The OPD waiting time for patients is on average 2-2.5 hours which is quite large.
- ◆ The multiple steps involved in the registration of patients wherein the types of patient depending on their payment method and the steps involved before their file is made including the initial assessment, panel selection is a big process and is time consuming.
- ◆ Recommendation is that all the above process of initial assessment, panel selection be present in the same room for streamlining the process.
- ◆ The appointment system isn't at par with the patient downfall at BMCHRC, better digitalisation along with awareness to patients about the same is essential.
- ◆ Separate canteens for the staff and patients is pivotal as there needs to be no exchange of disease between the healers and to the person that has come to be healed. Especially in the covid times.
- ◆ The CSSD dept. is at the basement whilst the OT is at the second floor, the arduous journey can pose a risk from the infection point of view.



RESEARCH PROJECT REPORT

PROJECT REPORT

INTRODUCTION

RESEARCH RATIONALE

- Documentation is a major facet of health and disease progression of a patient in a hospital; hence, it is vital that it is recorded and maintained according to the established guidelines. Correct record is essential for determining the journey which the patient has made from the first day. Be it related to drug order sheet, doctor notes or nursing notes, physiotherapy recoveries to the basic pain score, the process is imperative to the patient's recovery.
- Patients in the IPD have a cluster of people overseeing them. From nurses to nutritionists to doctors. These along with other clinical records such as drug order sheet, it's schedule, disease progression, plan of care etc. are central for a holistic clarity for the patient's illness. Hence, the active files in the IPD of the admitted patients are imperative to be completed according to the guidelines of the NABH.
- Research conducted by **NCBI** on Quality improvement of medical records through internal auditing: a comparative analysis showcased through results that **Compared to the first analysis, a significant quality amelioration in all the sections of the medical chart was shown with the second analysis, with an increase of all the scores above 50%. The differences found for each section of medical records between the first and second analysis are all significant** and also mentioned that Internal audits are not just measurement activities but a necessary activity to support the organization in achieving its objectives and assessing the quality of clinical care and maintaining high quality professional performance.
- Also, research by PubMed on **Audit and feedback: effects on professional practice and healthcare outcomes** demonstrated that Audit and feedback generally leads to small but potentially important improvements in professional practice.
- Systematic literature reviews demonstrate that the effects of auditing and feedback on the behaviour of healthcare professionals and on patient outcomes range from none to substantial, with a maximum of a 70% increase in compliance with desired professional practice.

RESEARCH QUESTION

What is the adherence of the active patient files (admitted patient files) to the NABH guidelines before and after intervention and what is the scope of their improvement post intervention in BMCHRC?

SPECIFIC OBJECTIVES

- To conduct an internal auditing of the active patient files of the admitted patients in the IPD.
- To understand the adherence of the active patient files to the NABH guidelines and quality indicators on these.
- Analyse the data for the compliance rate and prepare a plan for intervention at the organisational level, team level, process level which will be the changes that will be at the meso level and the micro level.
- To see the efficacy of the interventions which will be in the form of training workshops, counselling to the HOD's and other staffs and other appropriate measures.
- Conducting an internal auditing post the intervention and analysing the collected data.
- Comparing the two sets of collected data and understanding if the intervention had any improvements on the adherence to the quality indicators.

METHODOLOGY

RESEARCH DESIGN

- The research was based on inductive reasoning wherein, we are beginning from observations and reaching the theory.
- Since, we were comparing the active patient files at the beginning and after the intervention, **it is analytical in nature and is a cohort study.**
- IPD Patient files were audited in the beginning and their adherence to the quality indicators of NABH were gauged and analysis made.
- Based on this, there were intervention programs, mainly counselling that were given to the dept. HOD like Nursing HOD, floor nursing in charge, floor operations in charge and so on for all the related dept that intervention is to be made.
- Apart from this, capacity building programs were given by the quality assurance dept. and infection control dept. among others.

- Post intervention, there was an audit again and improvements gauged.

SAMPLE SIZE

- A sample size of 300 active patient files was used for the initial internal auditing.
- Post intervention, a sample size of 305 active patient files was used.
- **Criteria for inclusion** in the sample size included the patient files (admitted patients) in the **IPD dept., SICU and MICU**.
- **Exclusion criteria** was those of the **day care patients** and **OPD** patients.

SAMPLING PROCEDURE

- **Simple probability sampling technique** was used wherein, during the internal auditing, random patient files were picked up and analysed.

MODE OF DATA COLLECTION

- The primary data was collected by questionnaires which were approved by the concerned department.
- The data was collected in person by visiting the various wards and floors of the hospital.

-First, second, third and fourth floors of the hospital consisted of the general wards.

-The sixth and seventh floor housed the semi-deluxe and deluxe rooms, respectively.

- **Computer-Assisted Personal Interviewing (CAPI)** mode of data collection was used, wherein, the patient files were checked for the established standards upon which the questionnaire was constructed upon, and the data and compliance was then inputted for every guideline in every question, respectively through the google forms created.

ANALYSIS FOR THE DATA COLLECTED.

- The data collected through the questionnaires through the google forms where the patient files were audited for each quality indicator and the recorded data is cleaned up in the MS excel first.
- Since the data is collected in the dichotomous form wherein, they're either yes or not with the option of NA given at certain places, the 'yes' are changed to '1', all 'no' are changed to '2' by the function of 'Find all' and 'Replace all'.

- The function of '**countif**' is employed to count the number of yes and no.
- The result of number of 'no' is then divided by the total number of files and multiplied by 100 to get the percentage of non-compliance of every indicator checked for.
- This process was repeated for both sets of observation, that is, pre and post intervention.
- Then the comparison was done for the two sets of data for every indicator wherein, each indicator was compared for the changes in their non-compliance. The average for the non-compliance comparison for all the indicators was found using the average function of the excel.

DATA COMPILATION

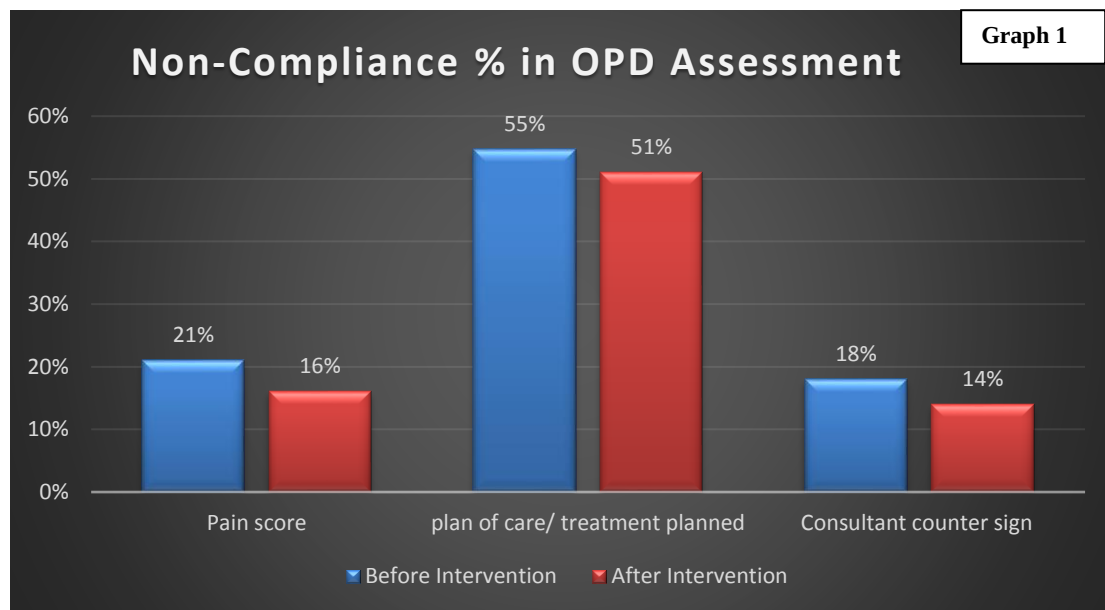
Quality Indicators matched against		Non-Compliance% before intervention	Non-Compliance % after intervention
OPD Assessment			
2	Pain score marked (from 1 to 10)	21%	16%
3	Plan of care/ treatment planned mentioned	55%	51%
5	Consultant counter sign done	18%	14%
IPD Assessment			
6	Timeliness of doctor's assessment (standard is within 60 min)	33%	29%
7	Form Completeness	38%	33%
8	Pain score marked	43%	37%
9	Plan of care/ treatment planned given	32%	28%
10	MO sign,date marked	16%	12%
11	Consultant counter sign done	27%	23%
Nursing Admission Assessment			
12	Timeliness (30mins)	9%	5%
13	Form Completeness	5%	1%
14	Fall assessment marked	5%	1%
15	Vulnerable Scoring marked	6%	2%
16	Pain assessment marked	7%	3%
17	Plan of care mentioned	8%	3%
Other Assessment			
18	Nutritional Assessment given	32%	28%
19	Physiotherapy Assessment given	31%	27%

Consents			
20	Operation	20%	14%
21	Anaesthesia	29%	24%
22	Blood transfusion	40%	35%
23	Restraint	93%	88%
24	High risk	37%	30%
25	Chemotherapy	33%	28%
Progress Note			
26	Date & Time of notes	4%	0%
27	Legibility / Capital Letter	38%	33%
Drug Order Sheet			
28	Allergies documented	15%	11%
29	Written in capital letter	9%	6%
30	Clear Dose mentioned	6%	3%
31	Clear Route mentioned	8%	4%
32	Clear Frequency mentioned	7%	4%
33	Verification for high-risk medication done by 3 doctors	21%	16%
34	Resident Signature	35%	30%
35	Stop order marked	73%	69%
36	Admin. Time marked	6%	2%
37	Nurse sign marked	9%	4%
Anaesthesia Record			
38	PAC complete	25%	20%
39	Intraoperative record complete	34%	29%
40	Recovery score marked	37%	31%
41	Anaesthetist name & sign	35%	30%
Surgery Record			
42	Post OP Notes given	36%	30%
43	Surgical Safety Checklist complete	32%	26%
44	Pre-Operative checklist complete	32%	27%
45	Blood Loss marked	61%	55%
Nursing Part			
46	Nursing Notes present	5%	1%
47	Nursing Care plan given	5%	1%
48	Legibility of notes	8%	3%
49	Nurses Handover done	4%	0%

An Average of 4% improvements was seen in the non-compliance that was present before and after intervention.

ANALYSIS AND INTERPRETATION

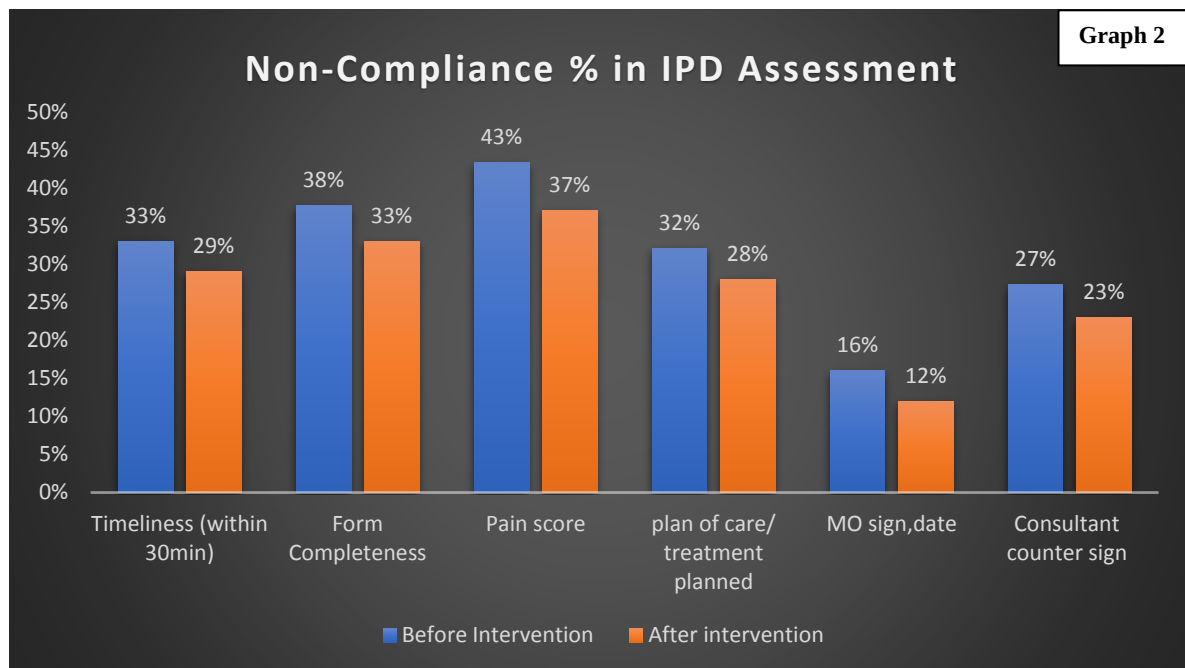
1. OPD Assessment non-compliance rate before and after intervention



Interpretation and recommendations

- OPD assessment of the active patient files painted a picture wherein pain score and consultant countersign had expected levels of non-compliance, but plan of care/treatment section was omitted regularly, almost half the times.
- Hence, counselling whilst on the floor to the doctors who fill the sections and advise to the nurses about constant reminders needed for the doctors to fill the forms which will lead to effectiveness.
- Here, non-compliance was also counted in cases where just signs of doctors were present without either the stamp or the name of the doctor. Just signatures of doctors is not accepted towards compliance.
- The re-audit done after the intervention showcased that there was a significant improvement in the statistics of 4-6%. The efforts of counselling, reminders will be continued for further improvements.

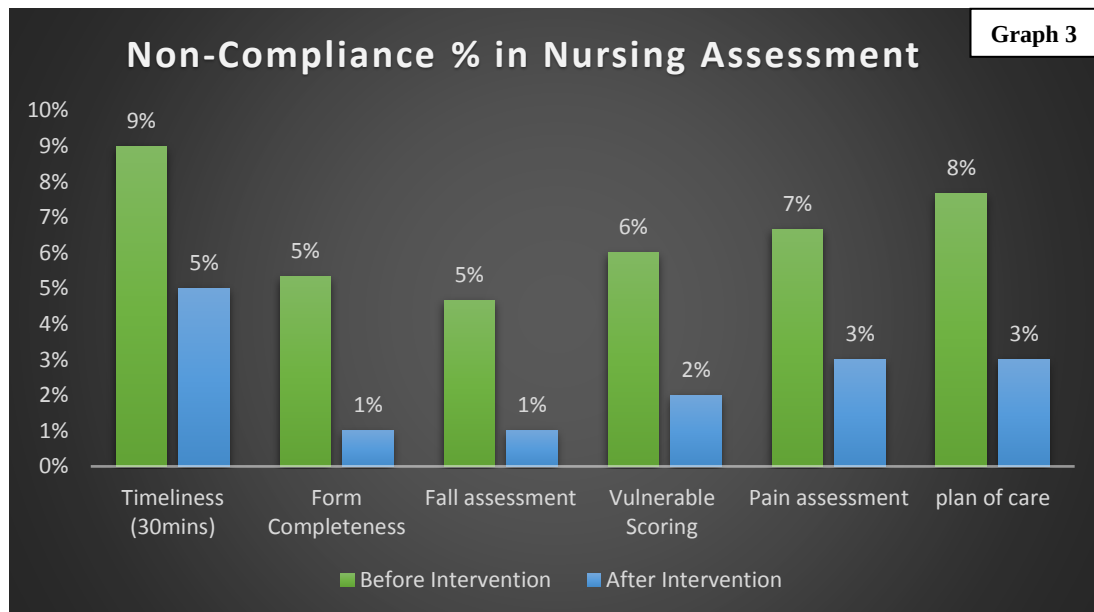
2. IPD Assessment Non-compliance rate before and after intervention



Interpretations and Recommendations

- Analysis of the IPD assessment non-compliance showcased an atypical and high non-compliance for various parameters. These parameters are imperative for appropriate patient records and their safety.
- Here, non-compliance was also counted in cases where even a single vital section of the form was not filled in form completeness.
- Similar approach of counselling along with hands on training was given to the doctors and nurses on the importance of filling the prerequisite sections as future treatment and course of action is determined on these sections. Such capacity building exercises were given on the floor and by organising workshops in the conference room.
- The signatures again were only counted if there was signature of the doctor along with name of doctor or his stamp.
- There were considerable improvements post the intervention of 4-5%.

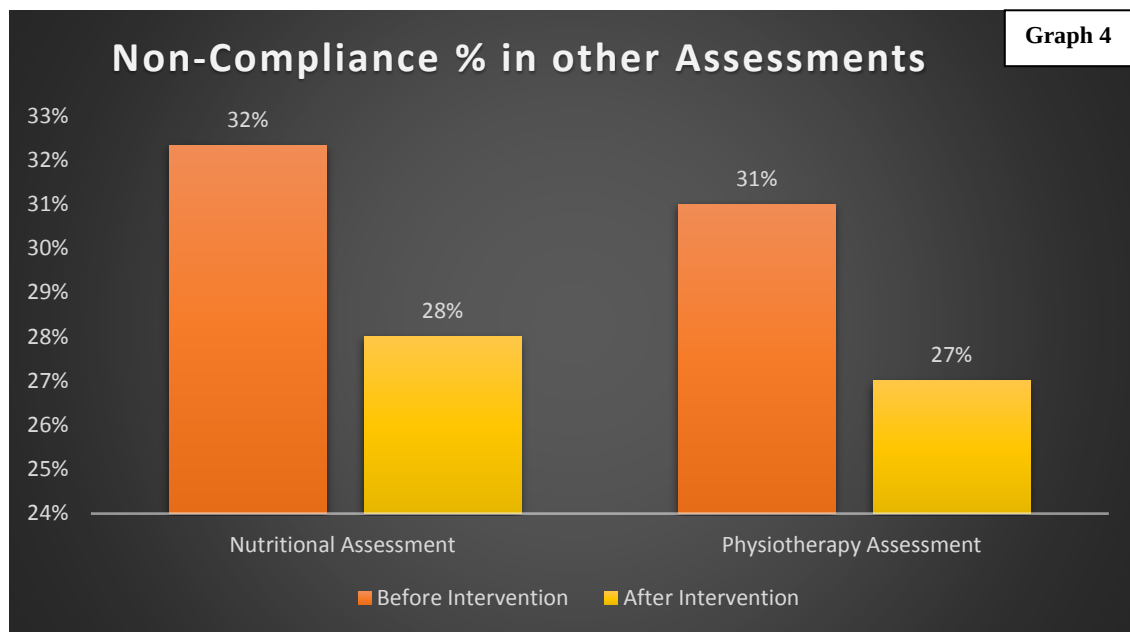
3. Nursing Assessment Non-compliance rate before and after intervention.



Interpretation and Recommendations

- Nursing assessment in the active file audit showcased that the nursing related documents had low non-compliance rate.
- Hence, minimal counselling, especially on time management for timely filling of forms and importance of these indicators for patient safety was explained.
- The audit done after this intervention reaped good rewards as the non-compliance further reduced.
- Efforts will be taken so that there is no complacency in this dept.

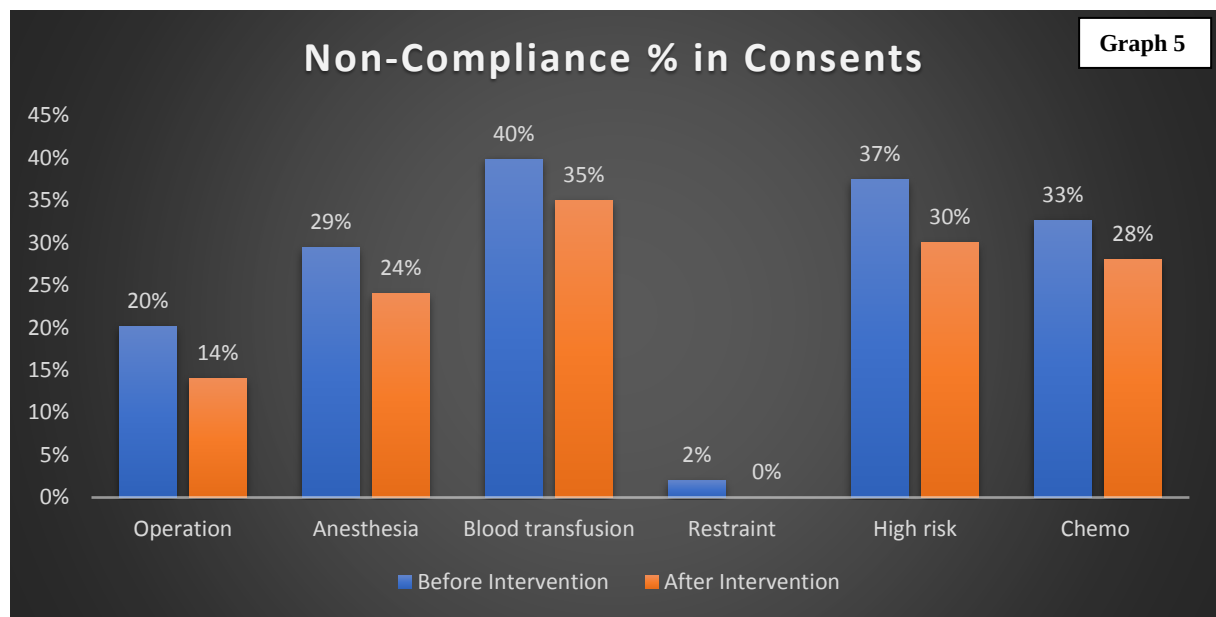
4. Other departments non-compliance rate before and after intervention



Interpretation and recommendations

- Analysis of the nutritional and physiotherapy assessment yielded results which showcased a problem wherein around 1/3rd of the files did not have the nutritional and physiotherapy sections filed.
- On inspection, it was found that the reason for these were the recent resigning of the related staffs, nutritionist coming from NGO's for patients admitted via govt. programs such as Jan Aarogya Yojana among others, hence, the schedule of them were difficult to keep a track of and many of staffs had been diagnosed covid positive.
- The management was contacted for the same, with the inclusion of more staffs for these sectors along with better timing schedule if in-house staffs and after deliberation with the nutritionists from the NGO's about their timings was done.
- The reaudit showcased a decrease in non-compliance rate, but the steps currently taken will be continued and newer ones will be taken for better results.

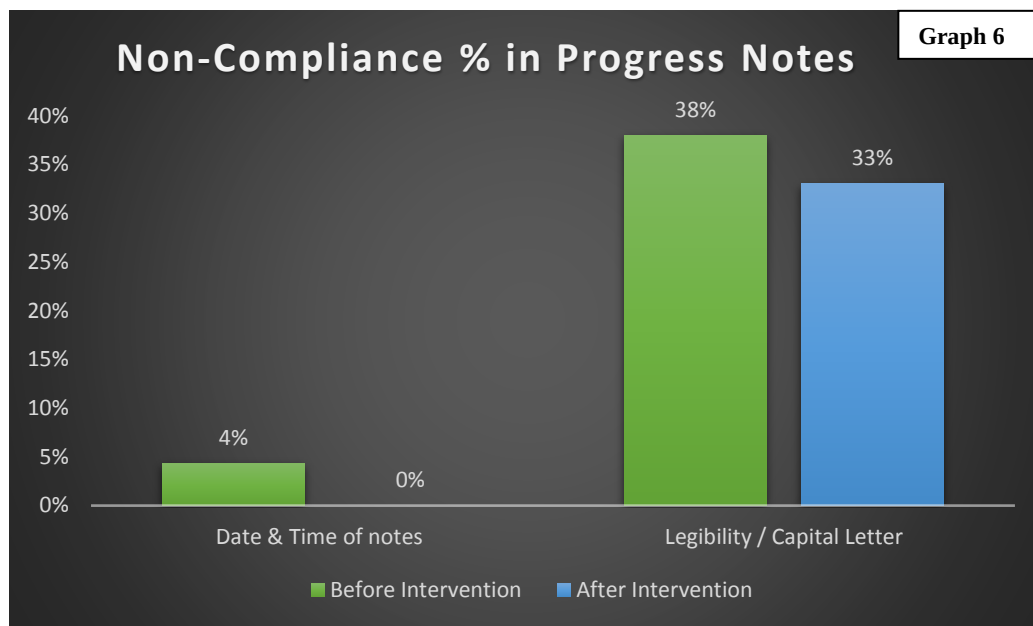
5. Consents Non-Compliance rate before and after intervention



Interpretation and recommendations

- Analysis of the data for consents had the non-compliance rate showcased the results in the lower middle range of 20-30%.
- For not further amplification of this, steps needed to be taken immediately, hence on floor counselling, workshops for capacity building of the nursing staff and staffs who are involved in the process of acquiring consent.
- The re-audit showed the non-compliance decreased by 5-6%.
- Further steps will be taken to bring down the rate to less than 10%.

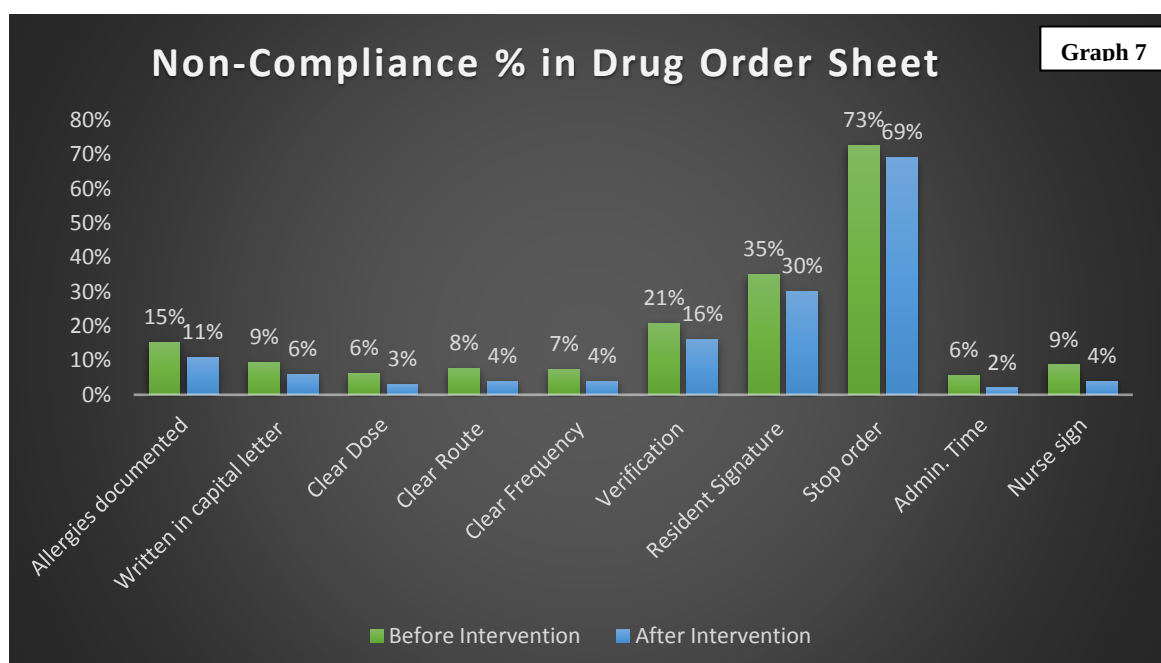
6. Progress Notes non-compliance rate before and after intervention



Interpretation and recommendations

- The condition of the date and time part in the progress notes was quite encouraging as only 4% files has theirs not mentioned.
- Hence, moderate counselling helped his come to a 100% compliance in the re-audit, whilst the legibility of the doctor's handwriting increased by 4-5% after minimal counselling.

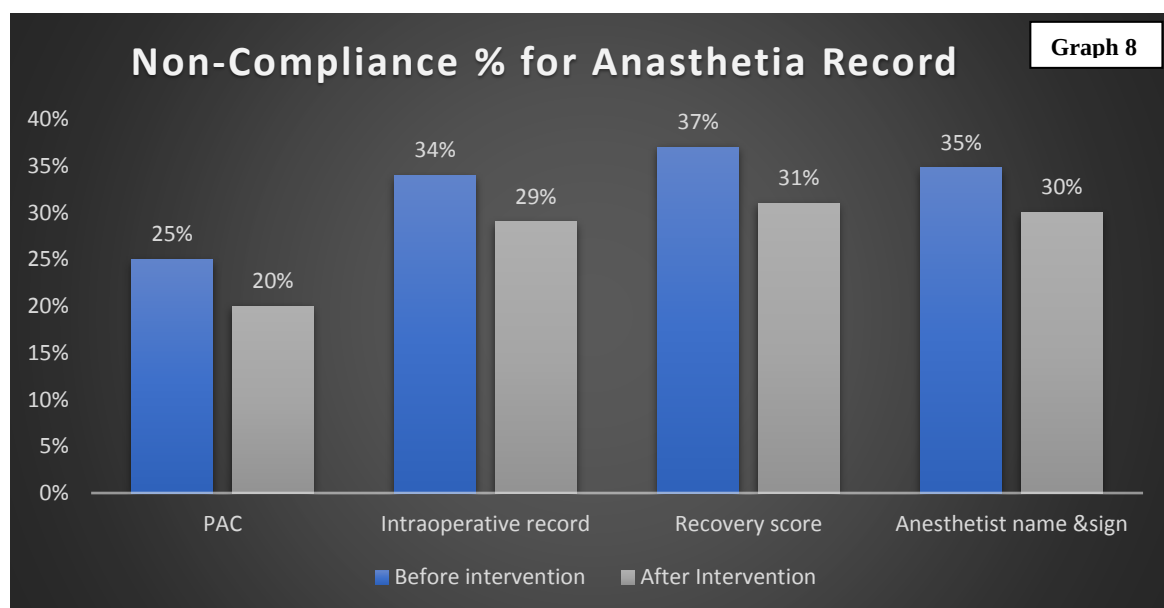
7. Progress Notes non-compliance rate before and after intervention



Interpretation and recommendations

- Analysis of the drug order sheet yielded an encouraging picture, with almost all the indicators having their non-compliance within 15% except the stop order and resident signature indicators.
- Here, non-compliance was also counted in cases where for where allergies section was left blank instead of mentioning no allergy, and verification, which is for the high risk medication stamp which should ideally have signatures of three levels of doctors, if this section was left blank by a single doctor, this was non-compliance.
- Counselling was given to the HOD for upkeep of the current work so that the parameters plummeted even further down.
- The doctors were counselled to make sure that they signed the drug order sheet to
- prevent any forgery and potential side-effects and also to have stop order written where applicable to prevent over-dose.

8. Anaesthesia non-compliance before and after intervention



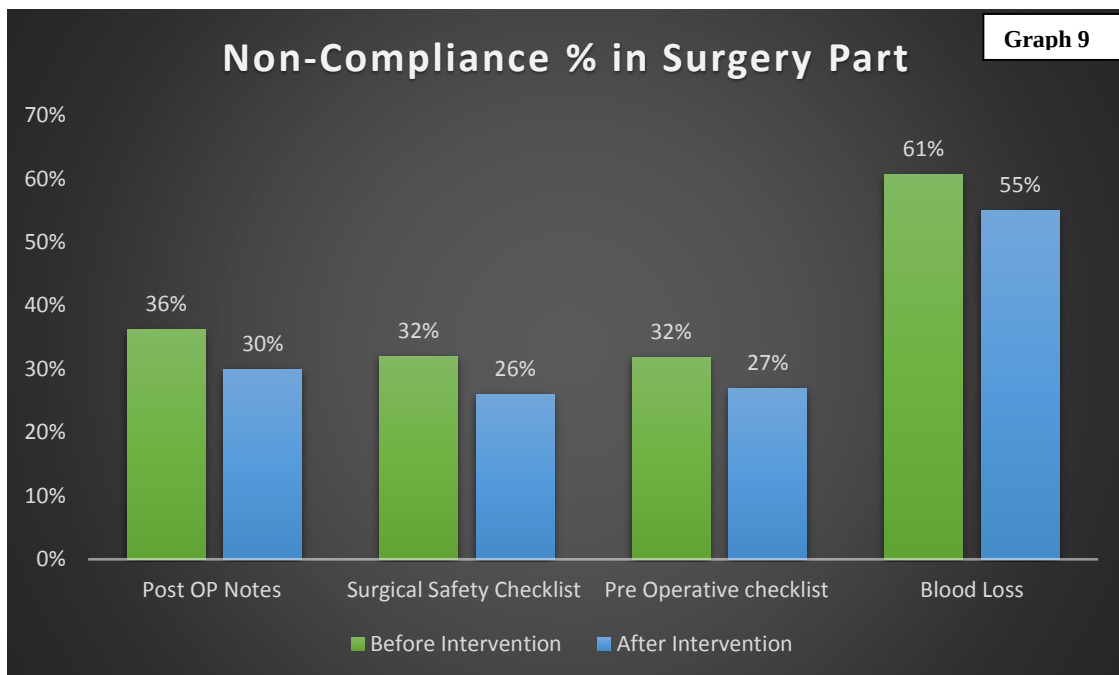
Interpretation and Recommendations

- Anaesthesia records typically had a mid to high non-compliance rate from 25%-35%.
- For curbing this, all the anaesthesiologists were given counselling along with the nurses and the staff in the operation theatre so that vital details belonging to anaesthesia are

filled correctly, especially signature and existence of the important records such as PAC and Intra-operative record.

- Here, non-compliance was also counted in cases where only the names of the anaesthesiologists were present and not sign or stamp (any of the two with sign needed).
- Re-auditing saw an increase in compliance by 4-6% percentage.

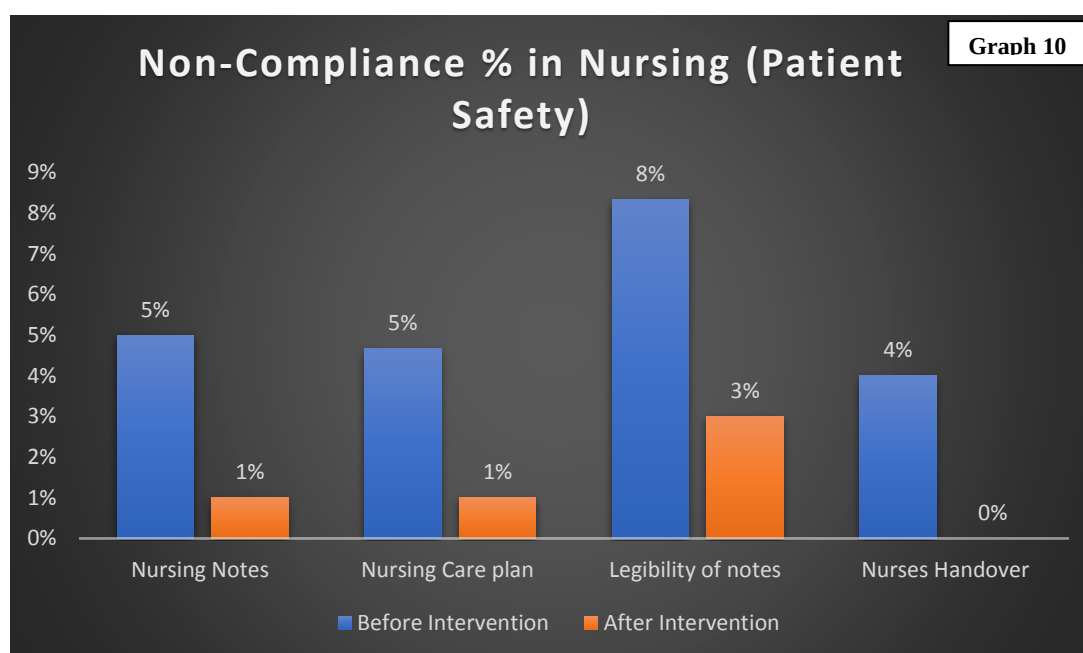
9. Surgical documents non-compliance rate before and after intervention



Interpretation and Recommendations

- Like anaesthesia records, surgical records showed a trend to non-compliance in the range of mid-30's.
- Here, non-compliance was counted in instances such as the surgical or pre-operative checklist not being fully filled and in the cases of blood cases, non-compliance was counted if 'nil' or 'zero' wasn't mentioned as in this cases, the event related to blood loss becomes unclear.
- Counselling while auditing to the doctors in the SICU and also to the nurses was given for paying more attention to the surgical records to be filled by the doctors immediately after operation procedure or to be reminded by the nurses to do the same.
- The counselling increased the compliance by 5-6%.

10. Nursing records (patient safety) non-compliance before and after intervention.



Interpretation and Recommendations

- Nursing records relating to patient safety too, like the usual nursing records showed exceptional non-compliance rates.
- Hence, to slightly improve the same and to also upkeep the current work, on floor counselling was given to the HOD of the floor and the floor coordinator.
- The re-audit yielded results by further decreasing the non-compliance by 5-6%.

CONCLUSION

- The audit was an attempt to understand the compliance of the IPD patient files to the quality indicators of NABH and analysing the results and introducing an intervention program.
- This intervention programs consisted of counselling to the dept. HOD who would then percolate the same to the whole of the dept. and also capacity exercises to other staffs.
- The re-auditing and the analysis yielded an improvement for average 4-5% across the quality indicators which is a significant improvement.
- Current steps need to be enforced more and more accountabilities will help avoid any complacency in the development of compliance.

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ANNEXURE

a) Time Schedule

S.No.	Name of the Department	Date(s) of visit	% of time spent	Interacted with (Name and Designation)
1.	Quality Assurance Dept.	10 th May	30 days	Dr. Sonal Rai (Senior Quality Executive) HOD
2.	Operation Theatre	20 th June	7 days	Dr. Renu Joshi (HOD)
3.	Medical Administration	13 th June	7 days	Dr. Subha Pathania (MS)
4.	CSSD	7 th June	1 day	Mohammed Khalid (HOD)
5.	Central Store	8 th June	1 day	Anil Kumawat (HOD)
6.	Blood Bank	9 th June	1 day	Dr. KC Lokwani (HOD)
7.	Engineering Dept.	10 th June	1 day	Shankar Jha (HOD)
8.	MRD	11 th June	1 day	Radha Mohan Sharma (HOD)
9.	Support Services	26 th June	1 day	Manish Goswami
10.	IT	27 th June	1 day	Deepak Talukdar (HOD)
11.	Marketing	28 th June	1 day	Siddhart Verma (HOD)
12.	Pharmacy	30 th June	1 day	Praful Gulecha (HOD)
13.	Bio-Medical Engineering	1 st July	1 day	Manendra Bele (HOD)

*Thank
you!*