SUMMER
TRAINING REPORT

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1145

SHALBY
MULTI-SPECIALTY
HOSPITALS

- Shalby Hospitals (Shalby Limited), was first established by Dr. Vikram I. Shah in 1994 in the heart of Ahmedabad, Gujarat ,It now operates as a chain of multispecialty hospitals across India having branches in ten and more cities. Shalby Hospitals has been awarded the NABH and NABL accreditations, as well as the CQI certification for excellence in quality. Shalby Hospitals is a world renowned Joint Replacement Centre today establishing many records. Since 2007, they have successfully performed thousands of joint replacement surgeries, and the number is rising day by day.
- Shalby Multispecialty Hospital, Jaipur, tertiary care hospital chain has global leadership in Total Knee Replacement (TKR) and is a providing medical care in all spares of specialty.
- The hospital is full of modern amenities housing 225 beds (125 operational beds),as a global chain it was launched in Jaipur on 23 march 2017 and was unveiled by Dr. Ashok Lahoti, Hon'ble Mayor, Jaipur City .
- The hospital unit is spread over a plot area of 42033 Square Meters has a built up area of 192550 Sq. Ft.
- . The hospital is equipped to manage medical, surgical and neonatal critical care with experts and trained nursing staff, technologies at Shalby Hospital includes CT scan, MRI, X-ray and USG.

Source :https://www.shalby.org/

To study the compliance of active IPD medical records and billing process accuracy at shalby hospitals.

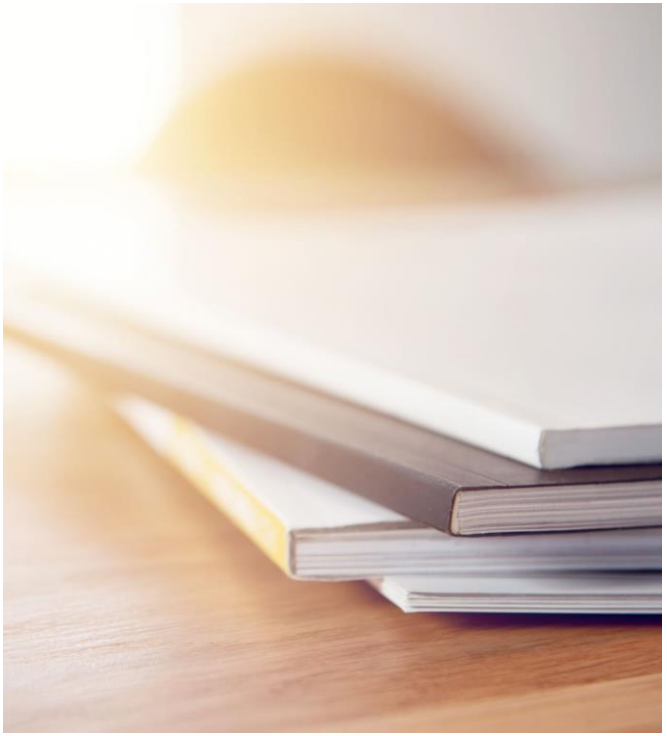
To study the compliance of active IPD medical record

INTRODUCTION

- A medical record is a record of a patient's medical information (such as medical history, care or treatments received, test results, diagnoses, and medications taken).
- A medical record enables healthcare professionals to plan and evaluate a patient treatment and ensures continuity of care among multiple providers.
- The quality of care a patient receives depends directly on accuracy and legibility of the information the medical records contains.
- Maintaining a complete record is important not only to comply with licensing and accreditation requirements but also with the adequate care received by the patients.
- The medical record serves as a document to provide data for internal hospital records and auditing quality assurance.
- Good medical care generally means a good medical record, while an inadequate medical record generally reflects poor medical care therefore periodic auditing and maintenance of medical record is important.

The IPD Medical record has following documents:

- Admission Form And General consent
- Accident and Emergency department patient assessment
- First Consultation form
- Initial assessment form
- Consultant Notes (Consultant Doctor , Medical officer)
- Medication Chart
- Nutritional Assessment form
- Nursing initial admission Assessment Form
- Nursing Notes
- Surgical Consents (If Applied)
- Surgical Check list(If Applied)
- Operative notes(If Applied)
- Reports of multiple investigations



EXECUTIVE SUMMARY

- According to hospital policy the documentation of the inpatient file must start within 30 min of arrival of the patient on the floor starting with initial assessment done by medical officer and nursing staff and then continuously documenting the other procedures carried out on the patient.
- The proper sequencing of file is being followed so that it becomes easy for other staff also to read it. Regular audit is being carried out so as to keep a check on the documentation like Assessment forms, plan of care, consultants notes, consent forms, etc.
- A structured checklist was used and that was only used for active audit of IPD files. Random visits to IPD floors was carried out and the checklist was filled for 10 patients each day and the compliance on those files was carried out over a period of 21 working days and data of 210 files was collected and no file was repeated during this period.

Aim and Objectives

To Assess that the existing documentation is in accordance to NABH Standard.

To identify lacunae in the same and to propose possible solution.

Methodology

Study Period - (18th May to 10 th June 2021)

Sample Size : 210

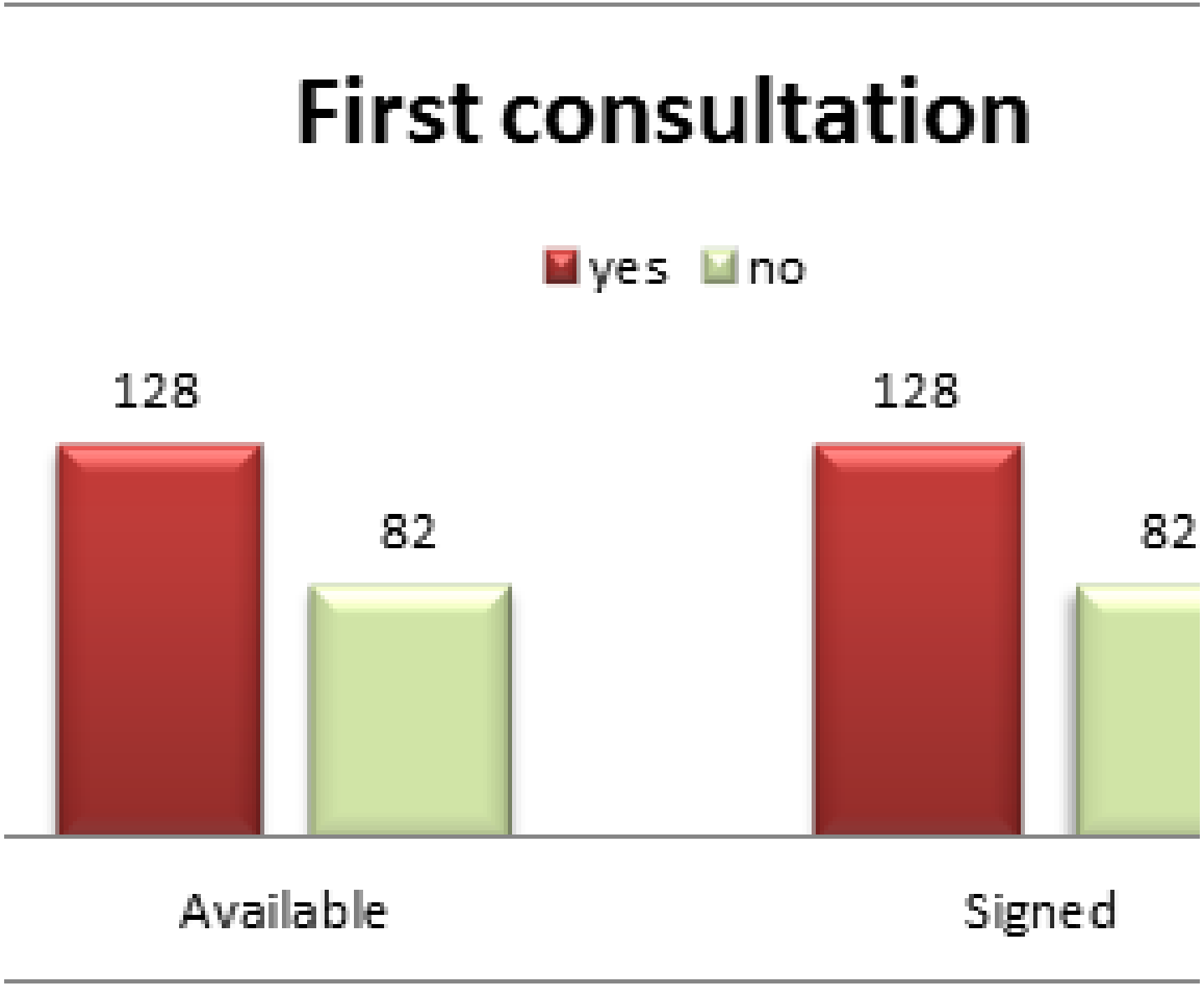
Tool Used : Structured Check list

Data Source : Primary

Data Collection Approach : Systemic Random Sampling

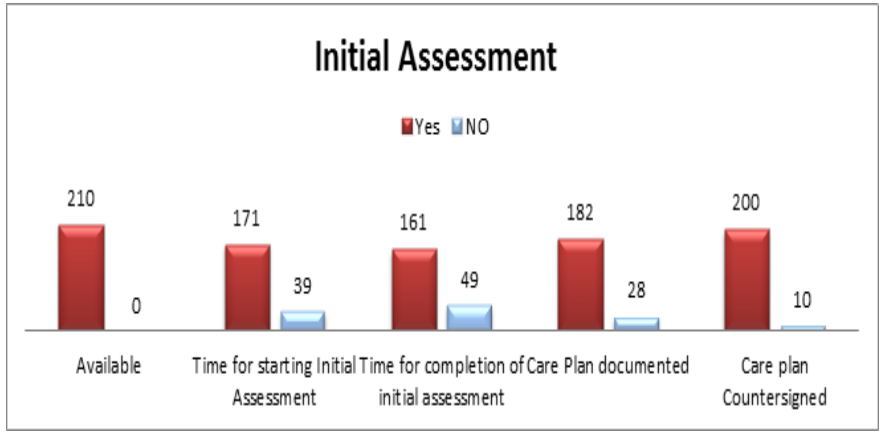
First Consultation

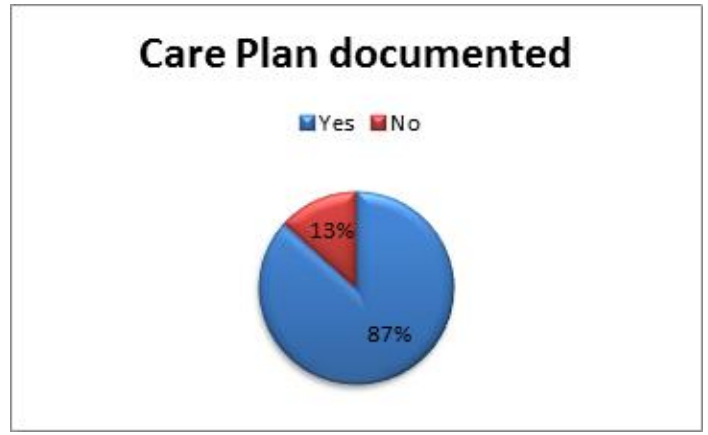
- The first consultation is very important as it is the point where the consultant doctor guides the patient whether to get admitted in hospital or not.
- The number of files having first consultation mentioned in them was 128 out of 210 which contributed to 61% of total files.



Initial Assessment

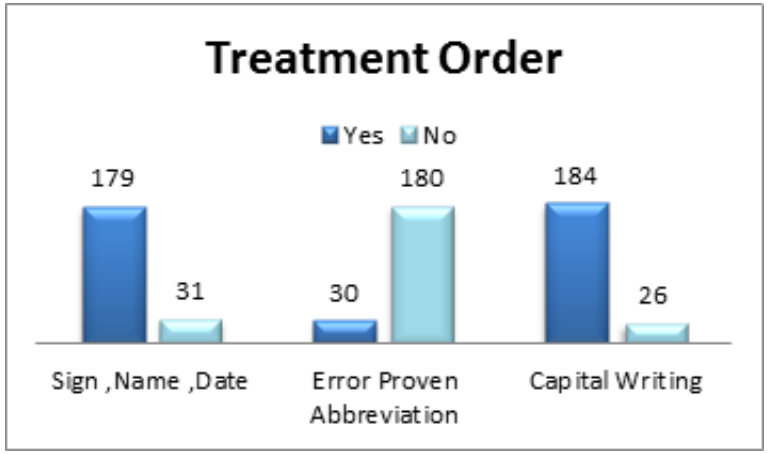
- Initial Assessment has to be conducted within 30 minutes of patient arrival on the floor. The medical officer present on the floor is responsible for filling this form and he has to take into consideration the following points:
- Time of starting initial assessment, Time of completion of final assessment , care plan documented and care plan countersigned.
- Care plan documented is an important factor as it conveys the desired outcomes. Out of 210 files only182 had care plan documented which accounts to 87% of total files .
- Care plan countersigned directs to the person who actually filled the initial assessment form and out of 210 only 200 files had care plan countersigned which accounted to 95.2% of total files.

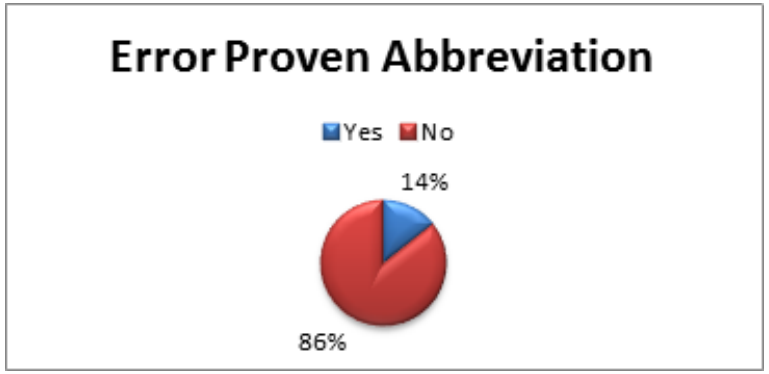




Treatment Order

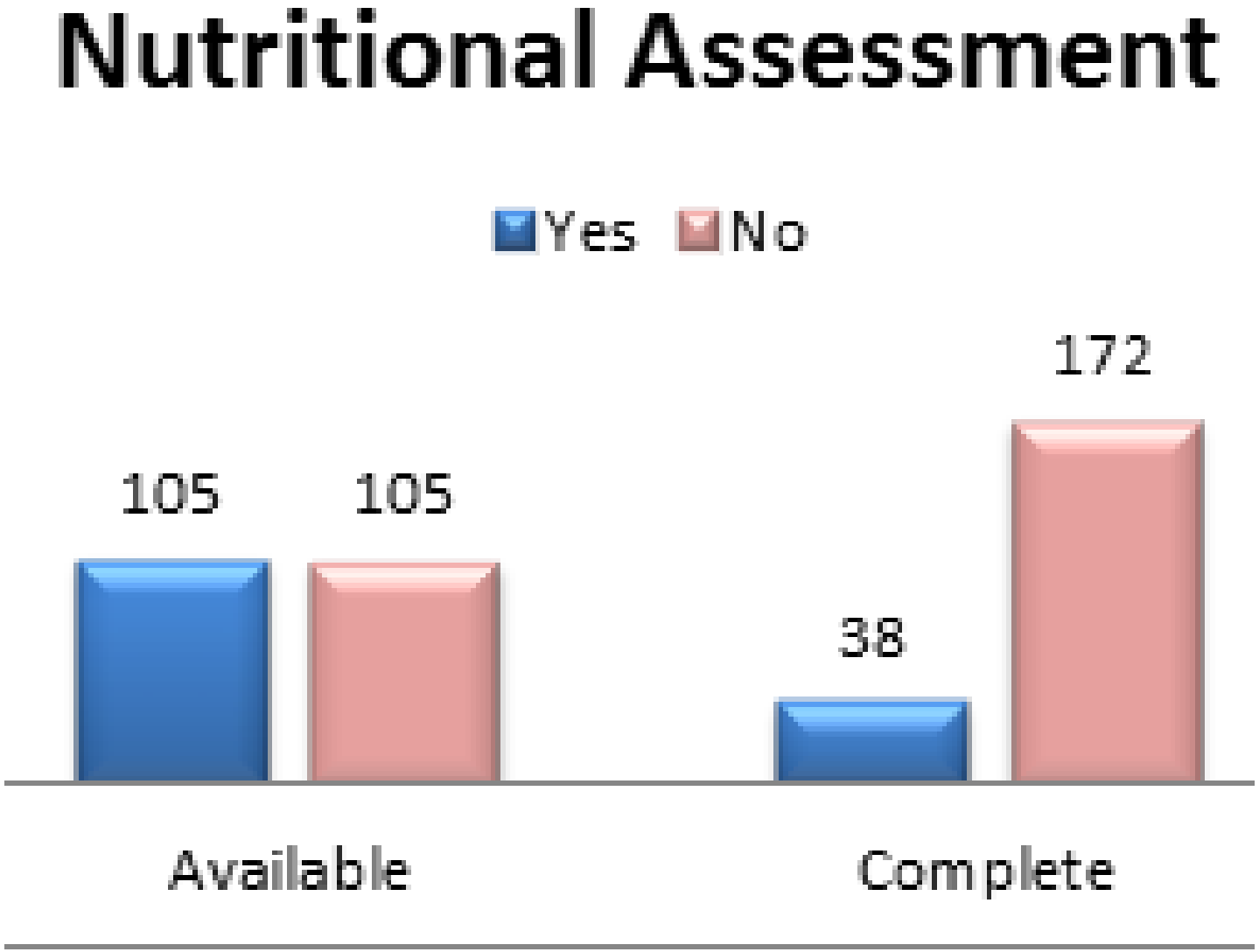
- Treatment order consists of all medication, their time of administration, dosage, route of administration so that the nursing staff can follow them accurately therefore they have to be written in capital letters, clear and legible. The treatment order must be signed and name and date have to be written on it. The error proven abbreviation must not be written on the files as it causes confusion and can lead to medication error and for these some of the abbreviations are accepted by the organizations that are accepted by ISMP.
- The no of files having named, date and sign was 179 out of 210 accounting to 85.2% of total files.
- The no of files having capital writing was 184 out of 210 which accounted to 87.6% of total files.
- The no of files having error proven abbreviation accounts to 30 out of 210 which accounts to 14.2 % of total files.





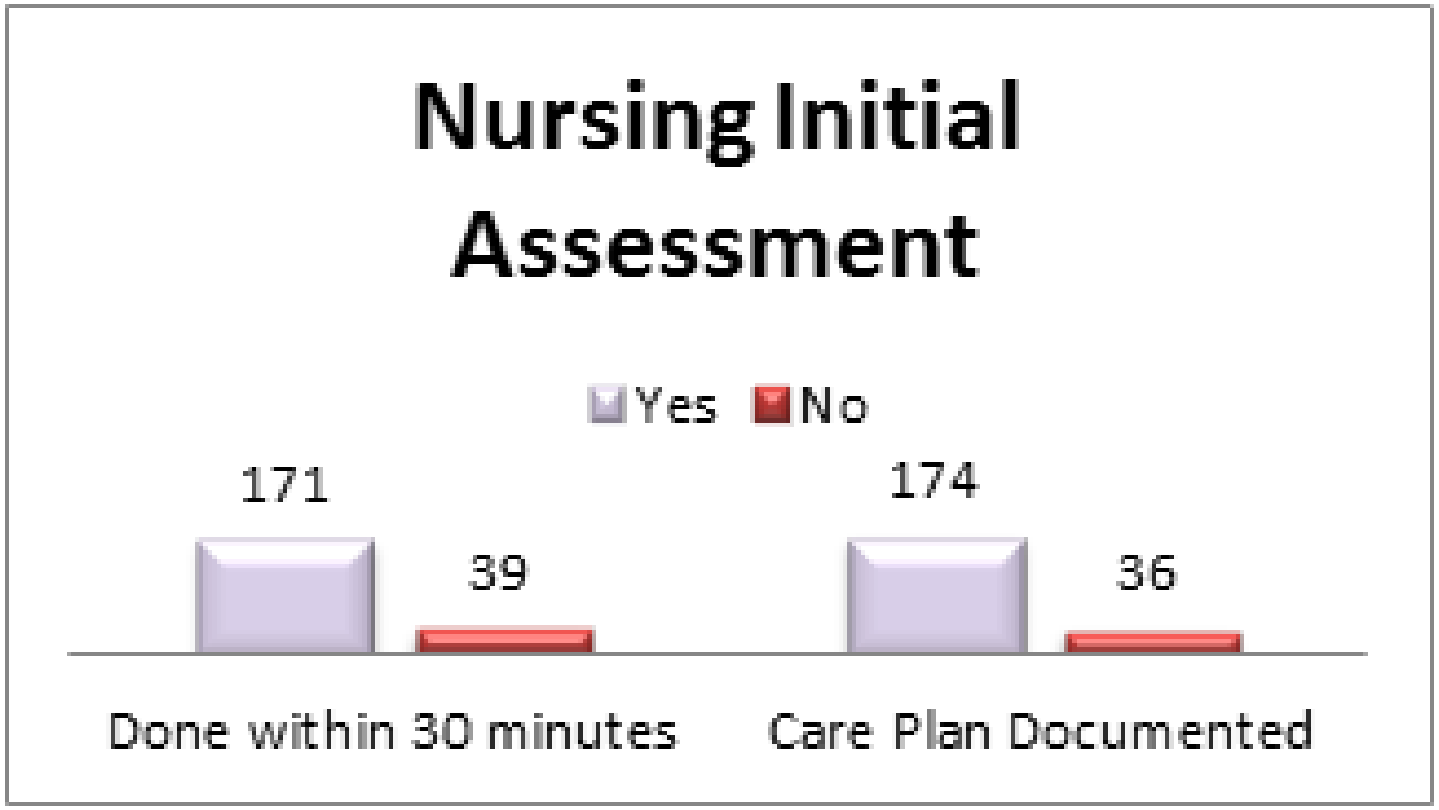
Nutritional Assessment

- Nutritional Assessment is done for every patient as the nutritional needs for each and every patient is different and therefore proper assessment is required.
- Nutritional assessment form has to be filled by the dietician and in accordance to this only the diet given to the patient is decided.
- The number of files having nutritional assessment form available was 105 out of 210 which accounts to 50%.The number of files having completed nutritional assessment was 38 out of 210 file which accounts to 18% of total files.



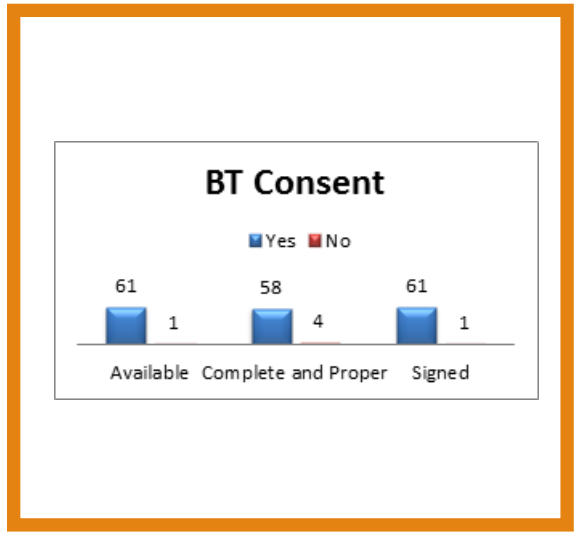
Nursing Initial Assessment

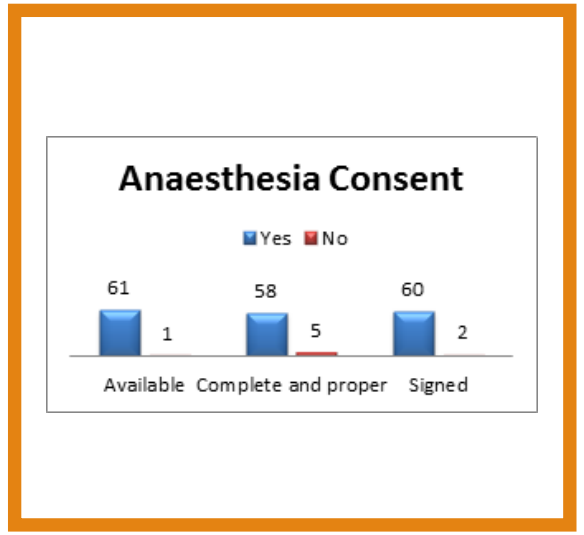
- Nursing initial assessment has to be done within 30 minutes of patient arrival on the floor and the care plan that nursing staff have to follow other than the medication is also documented on it.
- The no of files having assessment done within 30 minutes were 171 which accounts to 81.4% of total files.
- The no of files having care plan documented is 174 out of 210 which accounts to 82.8% of total files.

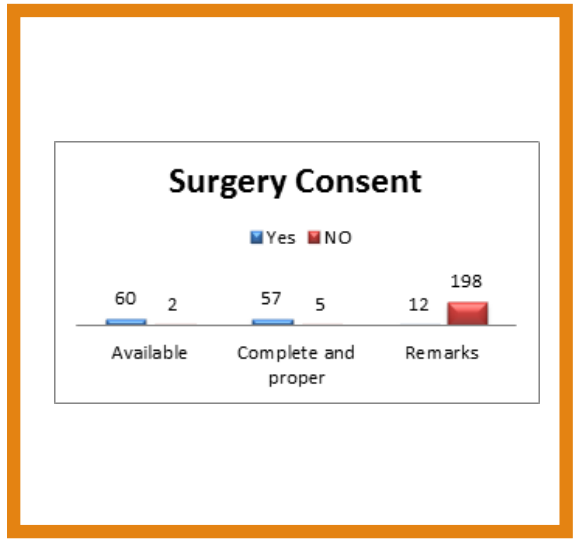


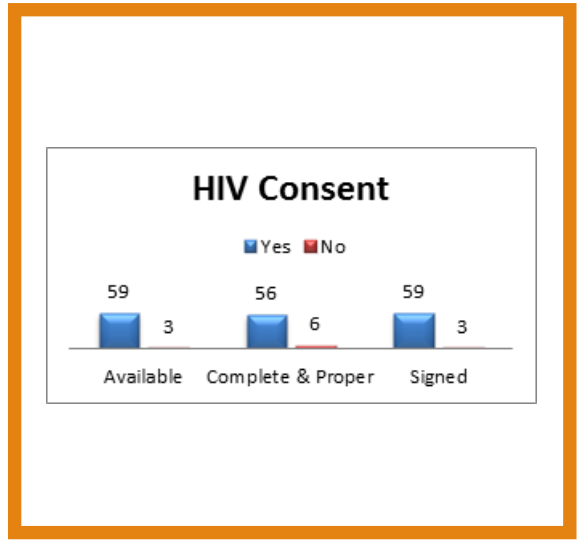
Consents

- Consents are important as they act as a permission given by patient himself or his relative to carry forward any surgical procedure or any other test or procedures that are required during a surgery.
- These consents have to be taken within the 24 hours before carrying out any surgical or other procedures.
- These consents must be complete and proper and signed as they include the risks that can occur during or after completion of a process.
- The compliance rates of consents are as follows:
- Anaesthesia consent is 93.55%
- Surgical consent is 91.94%
- HIV consent is 90.32%
- BT consent is 93.55%



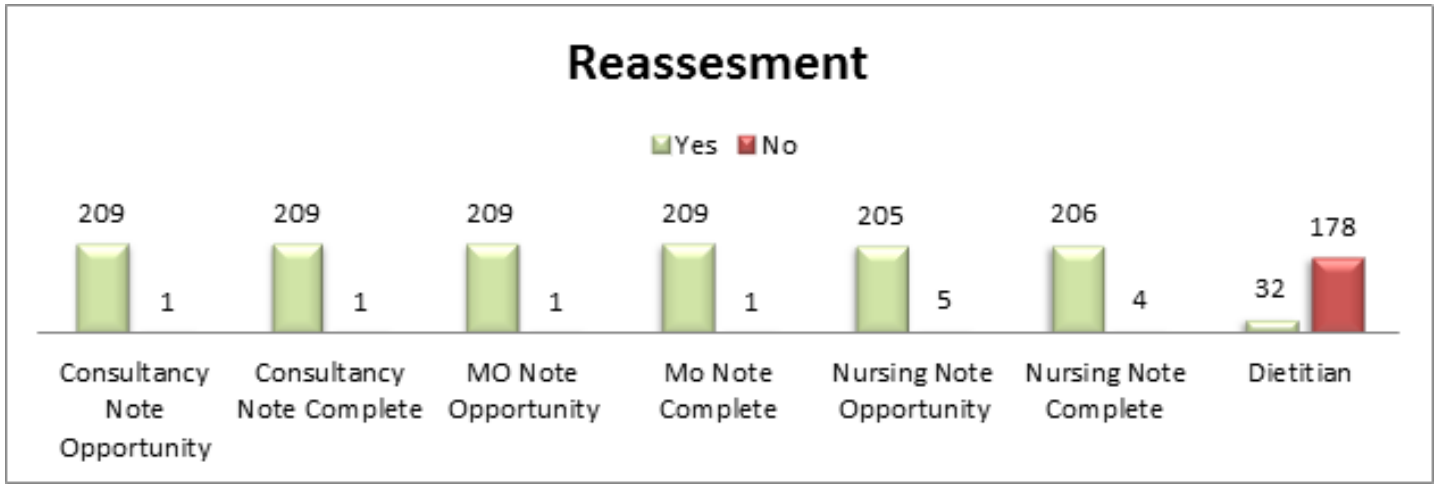






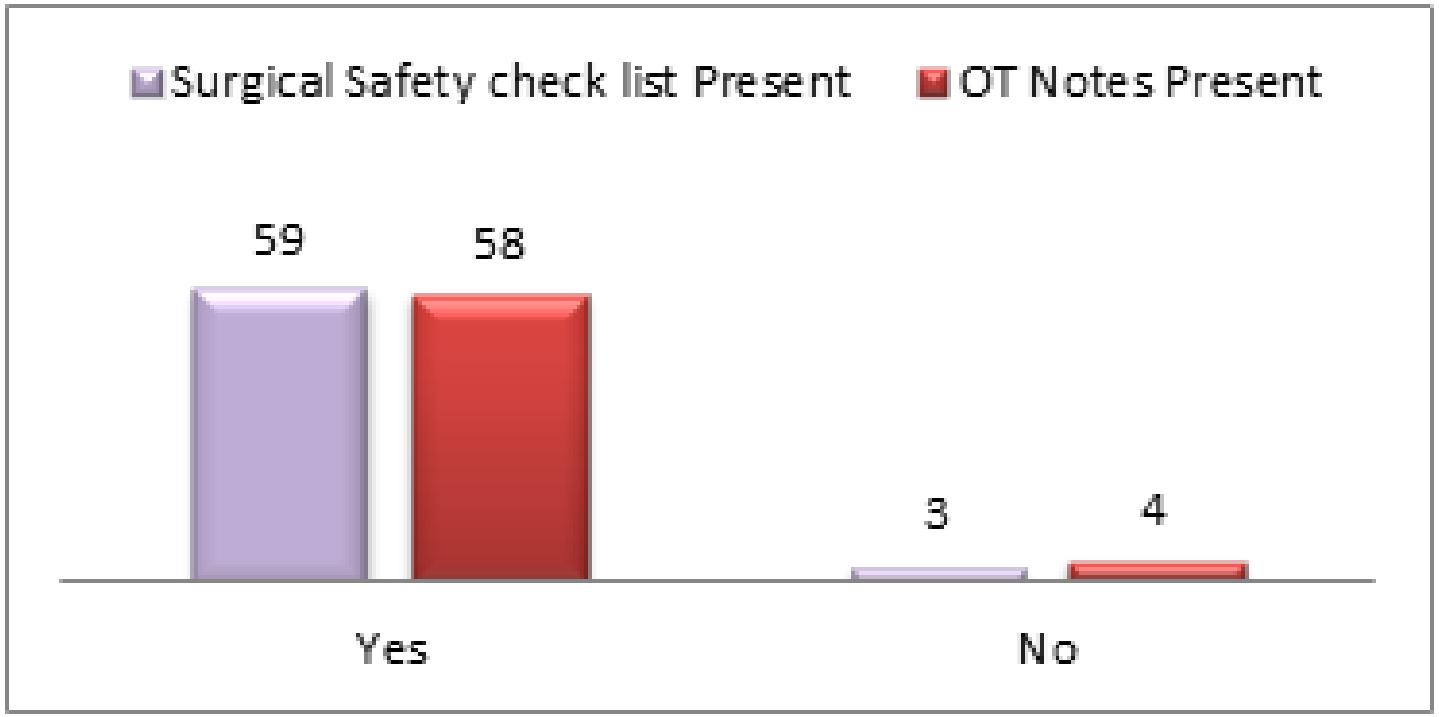
Reassessment

- Reassessment consists information of notes written by consultants, medical officer and nursing staff on daily basis .
- One consultant note , two medical officer note and three nursing staff notes must be documented in a day in medical record of patient.



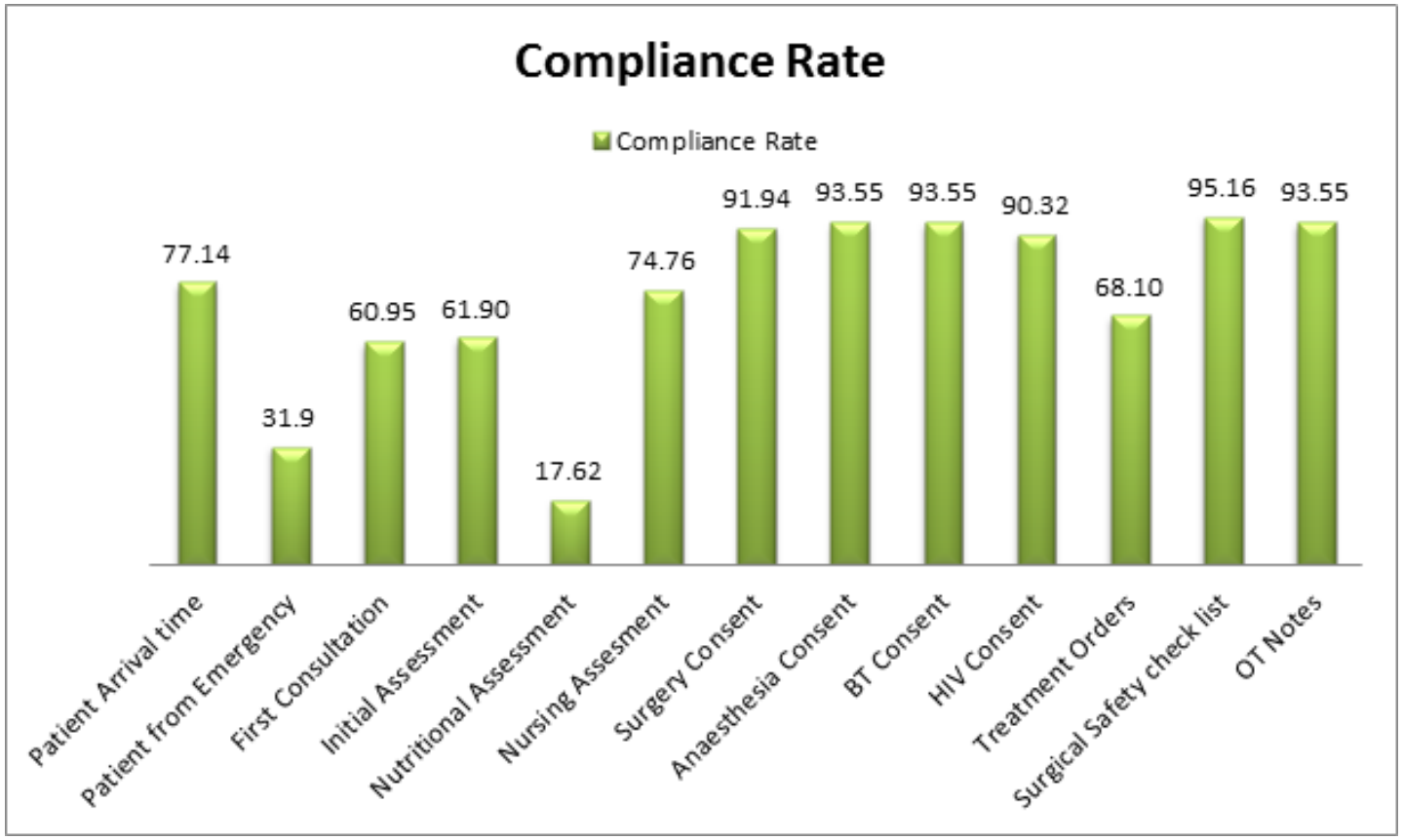
Surgical safety checklist and OT Notes

- The surgical safety checklist are the list checked and signed by the surgeons before performing the surgery and OT Notes are written by the surgeons after they have performed surgery so as the minute details of the surgery can be kept as record and also can be referred afterwards.
- The percentage of Surgical Safety checklist and OT notes present in files are 95.1% and 93.5% respectively.



Conclusion

The compliance rate of active IPD medical records as per the NABH Standards of Shalby Hospital is displayed in the following graph which clearly shows that their compliance rate in various parts of the medical record is not satisfactory such as in patient arrival time, first consultation , initial assessment, nutritional assessment ,nursing initial assessment and treatment order therefore steps to reduce them must be taken and steps to achieve the target compliance rate for each parts of medical record must be taken and must be maintained over the period of time

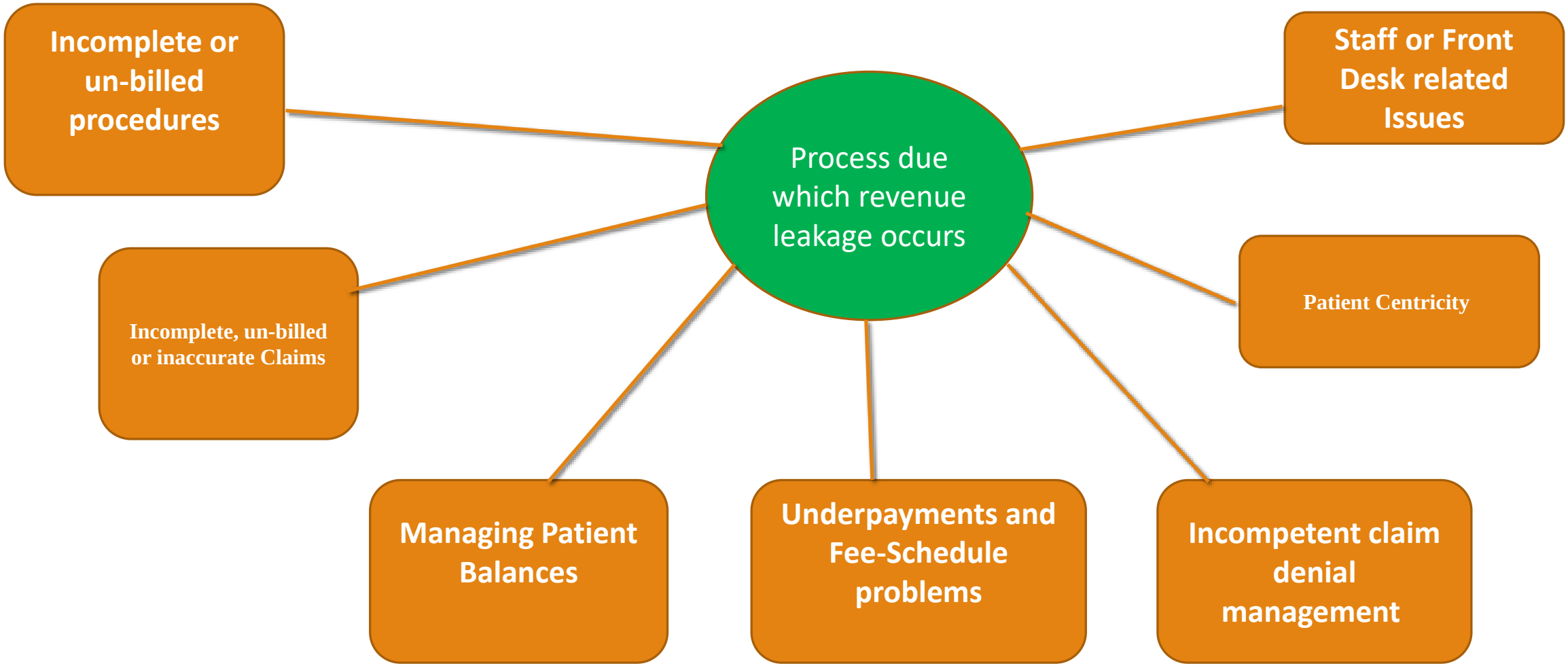


To study revenue leakage due to billing process inaccuracy.

INTRODUCTION

- Revenue leakage is the unnoticed or unintended loss of revenue.
- The leaks can come from both the revenue and the expenditure side.
- Revenue leakage refers to under-billing your customers for services and products provided by your organization.
- Revenue leakage occurs when you're not able to efficiently and accurately track and bill for different usage. If you can't accurately track and bill for consumption-based services, you could be missing out on a significant revenue stream.
- Usage-based billing helps you to ensure that charging for your services and never leaving potential revenue on the table.
- Hospital has different type of patients such as patients from emergency, outpatient, inpatient and daycare patients. Hospital provides a range of services including medical care , diagnostic services , surgeries and nursing care. All these patients in turn lead to revenue generation of the hospital. This part plays a vital role in functioning of whole of the hospital as whatever revenue is generated by this helps the hospital to expand itself as well as invest in new technologies and other requirements required by the hospital.

Source : https://www.recvue.com/what-is-revenue-leakage-and-how-to-stop-it-before-it-starts/



Source : https://www.viaante.com/2020/08/14/9-steps-to-restrict-revenue-leakage-in-medical-billing/

EXECUTIVE SUMMARY

- Shalby hospitals was also interested in analyzing the revenue leakage caused due to under billing .
- The internal auditing team of the hospital was analyzing the billing department for preventing the loss.
- They used a checklist so that they can keep a check on the under billing procedures.
- The hospital follows a procedure of billing on daily basis in which when the patient is admitted in the hospital the room rent is charged according to the room decided by the patient and the financial counseling department of the hospital. Each and every procedure carried on patient is documented on the daily basis on the medical activity record sheet and that sheet is submitted every day to the billing department at the end of the day and they compute each and every procedure written on that sheet and the procedures that are indented by the nursing stations on the floor.
- The internal auditing team used their checklist before discharging the patient and reviewed all the bills of the patient and they cross checked the bill with the daily activity record sheet and then changes in the bill were carried out and then final billing of patient was done and patient was discharged. At the end of the day a report was also being made so as to review their performance and files having no revenue loss, revenue loss prevented and revenue loss that occurred was analyzed so that at the end of the day they can improve their billing process and make necessary changes.

Objectives

To assess the revenue leakage incurred by the hospital due to unbilled procedures of inpatient and daycare patients.

Methodology

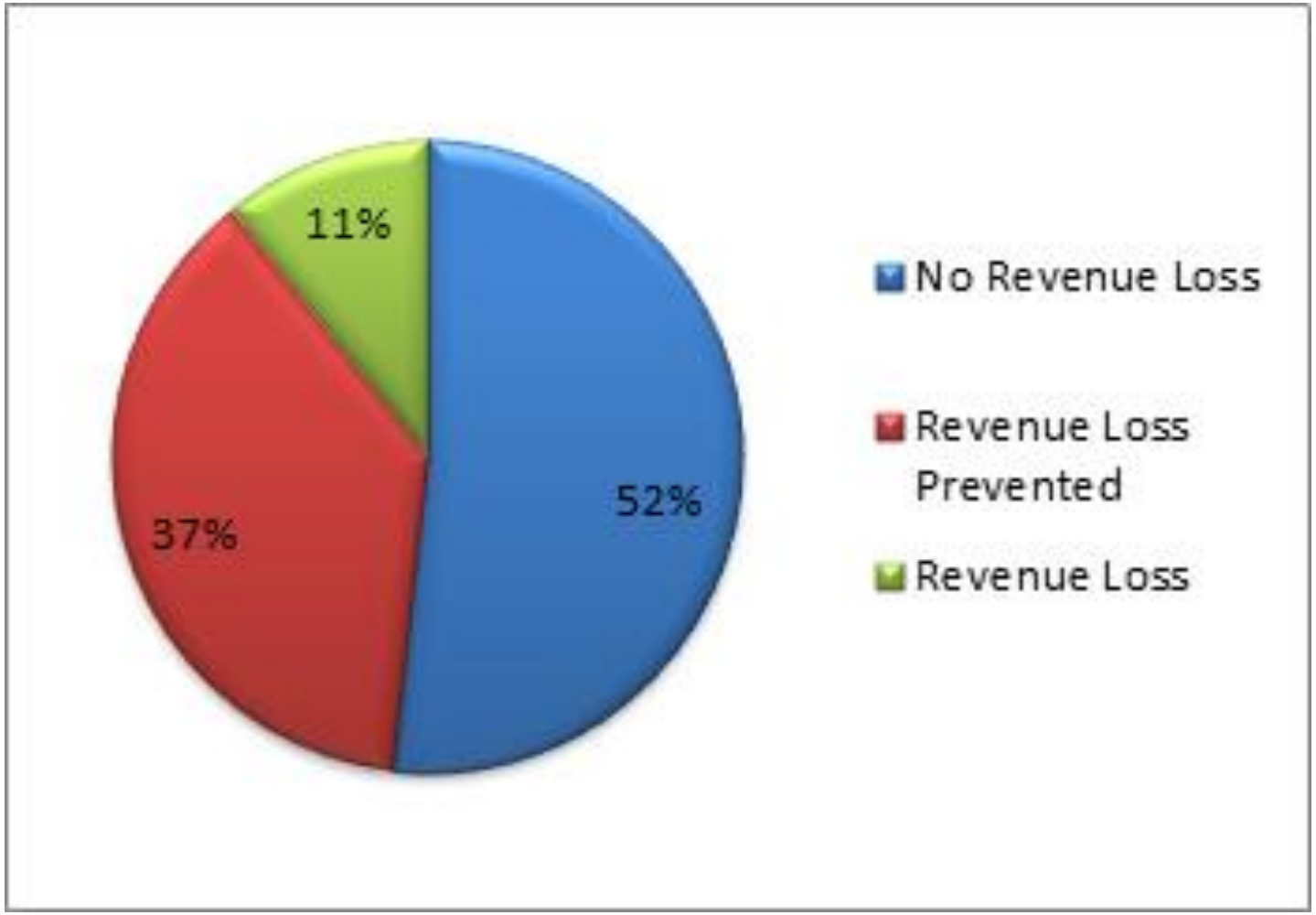
Study Period - (1st June to 15 th June 2021)

Sample Size : 112

Tool Used : Structured Check list

Data Source : Primary

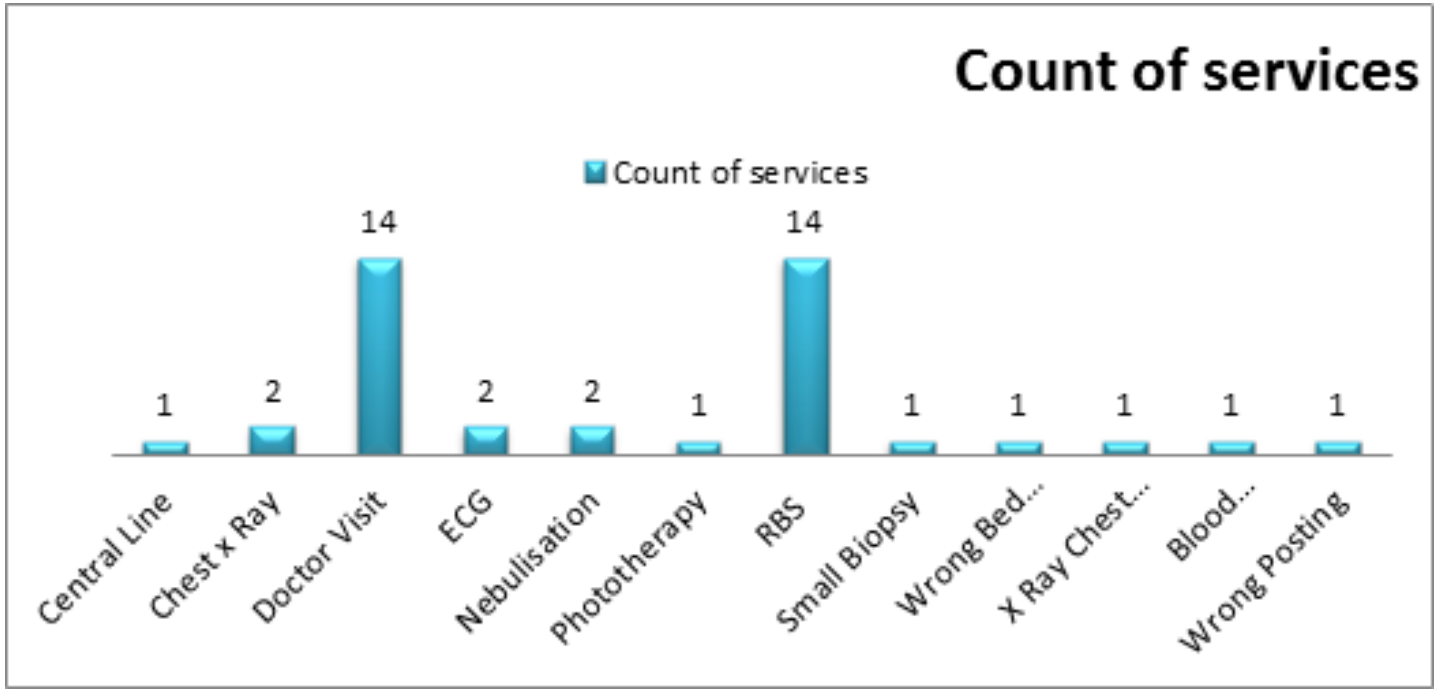
It was observed that out of 112 files 58 files reported no revenue loss, 42 files reported prevented revenue loss and 12 files reported revenue loss.



Revenue loss

These are those loses which were either missed by billing department during billing or those procedures that have to be mentioned in medical record sheet but were not written appropriately and therefore they were missed.

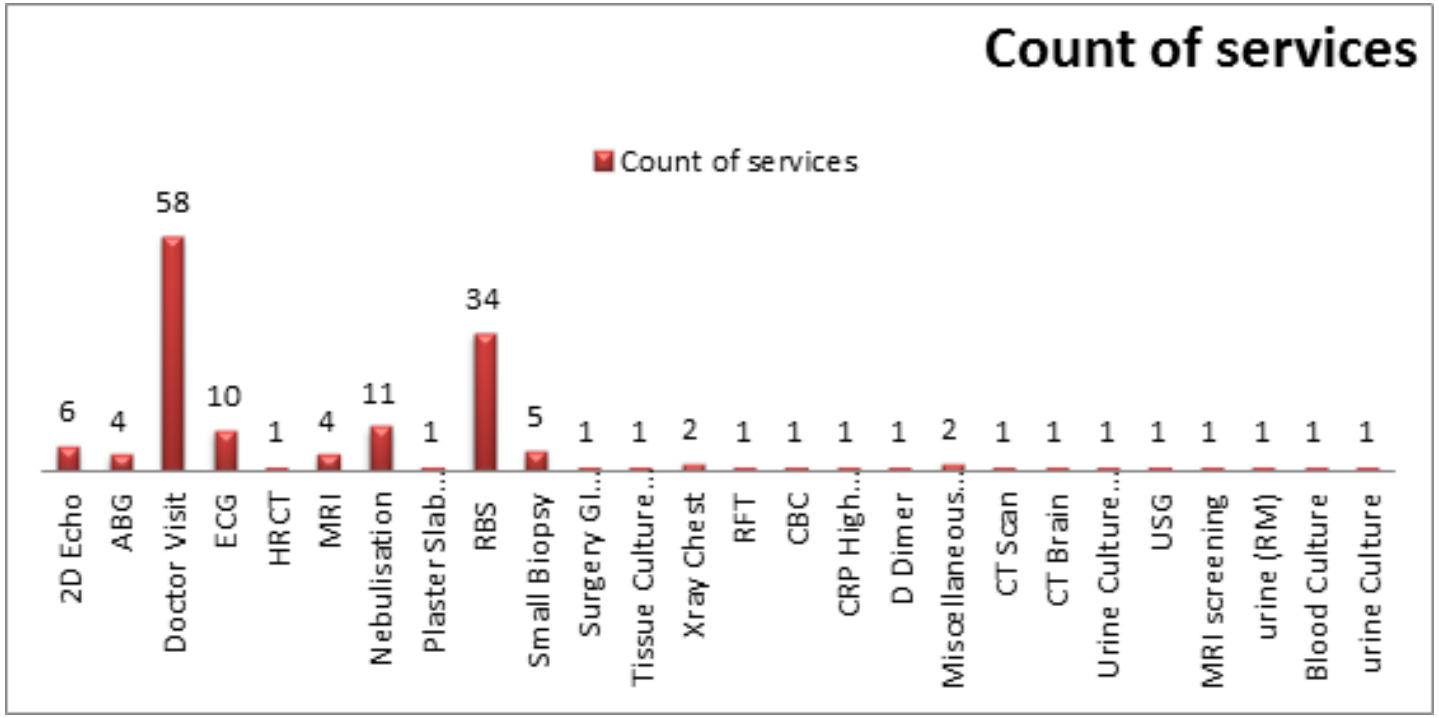
The following graph shows revenue loss in terms of their counts. It's evident from the graph that in terms of counts doctor visit, random blood sugar and ECG accounts to highest in revenue loss.



Revenue Loss Prevented

These were those loses that were prevented by the billing department by matching the medical record sheet and indent done by nursing staff that could have lead to revenue loss if gone unseen.

The following graph shows both revenue loss in terms of counts of services. It's evident from the graph that doctor visit, random blood sugar and nebulisation accounts to highest in revenue loss prevented.



CONCLUSION

Revenue leakage due to billing process non accuracy is present in almost all the hospitals and the percentage varies from hospital to hospital and therefore focus to control this must be given and strengthening the billing process is the most important factor that has to be considered.

There are various procedures which go under billed such as missing bedside procedures (catherization, intubation, ventilator, Bi-pep and dressing) and various investigations such as RBS, nebulisation, ECG, ABG, etc. therefore special emphasis must be given on these investigations.

Physicians and referral doctor’s visits are also the area of concern for the hospital.

RECOMMENDATIONS

1. Periodic training about the NABH standards to fill a medical record must be given to the existing staff as well as the new enrolling staff.
2. The dietician in the hospital must fill nutritional assessment form for each and every patient admitting in the hospital.
3. More frequent audit of medical records must be accomplished so as to track the discrepancies.
4. If possible one staff at each floor should be assigned the responsibility for proper documentation of active files.
5. Doctor's visit must be mentioned in the daily medical activity record sheet if consultant doctor doesn't mentions it then it should be responsibility of floor medical officer to fill it on their behalf.
6. Nursing staff must be trained for proper documentation of the investigations in the daily medical activity sheet.
7. Auditing of ECG rolls and proper ECG training must be given to the staff so that they don't repeat ECG frequently.

SCOPE FOR FUTURE WORK

1. Does active audit of files helps to improve quality of care ?
2. Did the target of compliance rate formulated by hospital achieved in future?
3. Does internal auditor helps to reduce the revenue leakage in hospitals?
4. These studies can be applied to other hospitals as well to see their impact on different organizations.

thank you
danke
рахмат
謝謝
ngiyabonga
teşekkür ederim
Баярлалаа
спасибо
mersi
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감사합니다
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