Summer Training

at

BHAGWAN MAHAVEER CANCER HOSPITAL AND RESEARCH CENTRE, JAIPUR

From 10th May 2021 to 2nd July 2021

Project Tittle – To study the compliance of admitted patient files as per NABH parameters.

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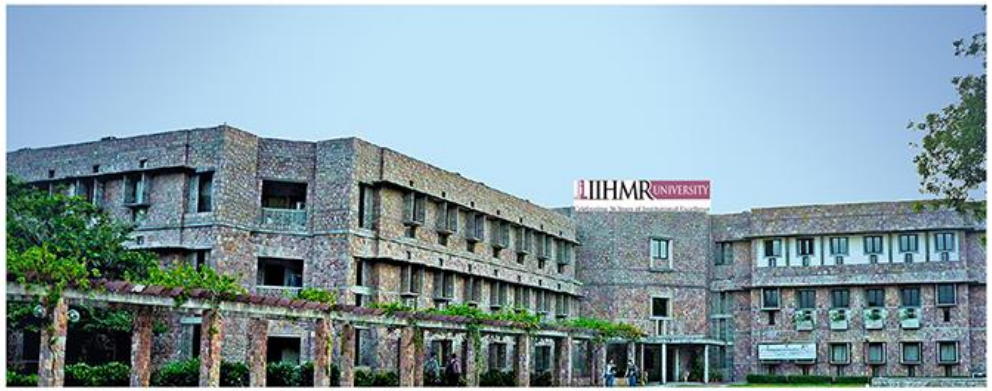
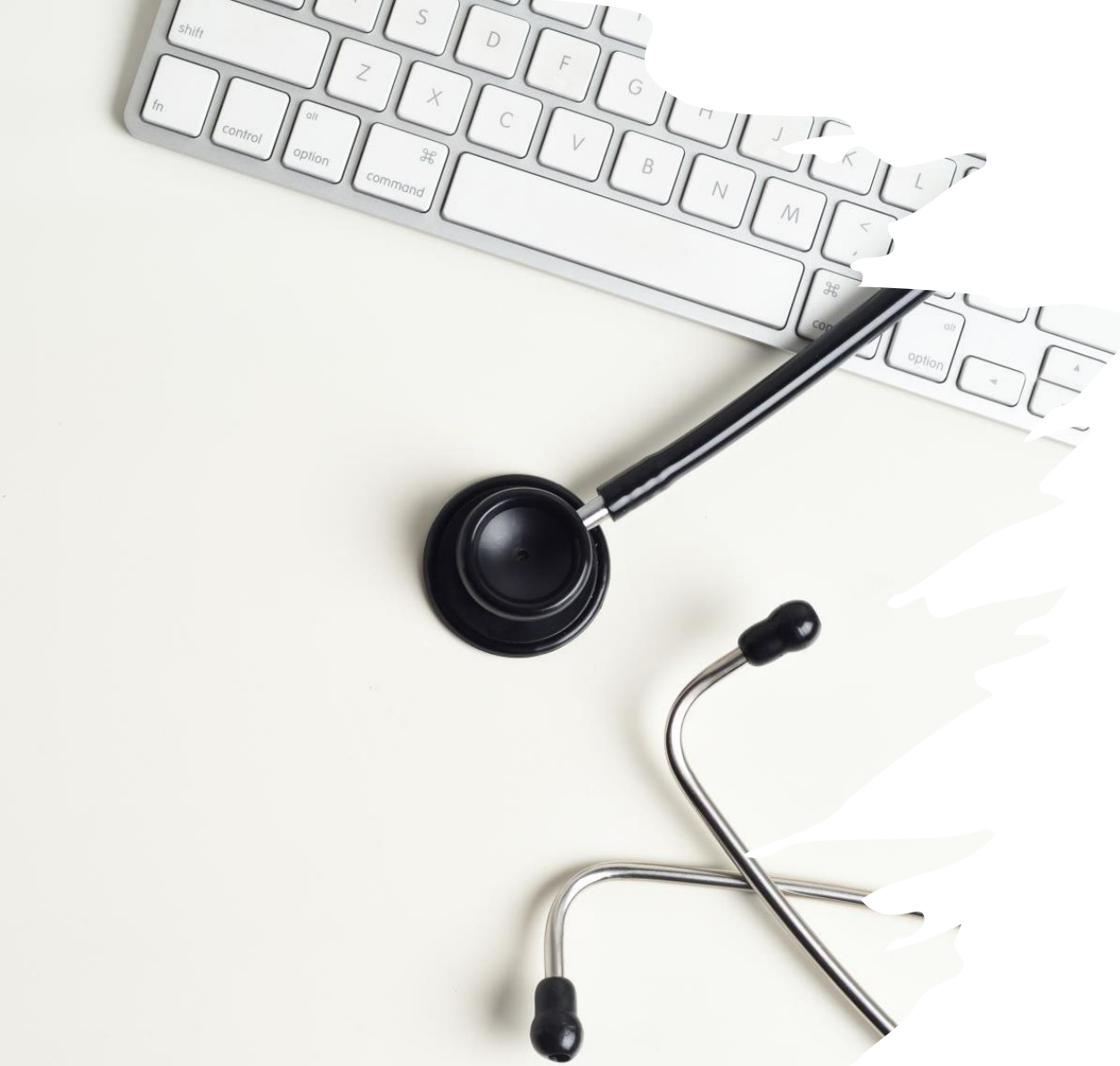


MBA HOSPITAL AND HEALTHCARE MANAGEMENT

2020-2022



AIM –

- TO STUDY THE COMPLIANCE OF ADMITTED PATIENT FILES AS PER NABH PARAMETERS.

OBJECTIVE –

- To assess the compliance and non-compliance of various parameters of documentation of admitted patient files in accordance with NABH guidelines of the hospital .

- To identify gap against documentation and recommend possible solutions.

BRIEF OF STUDY

Conduct an internal auditing of the active patient files of the admitted patients in the IPD.

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 at the macro level and the micro level.

The interventions will be in the form of training workshops, counselling to the HOD’s and other staffs and other appropriate measures.

- **Study Setting –** Bhagwan Mahaveer Cancer Hospital and Research Centre, Jaipur
- **Study Design –** Observational and Cross-sectional study
- The study is done on Active file.
- **Active File** – The file which are in the respective wards and the patient are yet to be discharged from the hospital.
- **Study Duration** – 1 month
- **Sample size** – 300 total medically managed patient file
- **Sampling Procedure -**
  Simple probability sampling technique was used wherein, during the internal auditing, random patient files were picked up and analysed.

- **Data Collection Technique –** Primary data collected by checking files at

1. Different Wards in the hospital
2. Semi-Deluxe Rooms
3. Deluxe Rooms
4. Super-Deluxe Rooms

- **Variable and their meaning –** In this report two variable are used – Compliance and Non-compliance.

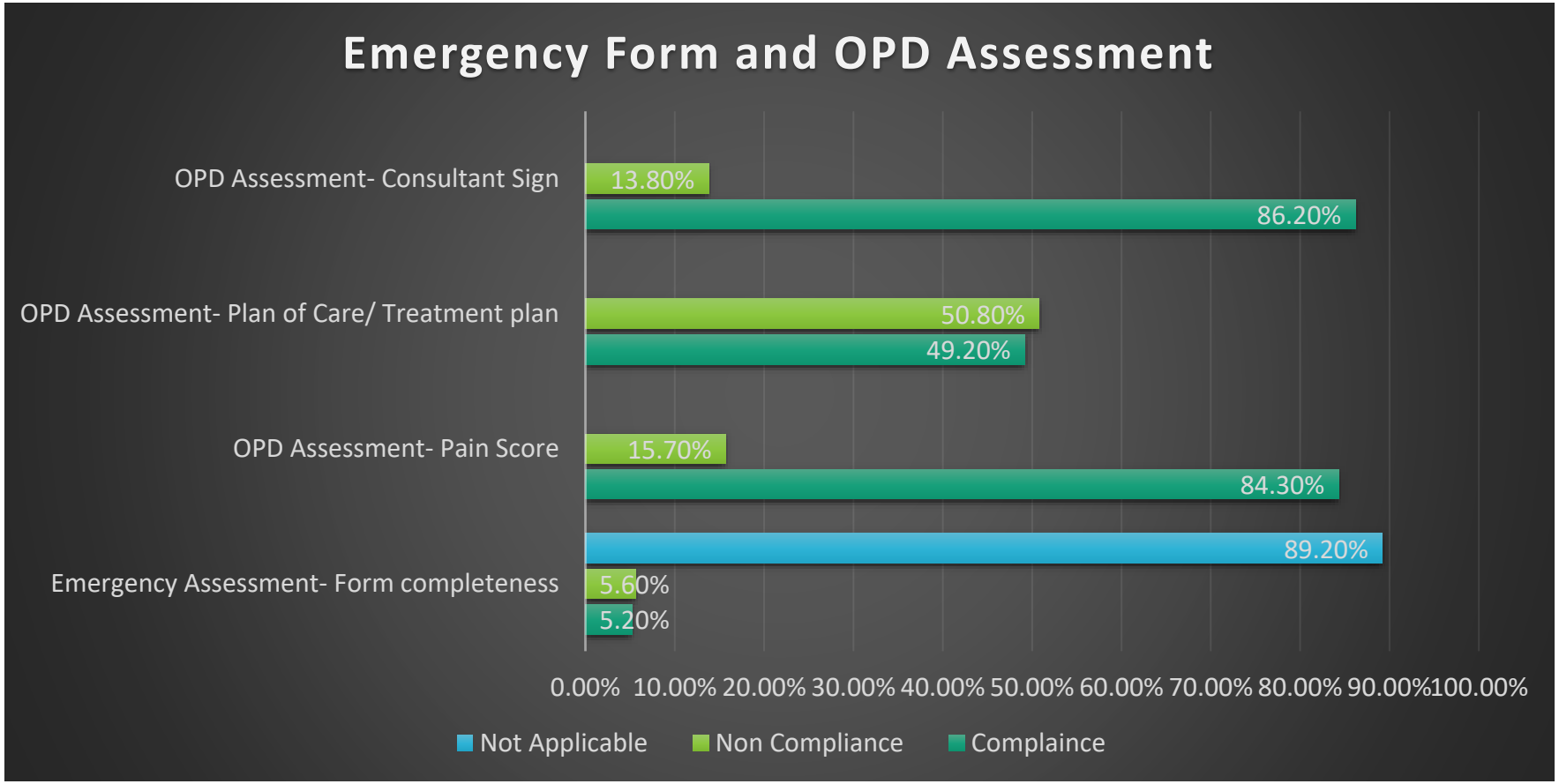
- **Compliance** as the name suggest is whether the parameter is being met with the requirement. In case the parameter is not up to the mark and does not satisfies the requirement, it is termed as **Non-compliance**.

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.
- Analysis was done through excel through the functions

Turn Around Time for Initial assessment of Patient

Nursing	within 30 mins
Resident	within 1 hour
Consultant	within 24 hrs
Dietician	within 24 hrs
Physiotherapist	within 24 hrs

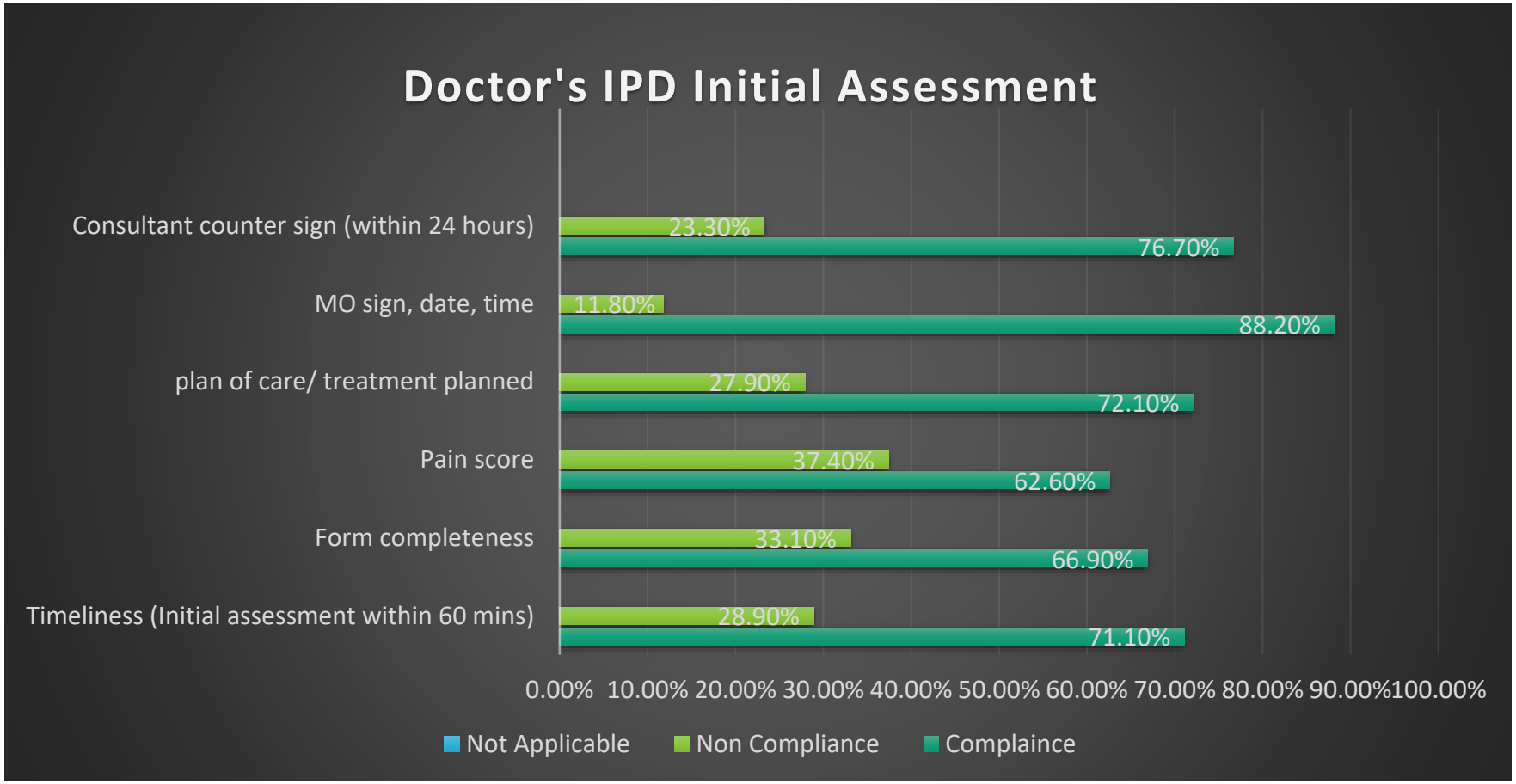


1. **Emergency Assessment – Form Completeness**
2. **Doctor's OPD Initial Assessment**

- Pain Score
- Plan of Care/ Treatment Plan
- Consultant Sign

Doctor's OPD Initial Assessment – Plan of care/ treatment plan shows a very high non-compliance rate of 50.8%. Plan of care helps to ensure consistency of care that a patient receives.
Documenting care plan was very important in each and every file.

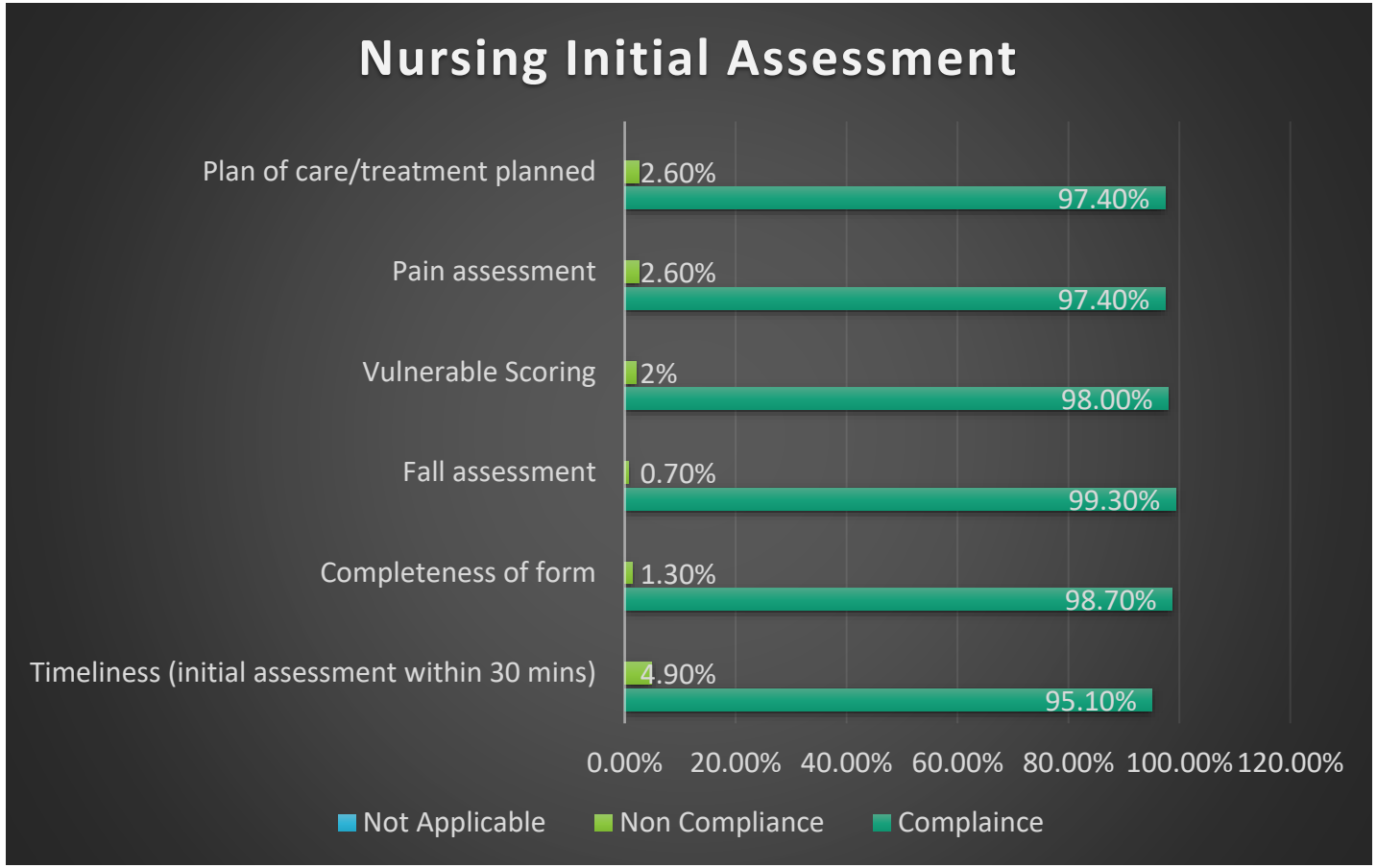
Mentioning of Pain Score is very necessary to assess the pain of patient and management of pain. Pain Score was not adequately filled in OPD Assessment Sheet of some patient's file with a non-compliance of 15.7%



3. Doctor's IPD Initial Assessment

- Timeliness (Initial Assessment within 60 mins)
- Form completeness
- Pain Score
- Plan of Care/ Treatment Planned
- MO sign, date and time
- Consultant counter sign (within 24 hours)

As per NABH 5th Edition, Countersigned by consultant of Doctor's IPD Initial Assessment sheet was very important. It shows a non-compliance of 23.3%. It is the duty of the admitting consultant to counter sign.
Filling of IPD Initial Assessment was done by Resident Doctor within duration of 60 mins acc. to NABH. It shows a very high non-compliance rate of 28.9%.

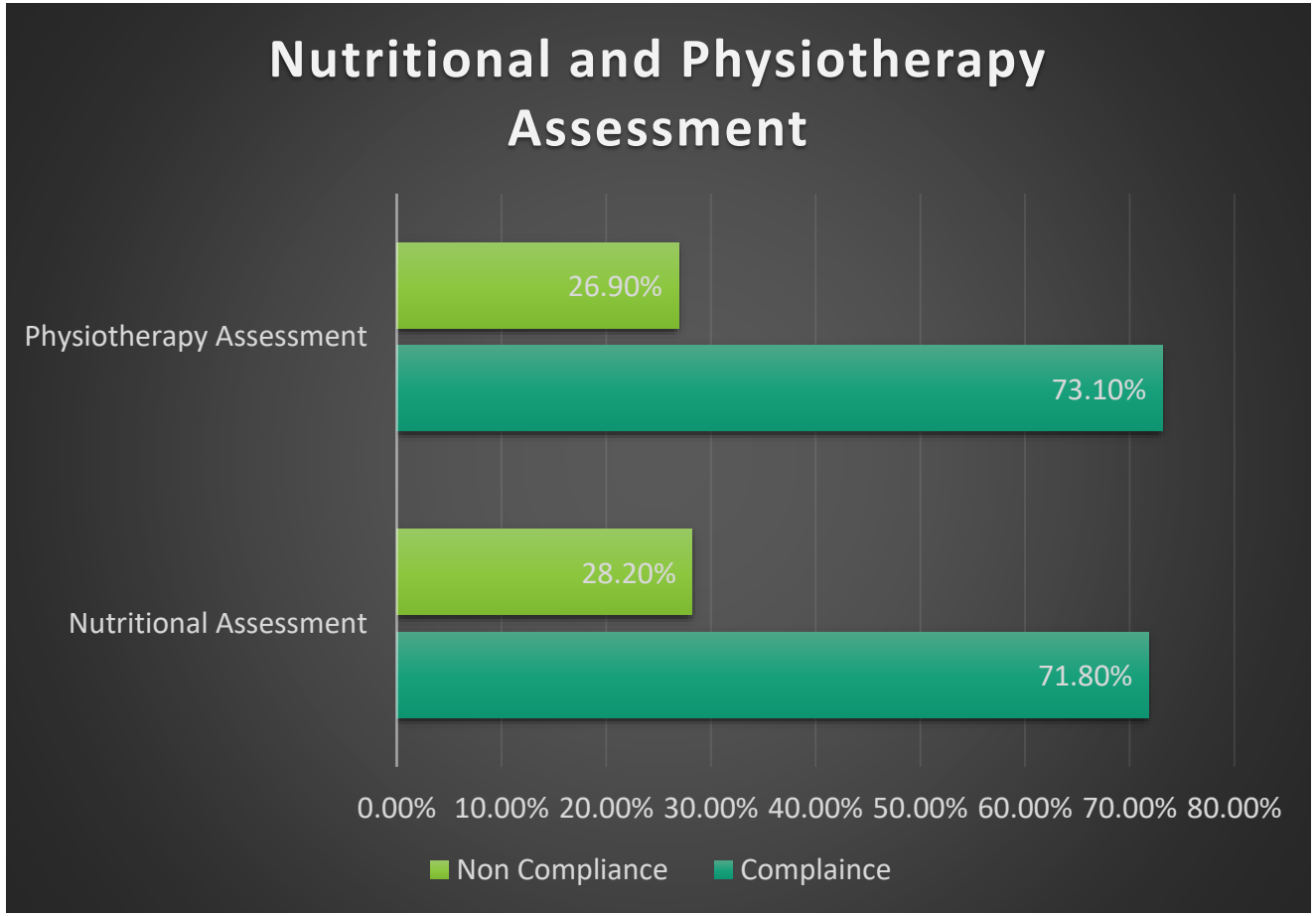


4. Nursing Initial Assessment

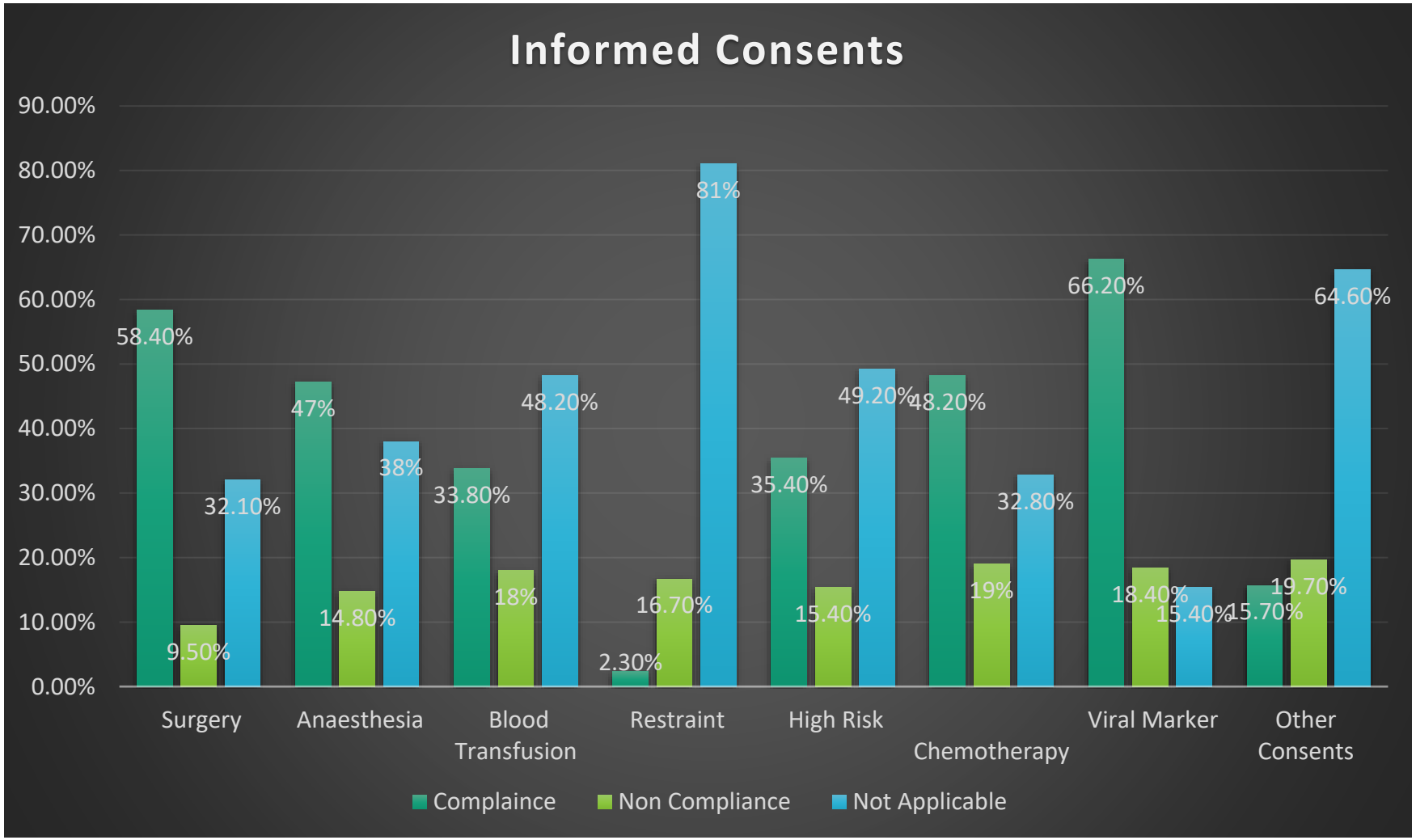
- Timeliness (Initial Assessment within 30 mins)
- Completeness of form
- Fall Assessment
- Vulnerable Scoring
- Pain Assessment
- Plan of care/ Treatment planned

Nursing Initial Assessment shows a non compliance rate of less than 5% in all the six parameters which was a good sign. Most of the part is under the control of the nursing department and as the result shows it has the high level of documentation compliance.

5. Nutritional Assessment
6. Physiotherapy Assessment



Nutrition and physiotherapist assessment shows a non compliance of 28.2% and 26.9% respectively which was very high. It should be done for every patient after the admission. A Nutritionist and Physiotherapist on regular basis was hired by the hospital to improve on the non-compliance rate.



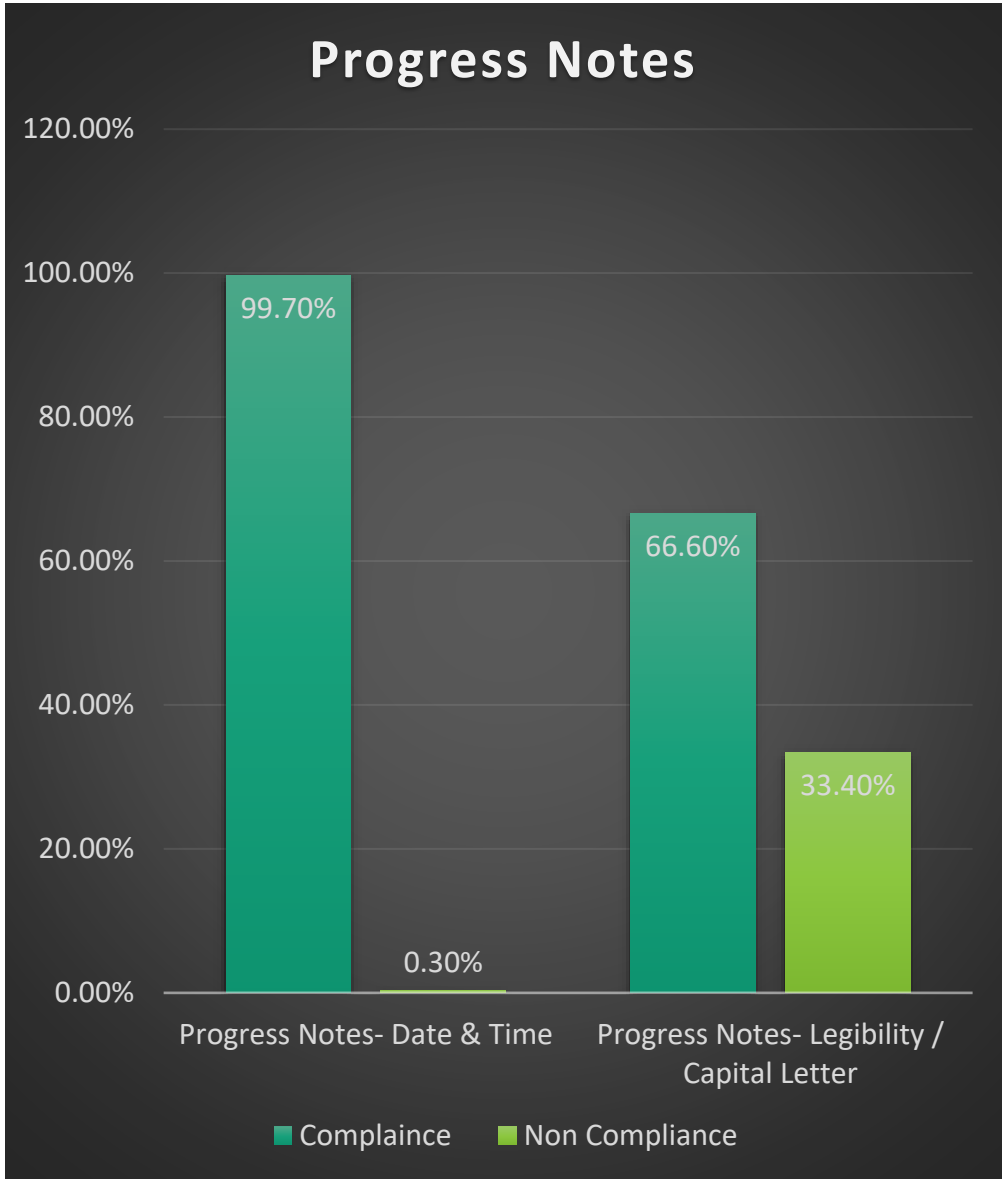
7. Informed Consents

- Surgery Consent
- Anesthesia Consent
- Blood Transfusion Consent
- Restraint Consent
- High-risk Consent
- Chemotherapy Consent
- Viral Marker Consent
- Consent – Others

- **Consent are the most sensitive part of the entire patient files. It also plays an important role in the medico-legal cases. A complete and documented consent is necessary because sometimes it saves the organization and its staff from any legal actions. Consultants or his/her team always document the benefits and risks of the procedures and signs them appropriately from the patient's attendants.**
- **The non-compliance rate in consents was vary from consent-to-consent from 9% to 20%. Either the consent was not signed by the consultant or the patient/attendant sign was not taken.**

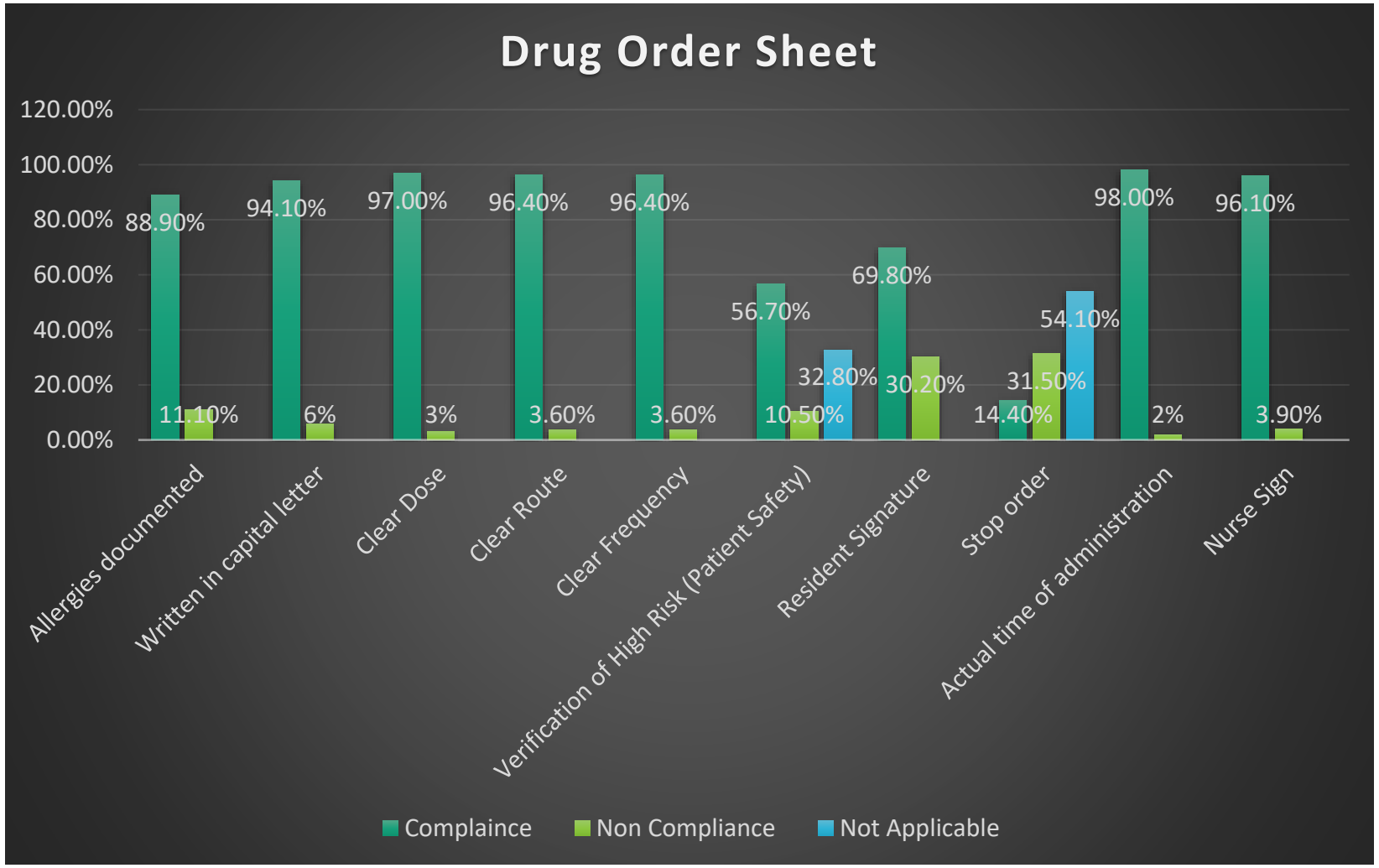
8. Progress Notes

- Date and Time
- Legibility / Capital Letter



Written in Capital Letter/ Legibility shows a high non-compliance rate of 33.4%.

Doctor's need to be educated for writing in Capital Letters.

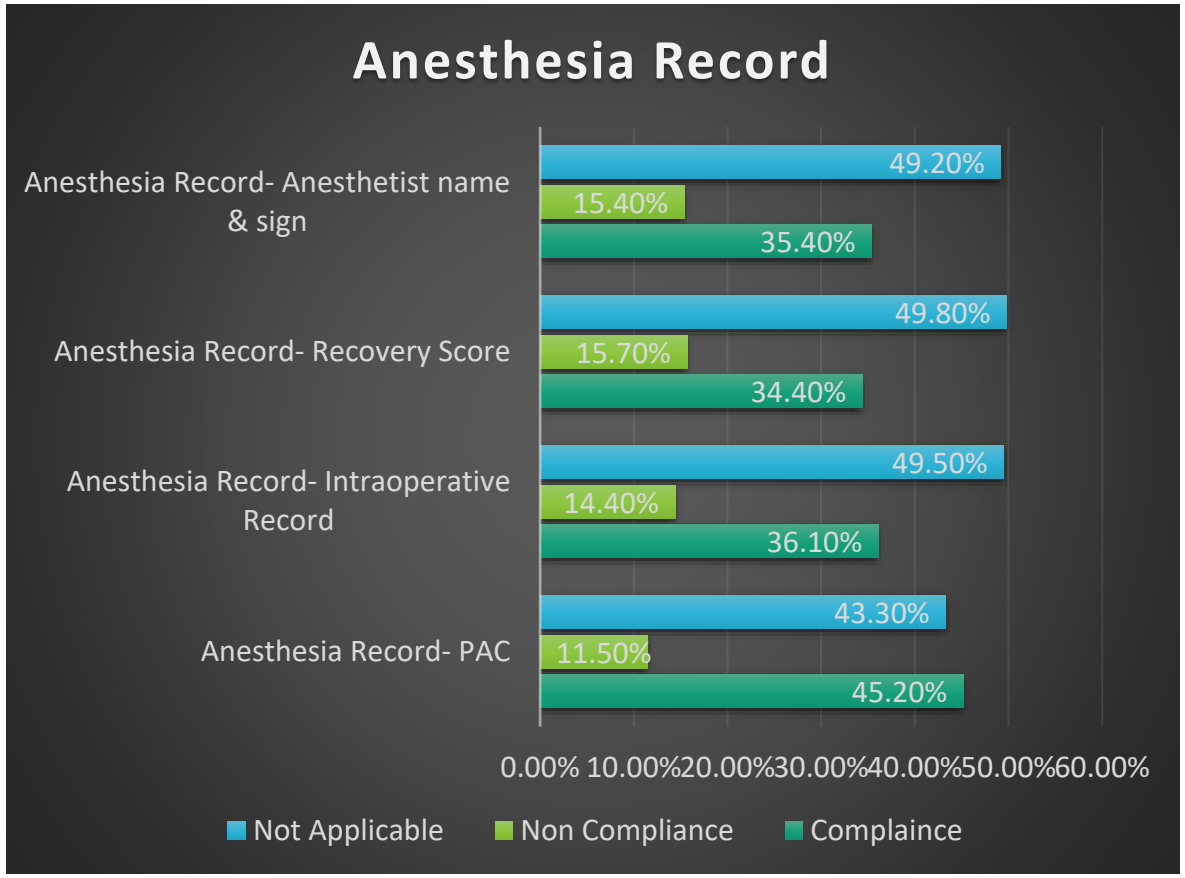


9. Drug Order Sheet

- Allergies Documented
- Medications written in Capital Letters
- Clear Dose
- Clear Route
- Clear Frequency
- Verification of High Risk
- Resident Signature
- Mentioning of STOP Order
- Actual Time of Administration
- Nurse Sign

Mentioning of Drug Allergies is the very vital point in drug order sheet that should not be missed. Many a times, patients are given medicines or medicinal compositions they are allergic turning the disease situation risky and fatal. Even though the documentation of drug allergies is so important, 11.1% of the files did not have any mention of the drug allergies that the patient is suffering from, neither marked as Not Applicable (NA).

Resident Signature and STOP order shows a very high non-compliance rate of 30.2% and 31.5% respectively.

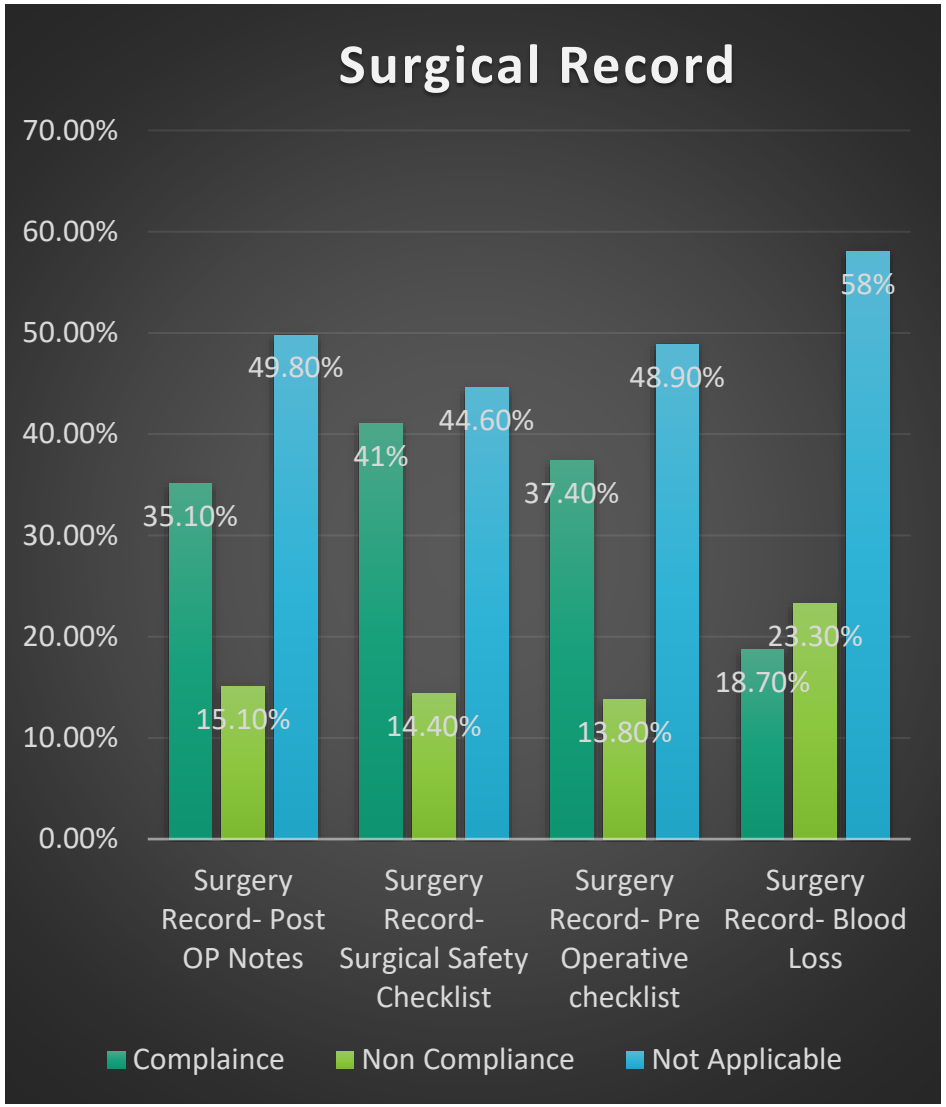


10. Anesthesia Record

- Pre Anesthesia Checkup
- Intra-operative Record
- Recovery Score
- Anesthetist Name and Sign

Pre-anesthesia Record shows a non-compliance rate of 11.5% to improve on this, communicate with the anesthesiologist who is responsible for administering the anesthesia to the patients before surgery is required. They have to filled PAC before administering anesthesia.

Also, they have to properly mention their name and signed in each anesthesia document and properly maintain the anesthesia intra-operative record and recovery score.



11. Surgery Record

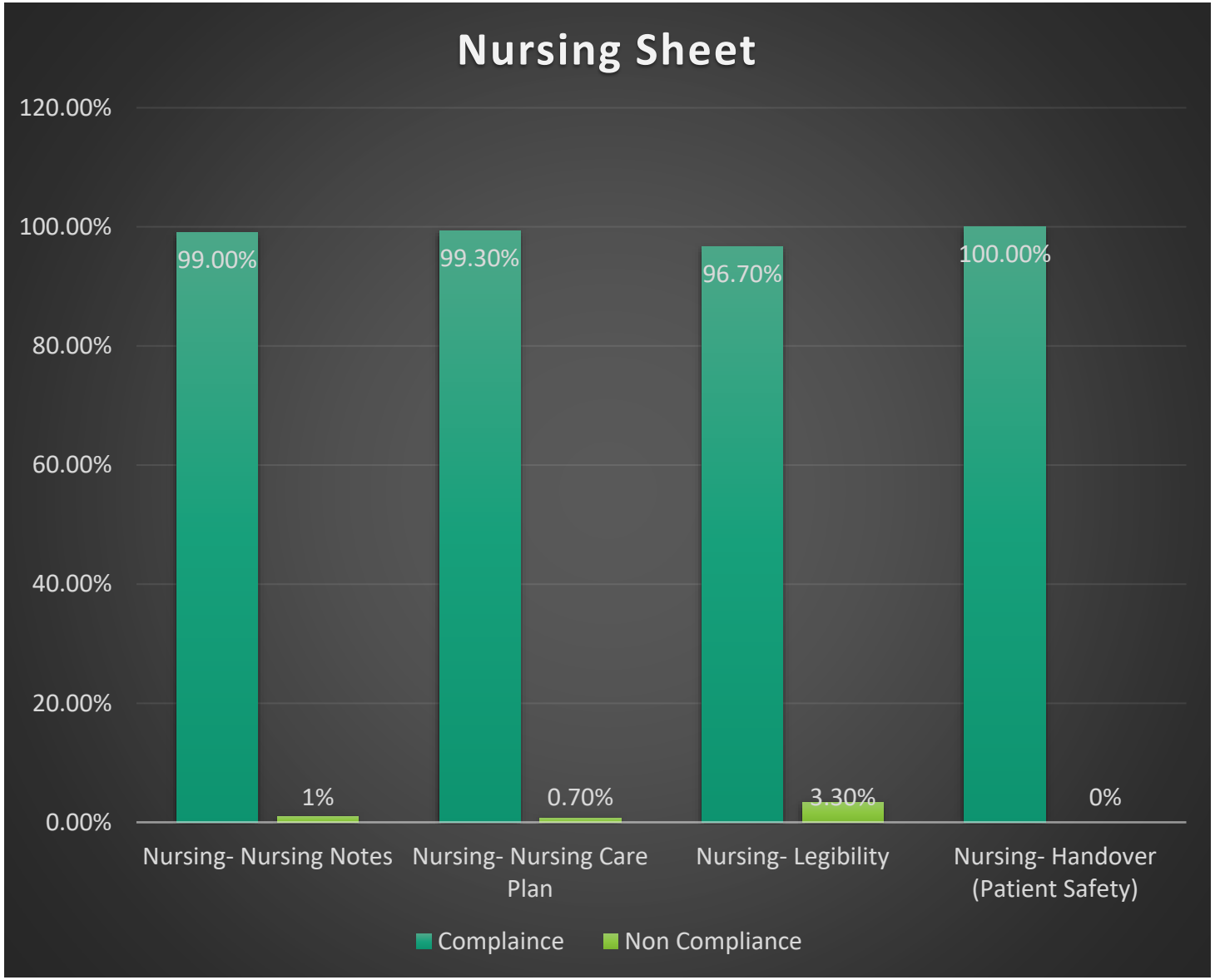
- Post OP Notes
- Surgical Safety Checklist
- Pre-operative Checklist
- Blood Loss

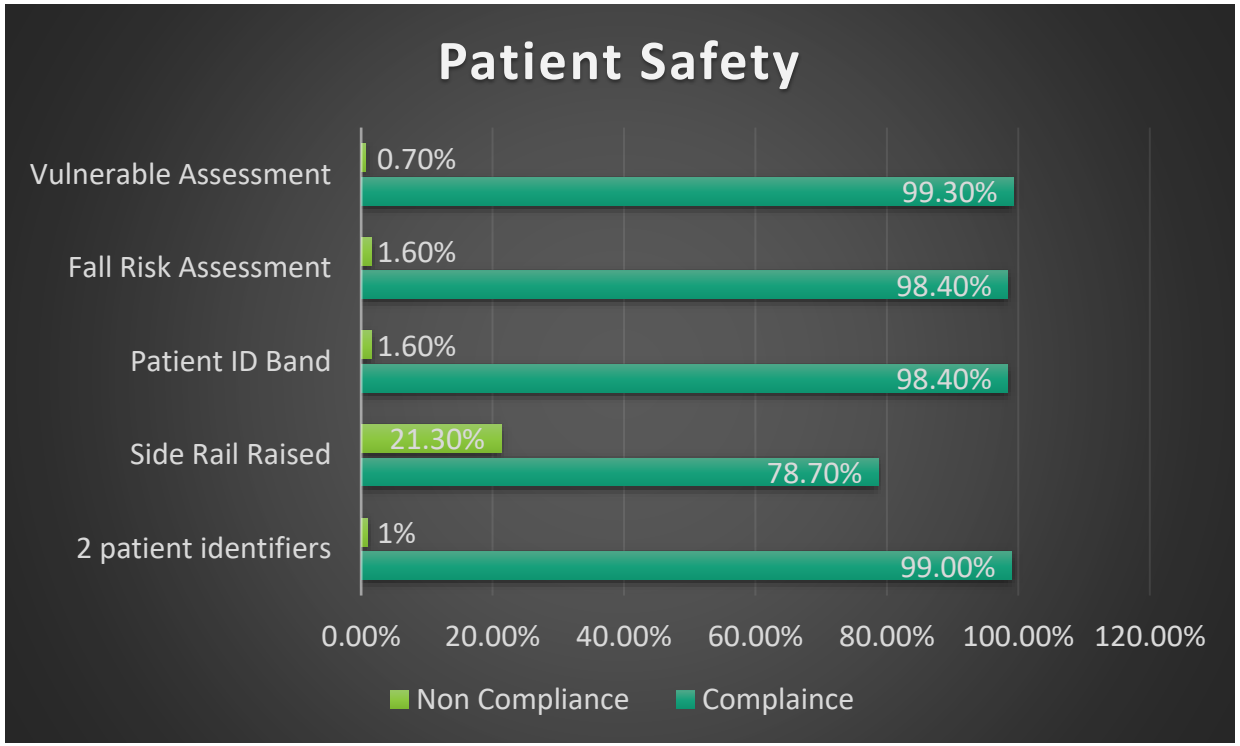
The four parameters of surgical record shows the non-compliance rate in between 13% to 23%.

Post OP Notes must be mentioned as it is necessary and helps the patient's attendant in caring of the patient, about their medication.

12. Nursing Sheet

- Nursing – Nursing Notes
- Nursing – Nursing Care Plan
- Nursing – Legibility
- Nursing – Handover





13. Patient Safety

- Patient Safety – Two patient Identifiers
- Patient Safety – Side rail raised
- Patient Safety – Patient ID Band
- Patient Safety – Fall risk Assessment
- Patient Safety – Vulnerable Assessment

Totally, five parameters were assessed in Patient Safety. Two patient Identifiers, Side Patient ID Band, Fall Risk Assessment and Vulnerable Assessment shows a very high compliance rate in between 95% to 99% and Side Rail raised shows a non-compliance of 21.3% which must needs to be improved. Majorly, the rails was not raised of general wards.

SUGGESTIONS

- **Orientation of Doctors and staff** – We need to sensitize the clinical staff regarding the importance of medical records and proper documentation of each form.
- Also, every time a new person joins he/she must be properly oriented about how and what are the things they need to fill up and the importance of filling up. Regular trainings should be taken on nursing and physicians documentation.
- Educate and train to nursing staff on NABH guidelines for documentation in medical records.
- Check whether the proper documentation was done of admitted patient file in a day or after a periodic interval of time.
- Also there should be a proper process of checking of each and every parameter before sending the file to MRD post patient care.

- **Delegation of Work** – The floor manager given a job of checking each patient file documentation. If not filled properly, then the floor manager can ask the nursing personnel and doctors to fill the remaining documentation or any part of it.
- **Using of 'NA' –** If some part of the documentation is not applicable for a particular patient, then that part should be mentioned as Not Applicable. Leaving the blank space implies, that the part has been overlooked or has not been documented.
- Since, a nurse prepares the patient for the procedures, explain the procedure to the patient and generally explains the consent form to the patients, the nursing staff can be given the responsibility of getting the consultant form signed by the doctors.
- With the Quality Department, we have to make a separate department for Internal Audit, which is responsible for doing monthly internal audit of documents and helps in continual quality improvement.
- Rewarding the best performing department /unit for documentation .

CONCLUSION

- Maintaining a complete documentation of records is not only important to comply with accredition and licensing requirement , but also as a proof to establish that the adequate care a patient received in the organization .
- 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 report highlights the area of medical records of hospital that need more concern and attention . Overall study shows that the documentation standards in the hospital is satisfactory except a few parameters which needs attention for improvement.
- To keep the standard and to improve them , the non compliances stated should be managed .
- The 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.


THANK YOU