SUMMER TRAINING

At

Fortis Healthcare, Shalimar Bagh, New Delhi

Date: May 10, 2021, to July 2, 2021

A SUMMER TRAINING REPORT

On

- ***Process Mapping of MRD***
- ***Assessment of Compliance of Consents Obtained and Medical Record Documentation in FHSB***
- ***Gap Analysis of Records Against the Set Standard Operating Procedure by NABH in FHSB***

by

Dr. Aayushi Sharma

MBA in Hospital and Healthcare Management

2020-2022

Under the guidance of

Dr. Daya Krishan Mangal, Professor

CERTIFICATE 1.

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Shalimar Bagh

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Date: 2nd July 2021

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Aayushi Sharma**, was engaged with Fortis Hospital, Shalimar Bagh from **10th May 2021** to **2nd July 2021** in the department of **Operations, Quality & Medical Record.**

She was engaged in following areas:

- Pharmacy & Stores
- Medical Record audit
- MRD Committee Meeting

We wish her all the best in her future endeavors.

For Fortis Healthcare Limited

FORTIS HEALTHCARE LTD. A-Block Delhi-110088

Shubhra Kohli
Unit Head – Human Resource

ACKNOWLEDGEMENTS

I consider myself highly fortunate for receiving a fantastic opportunity to pursue my summer internship at Fortis Healthcare, Shalimar Bagh, New Delhi. For this, I am indebted to Mr. Mahipal Singh Bhanot, Facility Director of the organization. I extend my sincere gratitude for his mentorship and invaluable guidance and suggestions that I am going to carry forward in my professional growth. I would also like to thank his executive assistant, Ms. Nidhi Dhamija, who has been a constant support during my tenure.

I want to express my warm veneration towards Dr. Divya Saxena, Head of the Department of Quality Management for her constant supervision and a keen interest in helping me learn and pushing my limits. I want to thank Mr. Vinay Chaudhary, HOD of IP Pharmacy and Stores, for sharing his valuable insights and genuine concern. I'm grateful to Mr. Satpal Singh, HOD of the Medical Records Department who allowed me access to the medical records and provided me with an opportunity to work on my research subject.

I am in awe of all the professionals at Fortis Healthcare, Shalimar Bagh, for being an example of grit, perseverance, and dedication in such dire circumstances of the COVID-19 pandemic and offering their best services to their consumers.

I want to thank my university mentor, Dr. Daya Krishan Mangal, Professor, and Advisor, SDG Svhool of Public Health, IIHMR University, for his active participation and his constructive feedback which guided me in making this report a successful project.

I would also like to thank my parents, who have always been pillars of great moral and emotional support.

At last, I would extend my gratitude to all the administrative members. They helped me directly or indirectly in completing this work and made it a learning experience that I would cherish forever.

Aayushi

Dr. Aayushi Sharma

MBA Hospital Management

INTRODUCTION

Summer Training in a reputed organization and carrying out authentic research is an integral part of the MBA in hospital and health management journey. This summer training intends to get the students oriented towards the operations and process flow in a hospital setting.

I got the excellent opportunity of working with the leading healthcare provider, Fortis Healthcare Limited as an intern during this summer training scheduled as a requisite in the curriculum of my coursework.

I joined Fortis Healthcare on May 10 2021. The duration of the summer training was of two months i.e. May 10, 2021 to July 2, 2021.

AIM OF THE INTERNSHIP

To learn the overall process flow and operations in the management of a healthcare providing organization, identify issues in some areas and provide solutions.

INTERNSHIP PROFILE

Initially, I was appointed in the Inpatient Pharmacy and stores located on the upper basement floor of the Wing A of the hospital.
To understand the system that Fortis managed its records on- HIS (Hospital Information System) and Oracle.

To learn about the stacking of various pharmaceuticals & medical supplies and the criteria behind it and differentiating between look-alike, sound-alike drugs, high-risk medication, costing standards, and storage of vaccines.

To observe and understand how indents were placed for in patient pharmaceutical requirements, their packing, billing, dispensing and discharge.

To evaluate turn-around time of dispensing of medicines in the hospital and where the process slacked so it can be improved upon.

To monitor whether staff requirements were met and the roster was appropriate.

Meanwhile, I observed the operations of the OPD and IPD billing departments along with the involvement of the TPA desk and financial counseling section.

Then, I was involved with the Quality department where I understood the different audits through various checklists quality department does to maintain and improve the Quality and delivery of the hospital services.

In June, I went on rounds for a fortnight and audited a total of 100 files of patients on the first, second, third, fourth and fifth floor of the hospital.

I was also engaged in the Medical Records Department and carried out the audit of the documentation of medical records patients' files and carried out a retrospective audit of the previous month's files (January to May 2021).

This audit led to the formulation of analysis, and I prepared the presentation for the quality department for the quarterly meeting (April to June 2021) of the MRD committee of the organization.

Meanwhile, I observed and learned the operational activities of the Radiology department.

HIGHLIGHT OF THE INTERNSHIP - For the entire duration of my internship, I attended the morning meeting comprising all the Departmental Heads and the Zonal Director. They presented the previous days' reports, discussed issues, suggested ideas, and implemented those in their scheme of operational duties. I'm truly enlightened by the experience.

Contents

Acronyms/Abbreviations used

FHSB- Fortis Healthcare Shalimar Bagh

NABH- National Accreditation Board for Hospitals

MRD- Medical Record Department

OPD- Out Patient Department

IPD- In Patient Department

HIS - Hospital Information System

TPA- Third Party Agreement

CSSD – Central Sterile Supply Department

PNDT- Pre-Natal Diagnostic Techniques

CSO - Chief Security Officer

CCU- Coronary Care Unit

ICU – Intensive Care Unit

NICU – Neonatal Intensive Care Unit

OT- Operation Theatre

AMS-Assistant Medical Superintendent

DMS- Director of Medical Services

MO- Medical Officer

PTCA- Percutaneous Transluminal Coronary Angioplasty

LSCS- Lower Segment Caesarean Section

MRI – Magnetic Resonance Imaging

CAG- Coronary Artery Graft

IVF- In Vitro Fertilization

BME- Bio Medical Engineering

SOP- Standard Operating Procedure

MLC- Medico-Legal Case

DAMA-Discharge Against Medical Advice

ABOUT THE ORGANISATION

1.1 Fortis Healthcare Limited is a leading integrated healthcare delivery service provider in India. Their verticals comprise hospitals, diagnostics, and day-care specialty facilities and provide their services in India, Dubai, Mauritius, and Sri Lanka with 54 healthcare facilities including projects under development.

Fortis Hospital-Shalimar Bagh, New Delhi, is a multi-super specialty hospital and offers services to provide quality medical care. It started in 2010 and has 262 beds. The premises spread over an area of 7.34 acres with a built-up area of 3.78 lac sq. ft.

With a NABH accreditation and TERI GRIHA green rating certification, the hospital has received 3 Star rating for its building by the Bureau of Energy Efficiency, Government of India, under the Ministry of Power, making it the only hospital in Delhi to receive such recognition.

Brand Logo

The brand has a unique logo representing human values of trust, ethics and service, and quality healthcare. They project clinical excellence, outstanding patient care, transparency in actions and, integrity in everything that its employees do. The symbolic human figure and the coming together of hands in green represents health, well-being, compassion, nurturing, and generosity while the red dot represents an association with our Indian roots, also indicating spirituality, courage, and the symbol of good luck.

Vision

'Saving and Enriching Lives'

Mission

'To be a globally respected healthcare organization known for Clinical Excellence and Distinctive Patient Care'

Core Values

Patient Centricity

Ownership

Integrity

Innovation

Team Work

Top Specialties

- Bariatrics
- Mental Health and Behavioural Sciences
- Plastic/Cosmetic Surgery
- Nephrology
- Obstetrics and Gynecology
- Cardio thoracic and vascular surgery
- Orthopedics and Joint Replacement

Clinical Specialities

1.Anaesthesiology	2. Bariatric	3. Cardio Thoracic and Vascular Surgery	4. Cardiology	5. Clinical Nutrition and dietetics
6. Critical Care	7. Dentistry and Maxillofacial Surgery	8. Dermatology	9. Diabetes and Metabolic Disorders	10. Emergency Medicine
11. ENT	12. Endocrinology	13. Foetal Medicine	14. Gastroenterology and Hepatology	15. General and Laparoscopic Surgery
16. GI and Hepatobiliary Surgery	17. Haematology	18. IVF	19. Internal Medicine	20. Mental Health and Behavioural Sciences
21. Minimal Access Surgery	22. Neonatology	23. Neurosurgery	24. Nephrology	25. Obstetrics and Gynaecology
26.Oncology	27.Ophthalmology	28.Organ Transplantation	29 Orthopaedics and Joint Replacement	30. Paediatric Surgery
31. Paediatrics and Neonatology	32. Physiotherapy and Rehabilitation	33. Plastic/ Cosmetic Surgery	34. Pulmonology/Respiratory Medicine	35. Radiology
	36. Rheumatology		37. Urology	

Connectivity of Floors

- Lifts: There is total of eight lifts in the hospital which has different capacity.
- Stairs: There is a total of nine staircases.
- There are no ramps.

Fire Safety System

- There are various safety equipment in OPD and IPD, which includes
- Fire Extinguisher and Hose reel
- Hydrant System
- Fire Detection System (Smoke Detector, Heat Detector, MCP, Hooter cum Flasher, Fault isolator)
- Fire alarms (Code Red)
- Emergency fire exits there are nine fire exits in the hospital.

Different Codes

- Code Blue - Individual Disaster.
- Code Red - Fire
- Code Grey - Internal Disaster
- Code Pink - Baby Missing
- Code Purple - Fight Physical Altercation
- Code Yellow – External Disaster
- Code Orange – Hazmat Spill.

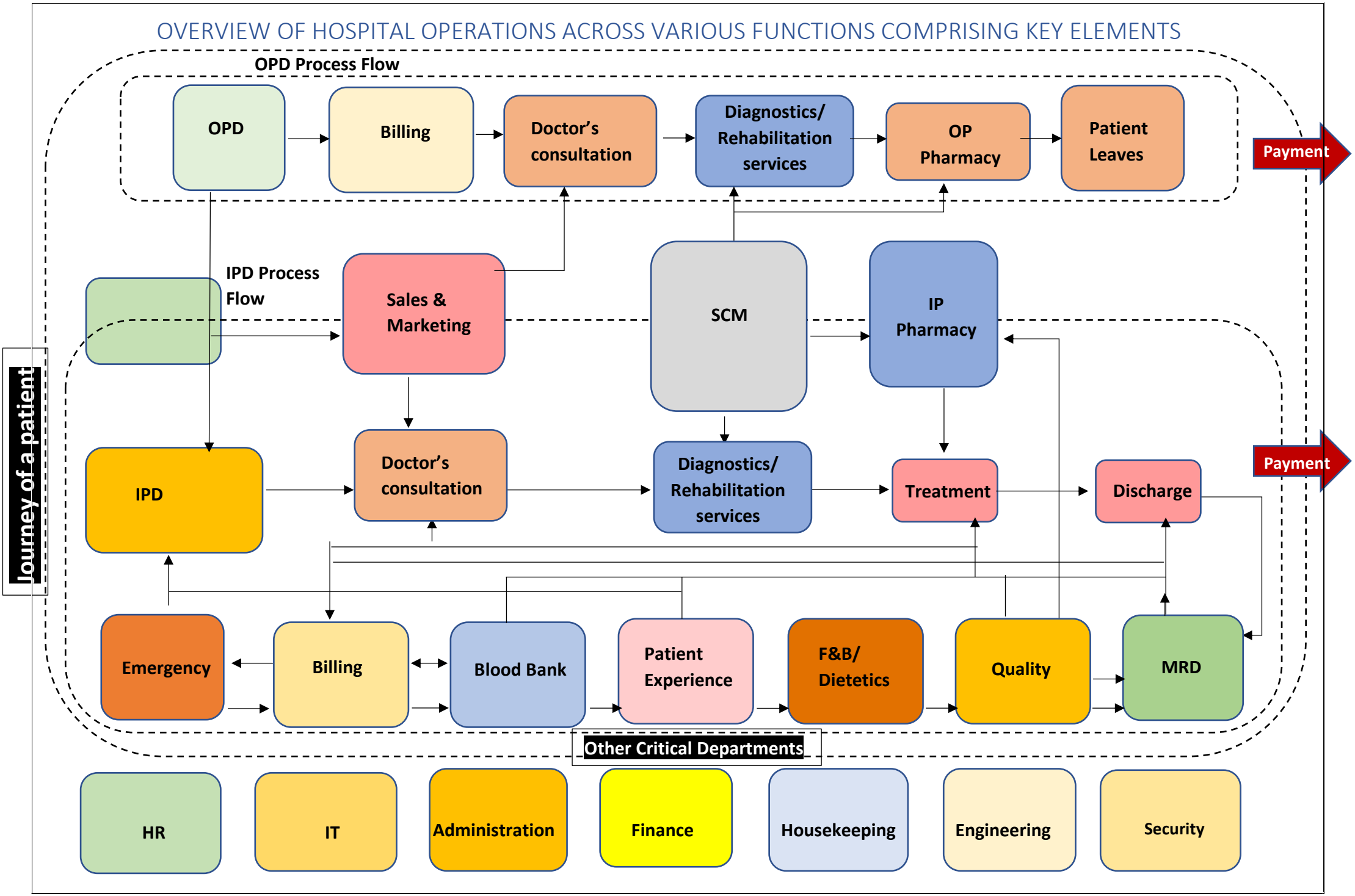
Floor Plan

Address (Location)	Building/Block	Level/Floor	Area/Activity
A-Block	Lower Basement	A – Block	Car parking
A-Block	Lower Basement	B – Block	Engineering
A-Block	Upper Basement	A – Block	Administration, Auditorium, Board Room, IP Pharmacy, CSSD, Linen Room, radiation Oncology, Nuclear medicine, Tumour Board, LAB, Blood Bank, Housekeeping, Time Office, CSO office, Mortuary, General Store, Purchase, receiving Bay, MRD, manifold Room,

			BME, Staff Cafe, Central linen and Staff uniform, Biomedical Waste Collection and General waste Room, Staff Changing Rooms
A-Block	Ground Floor	A – Block	OPD Chambers, OPD Desk, IPD Desk, TPA Desk, Billing Desk, Counselling Room, Patient Welfare Department, Prayer Room, Physiotherapy procedure Room, OPD Pharmacy, Café Coffee Day, International Patient Lounge, Neuro Lab, Dental, Audiometry, Ophthalmology
A-Block	Ground Floor	B – Block	Emergency, Radiology, IVF, NIC, TMT, Sample Collection, PHC, Kitchen, call Centre, Billing desk, Visitors cafeteria
A-Block	1st floor	B – Block	Labour room, NICU, OPD Chambers, MAMA Mia, Gynaecology & Obstetrics inpatient

			ward, Billing & Admission Desk
A-Block	2nd floor	A - Block	Endoscopy, Bronchoscopy, Dialysis, Chemo Day care, Urodynamic Lab, Lithotripsy, OPD Chambers, Procedure Room 1, procedure Room 2
A-Block	2nd floor	B – Block	4 Bedded & 6 Bedded category rooms, 2 room twin sharing & 2 single rooms
A-Block	3rd Floor	A – Block	OPD Chambers, Vertigo Lab, Cath lab, CCU, Neuro surgery ICU
A-Block	3rd floor	B – Block	Single & Twin sharing rooms
A-Block	4th floor	A – Block	Medical ICU, Surgical ICU, Pediatric ICU, Kidney transplant Unit, Counselling room
A-Block	4th floor	B – Block	Single & Twin sharing rooms
A-Block	5th floor	A – Block	OT Complex, Post-Operative Care Unit & CTVS ICU
A-Block	5th floor	B – Block	P.S. Suite & Deluxe rooms

OVERVIEW OF HOSPITAL OPERATIONS ACROSS VARIOUS FUNCTIONS COMPRISING KEY ELEMENTS



RESEARCH TOPIC

Process Mapping of Medical Record Documentation (MRD)

Assessment of Compliance of Consents Obtained and Medical Record Documentation in FHSB

Gap Analysis of Records Against the Set Standard Operating Procedure by NABH in FHSB

INTRODUCTION

Documenting is critical when it comes to healthcare. The information is vital for all the providers involved in patient care and any subsequent new provider who takes the patient's responsibility.

Quality of a service refers to the perception of the degree to which the product or service meets the standards. Quality of patient care depends directly on the accuracy and comprehensible accounting of the information in the medical records. It is essential to maintain a full record to comply with licensing and accreditation requirements and establish that a patient received adequate care.

Standard Operating Procedures (SOPs) for hospitals state that data should be collected in a timely, economical, and efficient manner using the degree of accuracy and completeness necessary for the data's required use and health records to be periodically reviewed.

Gap analysis is done to review the available service delivery system and find areas of improvement in the existing system. To carry out this function, the department of Quality and the department of Medical Records Documentation plays a vital role which will be discussed in other parts of the report.

QUALITY CONTROL DEPARTMENT

PRIMARY DUTIES: The department performs various functions which may be-

- To analyze patient feedback forms.
- To analyze different parameters from different departments and compare them.
- Infection control of the hospital.
- Induction and training of hospital staff.
- Accreditations

This department also maintains few quality indicators for the hospital:

- Return of patient within 22 hours
- Return of patient to ICU within 48 hours
- Return of patient to OT within 48 hours

DAILY REPORT: The department prepares a daily sheet and reports to the Director regarding the following events from the previous day-

1. By Blood Centre:

No. of Blood Units collected/donation

No. of blood units issued

No. of outside procurement/ Issue

No. of blood units discarded.

2. By Medical Record Dept:

No. of Discharge files pending to reach MRD beyond 48 hours

No. of death files pending to reach MRD beyond 48 hours (Till 4 pm)

3. By CSSD

Total no. of cycles in steam sterilizers

Total no. of pack resterilised

4. By Clinical Pharmacist

Medication, transcription and administration errors.

Total no. of files audited

No. of justification forms filled

5. By PNDT

Number of Antenatal USG done

Forms filled/uploaded

No. of Foetal echo done

6. Reporting of fall incidents, dispensing error and reporting error.

STAFF**:** This department consists of one quality manager who reports directly to the Zonal Director.

MEDICAL RECORD DEPARTMENT

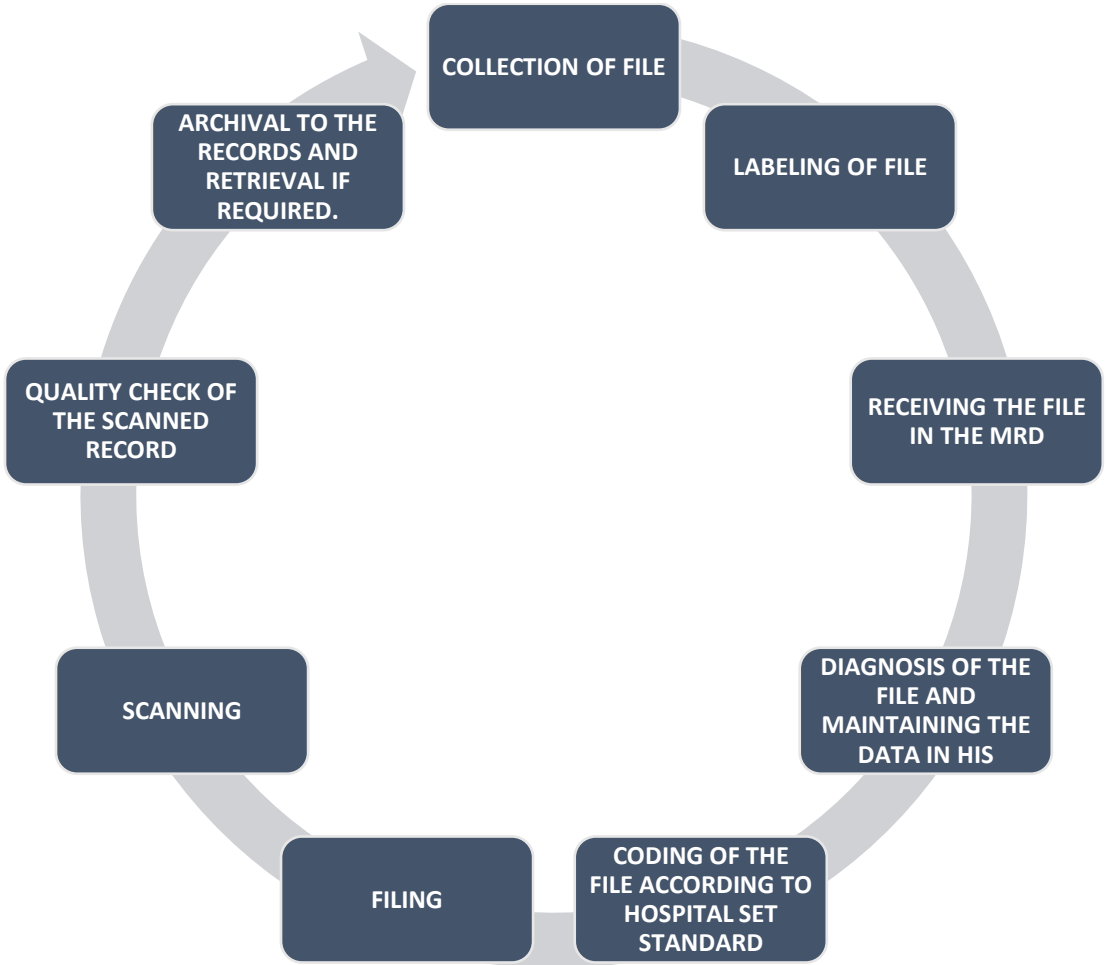
MEDICAL RECORDS:

A systematic documentation of a patient's personal and social data history, the disease, clinical findings, investigation, diagnosis, treatment given, account of follow-up and final treatment is called a medical record. It records data in the sequence of events to justify the diagnosis, treatment rendered and the prognosis of an individual. Keeping this record provides information on patient care to other healthcare professionals and support for the physician's defense in the event of a medical malpractice action.

ROLE OF MEDICAL RECORDS DEPARTMENT:

It is absolutely essential to maintain medical records in the hospital safely. This department checks, stores and allows retrieval of these files if needed in the future. The medical record department (MRD) also plays a part in community health studies. From the MRD, we can know if all the departments (especially the clinical part) are functioning to their optimum level. A failed medical record department can even lead to misplacing of documents from the file.

PROCESS FLOW FOR MRD:



If a file is found to be deficient in the expected completion of documents, it is sent back to the floor manager, and later the file is received in the MRD after completion of the missing documents.

The following documents or sheets are found in a complete medical record:

1) Checklist for the MR
2) Checklist for patient discharge report
3) Discharge slip
4) Admission Paper
5) MLC Copy
6) Death Summary
7) Birth or Death Certificates
8) Emergency Assessment Sheets
9) Case History or Initial Assessment in wards
10) Doctor's Progress Notes
11) All investigation reports
12) All consent forms
13) Assessments, checklist during surgery
14) PAC Evaluation sheet
15) OT Sheet
16) Surgical Safety Checklist
17) Initial Nursing Assessments
18) Nutritional Assessment Sheets
19) Nursing Progress Note
20) Daily nursing Assessment notes
21) Input-Output Charts
22) Infection control Checklist
23) Clinical Diabetic or Diet Chart
24) Risk of Fall Assessments
25) Paint and Palliative Assessments
26) Medicine Card
27) Observation Charts
28) Indent Forms
29) Other or Extra sheets if any)
30) Final Bills

Apart from presence of these sheets or documents, there are multiple signatures, stamps, dates and time, and other important aspects in these documents that need to be present to consider the file as a complete file. An open and closed audit is done of all files before keeping them for storage.

STORAGE AND STACKING OF FILES IN THE DEPARTMENT:

The arrangement of files is done in the following ways:

1. Year wise
2. UHID wise.
3. Based on their type:
    - Regular files
    - DAMA files
    - MLC flies
    - OT recovery files
    - Chemotherapy files
    - Dialysis files

FORMS AND RECORDS STORED IN THIS DEPARTMENT:

- Consent forms
- OT papers
- A&E Papers
- Certificates issued from the department:
- Patient fitness certificate
- Fit to fly certificate
- Leave certificate

QUESTIONS TO BE ANSWERED:

1. What is the protocol maintained for MRD?
2. What is the checklist according to NABH standards for MRD?
3. Are all the important sheets of medical records filled properly or not?
4. What is the percentage of completeness and accuracy of medical records filled by doctors, nurses and other paramedical staff?

NATIONAL ACCREDITATION BOARD FOR HOSPITALS & HEALTHCARE PROVIDERS:

It is a constituent board of the Quality Council of India (QCI), set up to establish and operate accreditation programmes for healthcare organizations. The NABH schedule has an audit parameter separately designed for the MRD.

Medical record audits are carried out. Most healthcare records are designed to aid in legal specification and availing of insurance claims. Auditing promotes medical records that will support high-quality treatment solutions. Also, the legal interests of the affected individuals and the medical professionals are protected by maintaining records that become references for a safer future.

CHALLENGES FACED IN IMPLEMENTATION OF NABH IN A HOSPITAL SETTING:

1. The documentation required in NABH is large.

2. Skilled staff is required.

3. There is a need for repeated on the job training in the implementation of NABH.

4. For attaining NABH certification, NABH certified trainer/coordinator is required.

5. The quality standards of NABH are descriptive and elaborative, where attention is paid to even small details that are difficult to maintain.

RATIONALE:

This project focuses on how the medical records are documented and where the loopholes lie that need to be taken care of.
Monthly auditing of the Medical Record's documentation is a part of daily jobs performed in the department for different quality indicators to check for incompleteness of files. It prepares the organization with its NABH accreditation.
With an increased number of MLCs against doctors and organizations, medical record documentation role is extreme.
This process gave me an opportunity to visit different wards and talk with medical professionals, to understand the part played by them.
The gap analysis is done to identify the level of training that is required for the hospital personnel. With regular and proper training, better quality of services can be provided to the patients admitted, and the staff would be able to understand and follow the process keeping check of the standards expected.

OBJECTIVE:

- To analyze the gaps and discrepancies in medical records concerning checklist prepared according to NABH standards.
- To measure the overall compliance.
- To recommend effective methods for the closure of gaps.

RESEARCH METHODOLOGY:

MODE OF COLLECTION OF DATA

- Primary Data Collection Technique: Observation & semi-structured interview
- Secondary Data Collection: Files of the in-patients in various departments of the hospital from the MRD

SAMPLING

- Study Design- Quantitative data is collected through a simple random sampling method.
- Sample Size- 300 in-patient files were picked randomly from the rack and to comply with the audit study.
- Study Duration Month- Months of April, May, and June of 2021(100 files for each month).
- Study Area- Fortis Healthcare, Shalimar Bagh, New Delhi, India.

SAMPLING INSTRUMENT

Pre-structural checklist - An audit tool was prepared with a structured checklist and analysed in MS Excel. Following is the checklist that has been incorporated for the research:

	Scoring	0/5/10/ NA
	Parameters	
1	General consent (Authorization form)	
2	Procedural consent	
3	Blood and Blood Products consent (Blood Transfusion consent)	
4	High-Risk Procedures and treatments consent	
5	Anaesthesia consent form	
6	Risk, benefit, potential of surgery/procedures, complications and alternatives of surgery/procedures (consent of surgery)	
7	Consent on sedation	
8	Others consents	
9	Doctor's admission assessment	
10	Doctor's daily progress notes	
11	Nursing admission assessment	

12	Daily nursing flow sheet and Nursing Care Plan	
13	Nutritional assessment and screening form	
14	Dieticians notes and diet chart (where applicable)	
15	physiotherapist assessment & NOTES (where applicable)	
16	(Critical care/coronary care flow sheet notes on Critical care flow sheets on critical care flow sheet)	
17	Medication order and administration chart	
18	Diabetic chart	
19	Vital chart	
20	preoperative checklist	
21	Pre-anaesthesia assessment (Anaesthesia sheet)	
22	surgical Safety checklist	
23	OT notes	
24	Patient and Family education form	
25	In house transfer form	
26	cross Referral records if any	
27	Discharge/death summary (applicable in only discharged/death patients)	
28	Check correct ID band on an In-patient	
29	Procedure Safety Check list (Cath lab/ endoscopy/ ERCP/Bronchoscopy)	
30	Remarks, if any	

1. TYPES OF FILES

The files are separated in two ways -

- Active Files: The files of the patients that not discharged yet, hence their files are in the ward are called Active files. To study such files, a prospective study was done. Patients admitted in the month of June.
- Closed Files: The files received in the MRD after the discharge of the patient. For these files, a retrospective study was done. For medical records from April and May.

2. VARIABLES AND THEIR MEANINGS

In this report three variables are taken – Compliance (marked as 10), Partial Compliance (marked as 5) and Non-Compliance (marked as 0). 'Compliance' as a term denotes whether the parameter is being met with the standard. Before we discuss the documents audited, we need to understand about consents.

CONSENT FORMS

Informed consent is an understanding from a patient or their attendant before they receive treatment.
Morally, informed consent speaks to a person's ethical appropriate to settle on choices about themselves and their consideration. Legally, informed consent speaks to an understanding by which the person's entitlement to consent to, or decline, restorative treatment is going to happen.
Significantly, one should be able to hear and additionally comprehend this data. It is a key part of informed consent and is the obligation of the specialist to get consent. Mediator and witnesses need to be present to assure that the patient can give thoroughly informed consent to the clinicians. This applies to all healthcare practices performed on patients.
Patients who are not capable in English or have impaired hearing ability run the risk of ineffectual correspondence during the informed consent process.

TYPES OF CONSENTS:

- Informed contents.
- Expressed consent
- Implied consent.
- Advance consent.
- Surrogate consent.

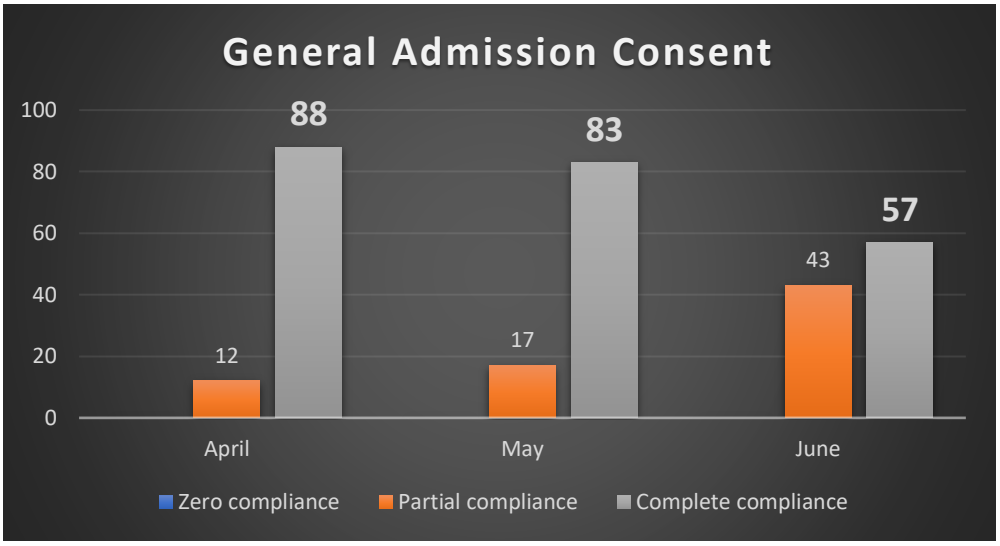
CONSENTS USED IN FORTIS HEALTHCARE FACILITY (FHSB):

- General Admission consent.
- Covid-19 Consent
- Procedure consent
- Blood Component consent
- HIV Testing consent
- High Risk Medication consent
- Anaesthesia consent
- Conscious Sedation
- Consent of Surgery
- Haemodialysis Consent.

-

FINDINGS & INTERPRETATIONS:

**********Document Audited – 1**********



INTERPRETATION: It can be observed that the compliance for general admission consent has reduced dramatically in the final month as compared to previous months.

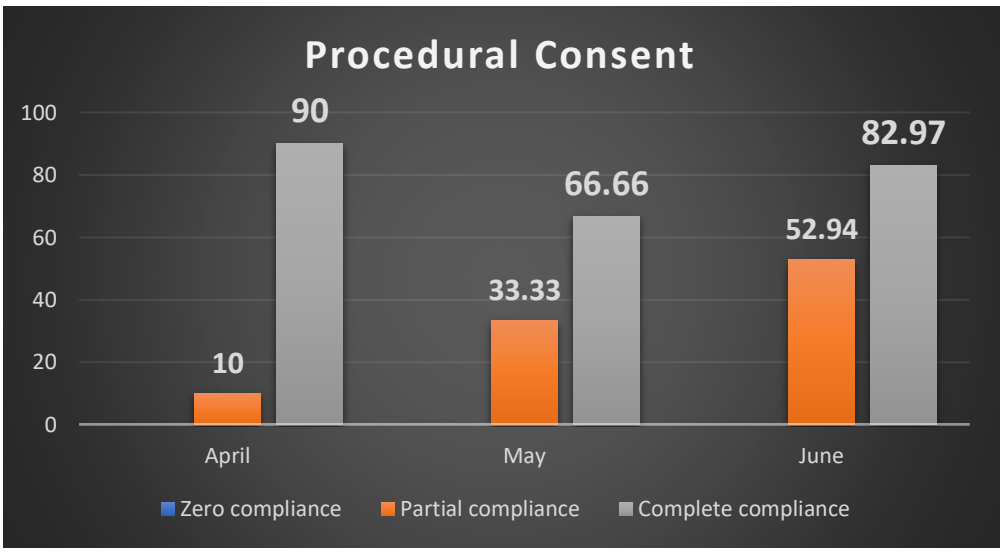
PARAMETERS NOT MET:

- Date and time missing in admission consent
- In case of surrogate signature, reason has not been mentioned.
- Patient gave a Hindi signature in an English language consent.

CORRECTIVE ACTION AND PREVENTIVE MEASURES:

- Escalate to PCS head
- Staff briefing for mentioning of date and time.

**********Document Audited – 2 **********



INTERPRETATION: There is an overall dip that can be observed in the month of May.

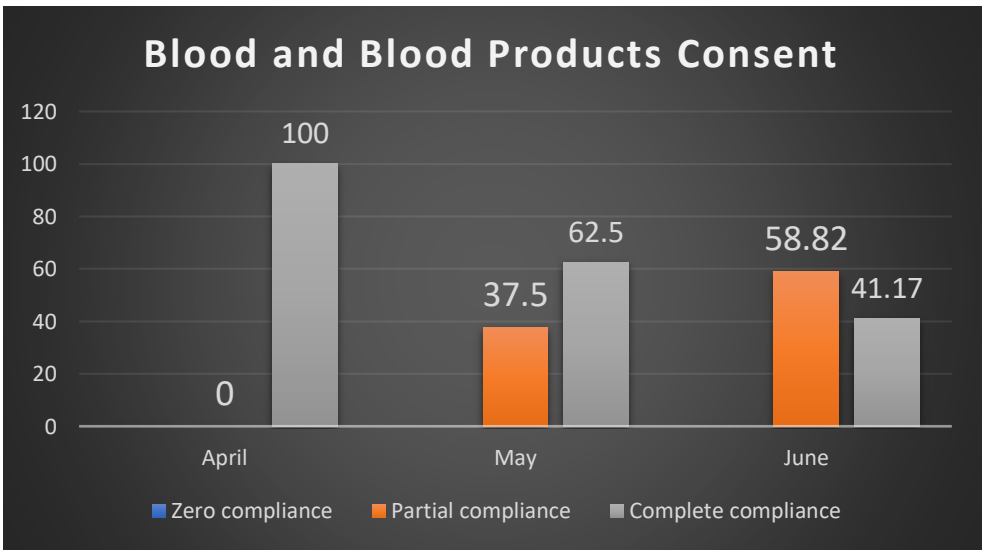
PARAMETERS NOT MET:

- Time is missing in many consent forms.
- Witness Signature was found missing.

MOST FREQUENTLY IN: Consent for LSCS, Hysterectomy, PTCA, MRI, CAG

CORRECTIVE ACTION AND PREVENTIVE MEASURES: Escalated to concerned departmental personnel.

**********Document Audited – 3**********

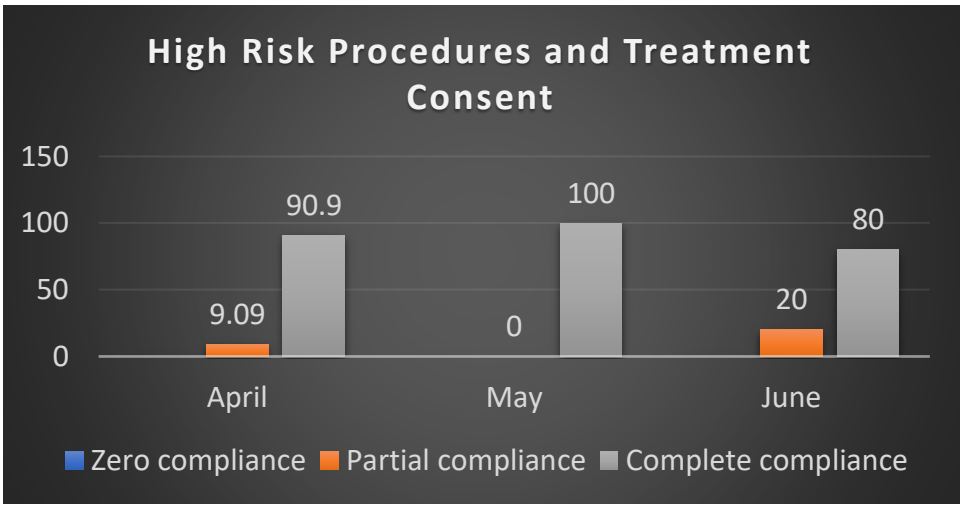


INTERPRETATION: Very few consents were there. And although the compliance has reduced in June but the total number of consents that were audited are less in number.

PARAMETERS NOT MET:

- Date and time were missing.
- Witness Signature was missing.

**********Document Audited – 4 **********



INTERPRETATION: There has been a rise in the partially compliant high-risk procedures and treatment consent. Also, a fluctuating dip in the figure of completely compliant forms can be seen.

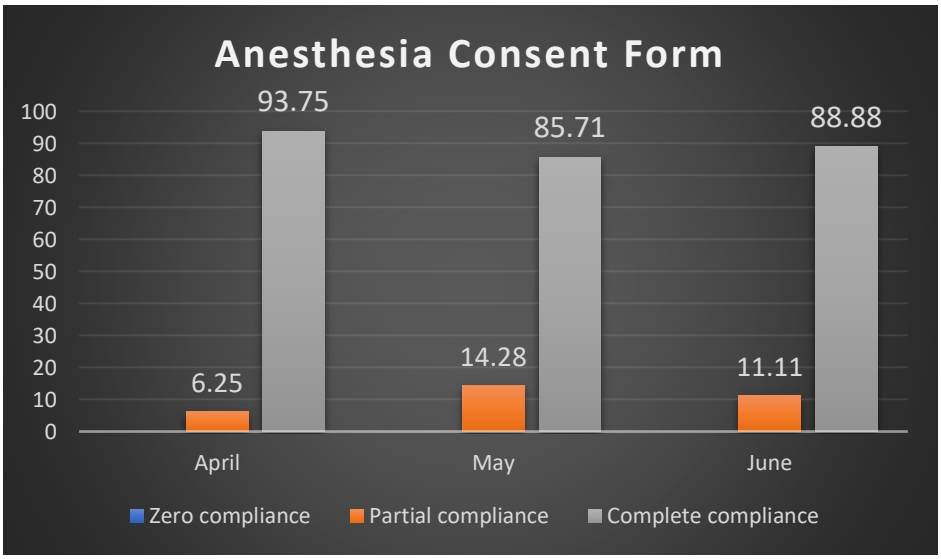
PARAMETERS NOT MET:

- Date and time is missing.
- Witness Signature is missing.

MOST FREQUENTLY IN: Orthopaedics, Neurology, Urology Cases

CORRECTIVE ACTION AND PREVENTIVE MEASURES: Sensitization of departmental medical professionals about the significance of filling of forms.

**********Document Audited – 5 **********



INTERPRETATION: There was an increase in the partially compliant consent forms in the month of May and a decrease in the completely compliant forms. However, overall, not much significant rise or fall can be observed.

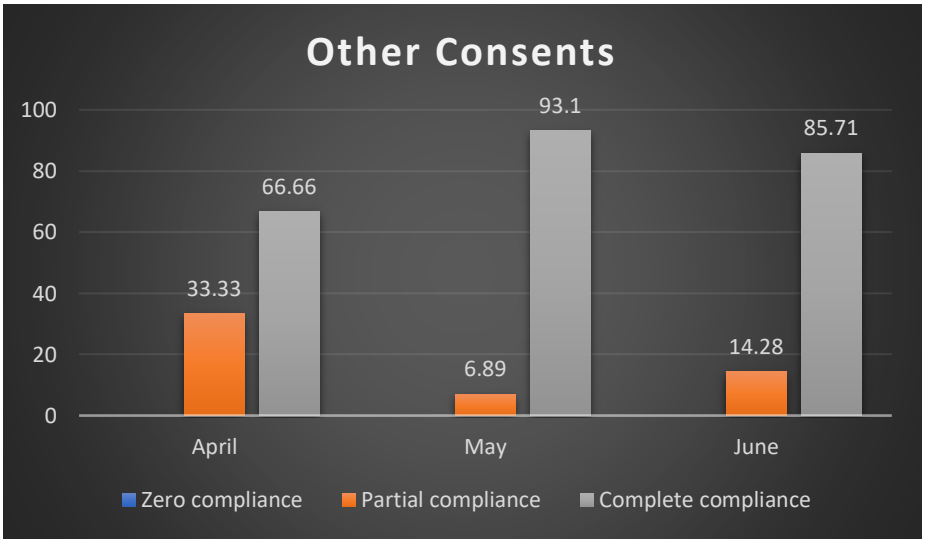
PARAMETERS NOT MET:

- Date and time missing
- Witness Signature missing.

CORRECTIVE ACTION AND PREVENTIVE MEASURES:

- Escalation to OT manager is needed.

**********Document Audited – 6 **********



INTERPRETATION:

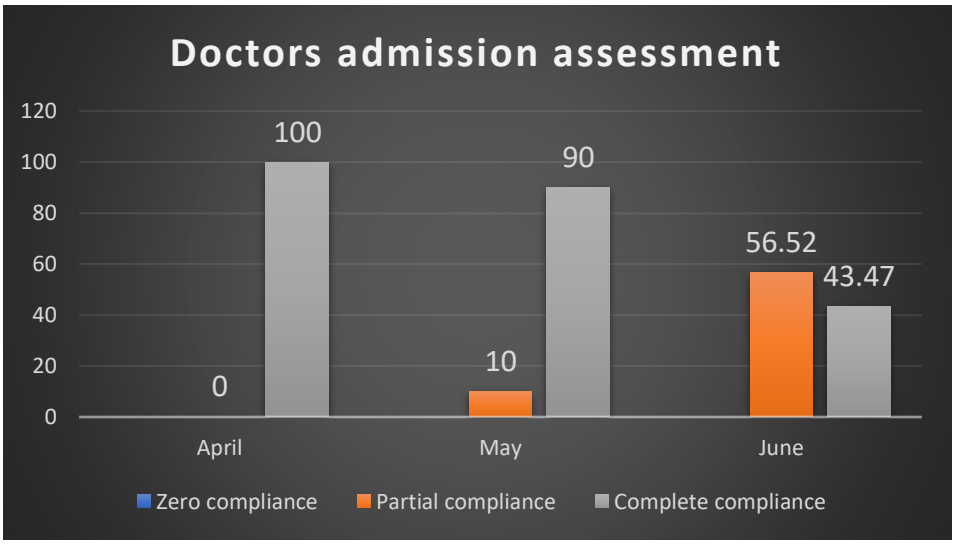
The overall compliance has become better, however in June the partial compliance has increased a little as compared to the previous month of May.

PARAMETERS NOT MET:

- Date and time missing
- Witness Signature missing.

MOST FREQUENTLY FOUND IN: Consent for CAG, PTCA, Investigational therapies for COVID-19 patients, NICU Admission, Radiological Investigation, Cystoscopy.

**********Document Audited – 7 **********



INTERPRETATION: In June, the doctor admission assessment has severely been compromised and lacks compliance as compared to previous months. The explanation for this was that quite a few residents left the hospital, leading to shortage of staff on floor and that is why the documentation could not be completed.

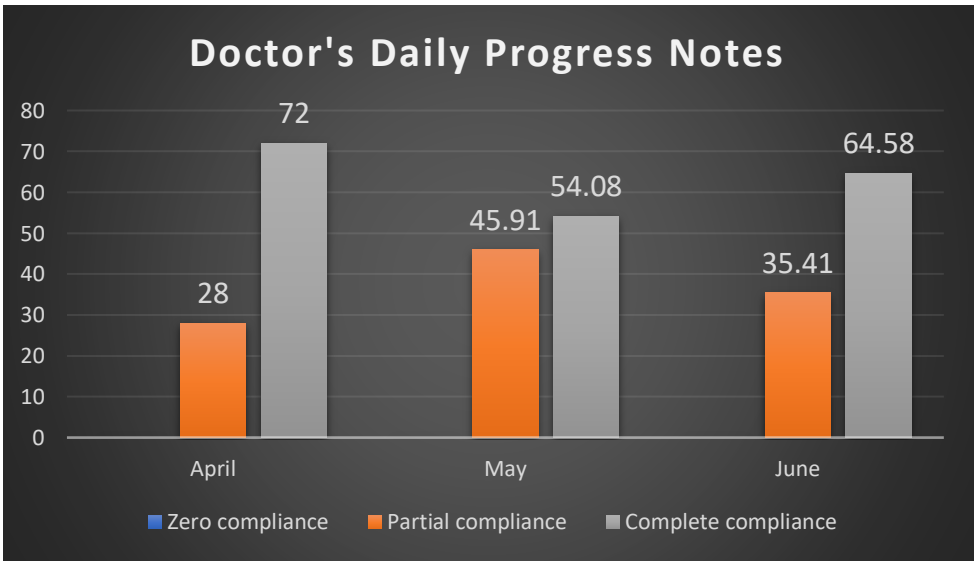
PARAMETERS NOT MET:

- Signature of Doctor missing.
- Countersign of consultant missing.
- Date, time missing.
- Blank sheets for patients more than 24 hrs. of admission.

CORRECTIVE ACTION AND PREVENTIVE MEASURES:

- Escalated AMS and DMS
- Daily completion of records and regular discussion in morning meetings.

**********Document Audited – 8 **********



INTERPRETATION: There is an increase in the compliance in June compared to May.

PARAMETERS NOT MET:

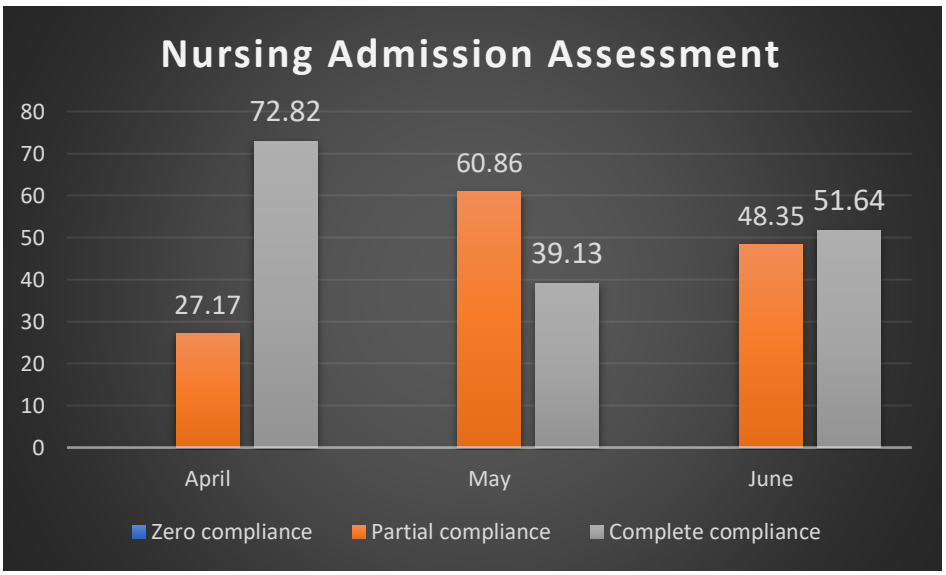
- Time is missing, only shifts were mentioned.
- Author name is not mentioned.

CORRECTIVE ACTION AND PREVENTIVE MEASURES: Escalated AMS and DMS

SPECIALITIES OBSERVED THAT WERE FREQUENTLY FAULTY:

- Covid team
- Pulmonology
- Internal Medicine
- Neurology
- Nephrology
- Medical Oncology
- CTVS

**********Document Audited – 9 **********



INTERPRETATION: It can be observed that the documentation of nursing admission assessment shows one of the most partially compliant documentation. Also, completely compliant forms are also very low in percentage.

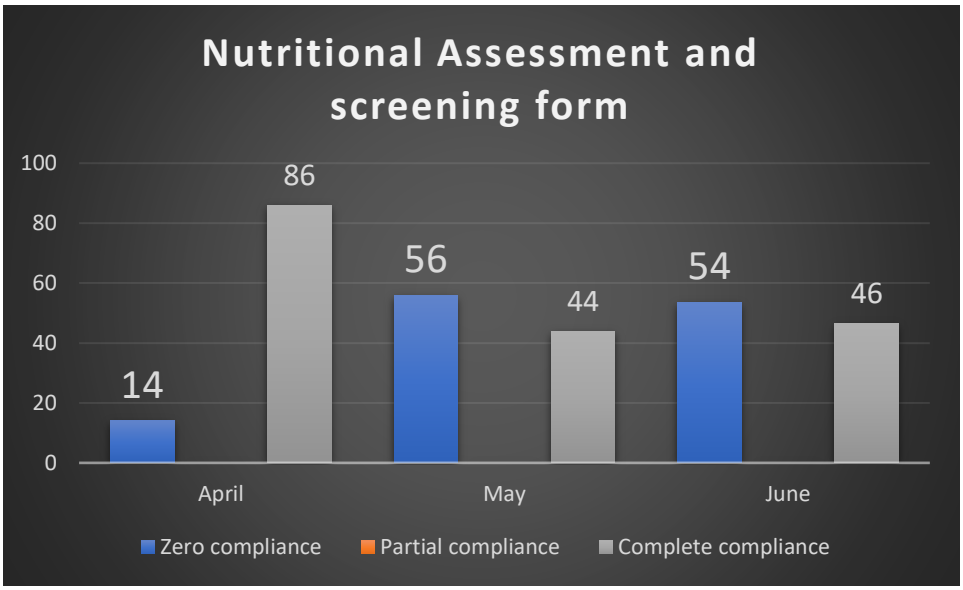
PARAMETERS NOT MET:

- Attendant signature on Fall prevention acknowledgment is missing (Score High Risk)
- Date, time and Nursing Team Leader's signature is missing.

CORRECTIVE ACTION AND PREVENTIVE MEASURES:

While auditing sensitization of nurses and sharing the same with Team Leaders of respective floors' nursing stations is essential.

**********Document Audited – 10 **********



INTERPRETATION:

There has been a consistent low in the number of compliant forms of nutritional assessment and screening. There is a lot of non-compliance because of missing sheets of nutritional evaluations from the medical records.

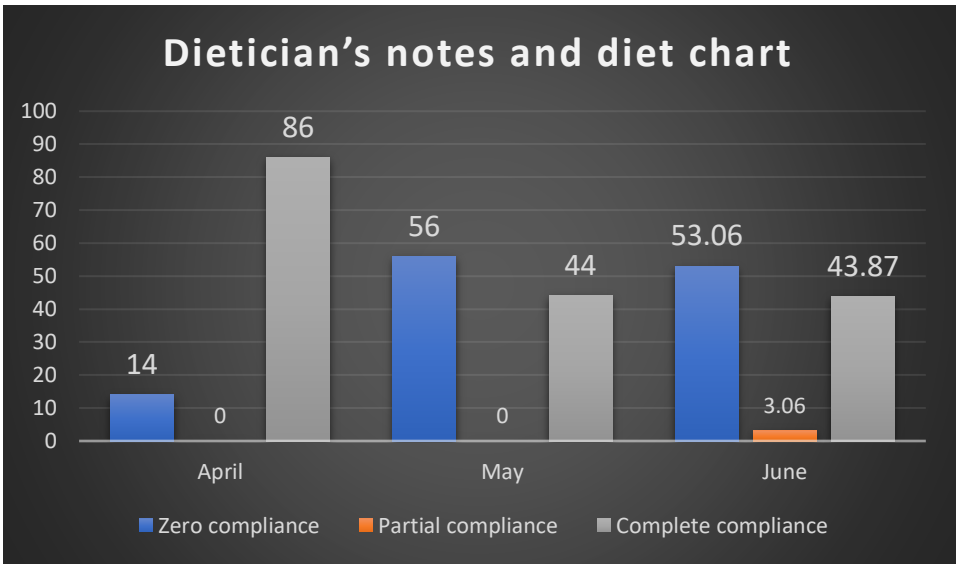
PARAMETERS NOT MET:

- Blank for admissions more than 24hrs
- Signatures of the dietician.

CORRECTIVE ACTION AND PREVENTIVE MEASURES:

- Escalation of same to head dietician
- Dieticians on the floor should be sensitized on same while auditing on floor.

**********Document Audited – 10 **********



INTERPRETATION: There has been a consistent low in the number of compliant forms of dietician's notes and diet charts. There is a lot of non-compliance because of missing sheets from the medical records of the IPD patients. Also, there were a couple of incidents of missing entries for some days.

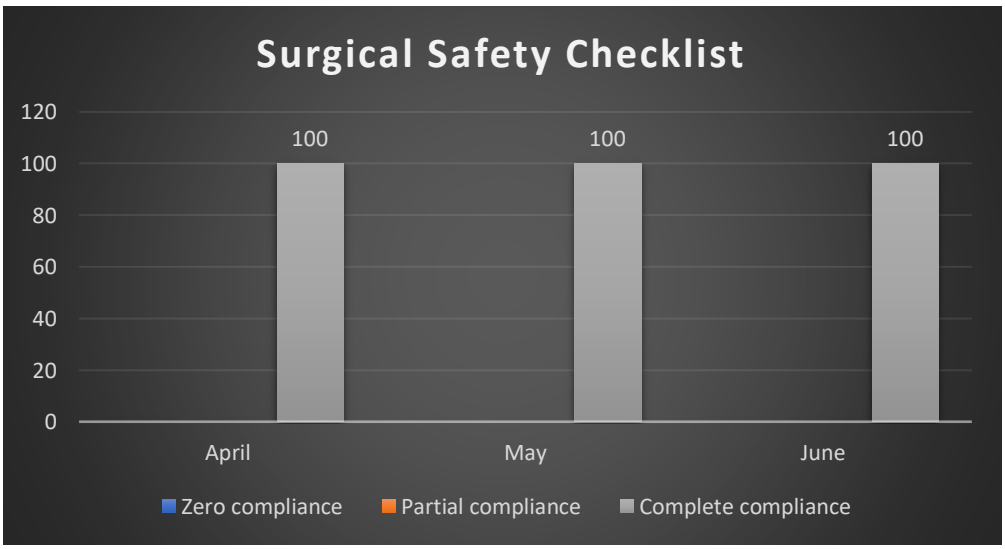
PARAMETERS NOT MET:

- Not filled for all dates.
- Notes for some days not present
- Assessment not present.

CORRECTIVE ACTION AND PREVENTIVE MEASURES:

- Escalation of same to head dietician
- Dieticians on floor sensitized on same while auditing on floor

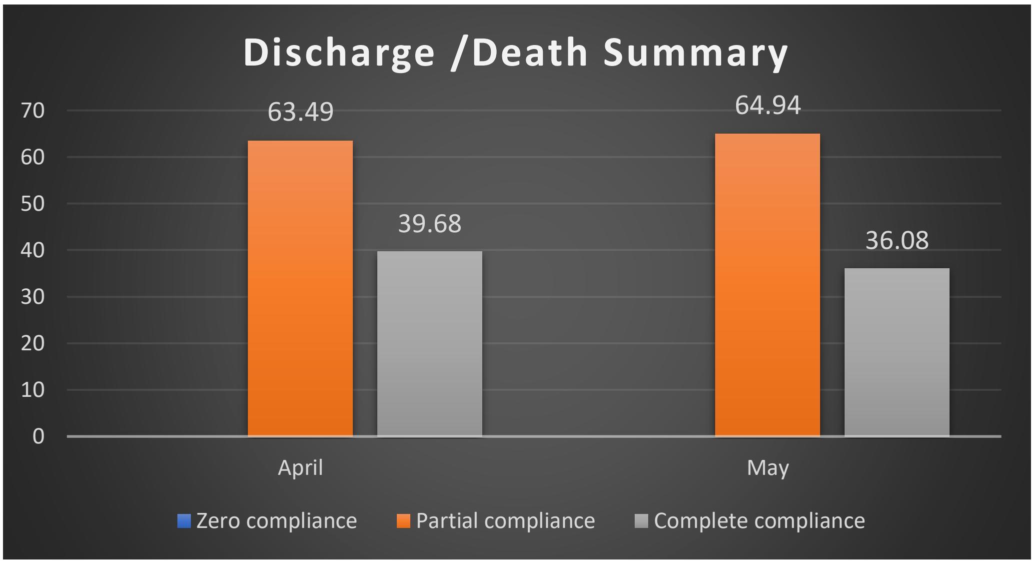
**********Document Audited – 11 **********



INTERPRETATION:

Complete compliance for consecutive months was observed.

********************************Document Audited – 12 **********************************



INTERPRETATION: Since, in the month of June, the files were in their respective wards, there were no discharge files. Only, April and May files were audited and the graph shows that there has been a consistent rise in the numbers of partial compliant documents.

PARAMETERS NOT MET:

- Instead of Doctor's signature, medical officer's signature is present.
- Consulting Doctor's signature is missing.

CORRECTIVE ACTION AND PREVENTIVE MEASURES:

Improvement in documentation in current month.

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GENERAL OBSERVATIONS

OBSERVATIONS AND RECOMMENDATIONS FOR THE MEDICAL RECORD DEPARTMENT.

1) The rooms that are allotted for MRD are insufficient. There is an immediate need to increase the number of rooms for better storage since there are many medical records.

2) Alternatively, the retention period of files can be reduced, so the space can be kept more organised.

3) The documents in one file sometimes increase due to the number of days patients stay in the hospital. The files are incredibly bulky and heavy. It also means a lot of stationery is used. So, the thickness of files also increases.

4) There is a requirement for the Electronic Medical Record system to be used more efficiently.

5) Requires more staff and GDA in the MRD as the process flow is slower than expected.

6) There is a need for security at the door of the department. Since MRD has an issue of security and confidential documents, an electronic door operator could be helpful.

7) Instead of putting all the reports in the file, an access to the hospital information system where in the MRD person can print the reports directly can be done. This is will reduce the number of pages in the file.

8) Pages like Doctor's progress notes are overused in a file.

9) Air conditioner and suction vents are not in proper condition in the MRD.

10) The doctors and the nurses should be given a proper orientation about the importance of complete documentation, to avoid sub-standard Quality.

CONCLUSION

This study was conducted to understand whether the medical record is documented in a proper manner or not. In FHSB, in most documents, there is a high percentage of compliance, but areas of concern are the name and signature of the Doctor along with the date and time in all the documentation. MRD maintains records to ensure Quality, continuity, assessment and evidence of care. Complete treatment sheets, timely signature of doctors and consultants, proper consent forms documentation could improve treatment analysis and retrieval of documents when needed.

The department was overall good but needed improvement in terms of storage space and stacking of records. Observing and assessing the contents of the files, authorization by the Doctor and consultants, signature, mention of date and time, and overall complete filling of the document is lacking here and there. Hence, there is need of improvement in these areas. Electronic medical records would present with a lot of advantages such as saving time, greater efficiency, reduced work, scanning costs and man-power. This would result in better compliance as well. Even, medical history of a patient can be made easily available in the hospital premises and beyond without requesting different departments for access to the medical files.

RECOMMENDATIONS

1. Based on the study findings and the observations made in the hospital, the following suggestions can be taken up.
2. Since there are many consent forms that need signatures, for minor procedures, a single consent form can be made - wherein the doctors can be given a provision to write the procedures required and mark the related risks.
3. Educate the patient about the consent forms and check for the Doctor's signature.
4. Orientation of all medical professionals (doctors, nurses, medical officers etc) should be ensured. Every time a new person joins, they must be oriented appropriately about how and what are the things they need to fill up, and its importance.
5. Regular training sessions should take place for the staff
6. It is essential to introduce Electronic Medical Record in the hospital. If not a complete EMR, then even a Partial EMR can be introduced.
7. Since one information is to be mentioned in multiple places, doctors/physicians/RMOs do not write the same in every place. These multiple entries of same data should be reduced.
8. If some portion is not applicable for a particular patient, then that part should be stroked off or marked as Not Applicable. Leaving the space blank- implies that the domain has been overlocked carelessly.
9. Root cause analysis should be done to trace the deficiency for incompletely filled records.
10. Rather than quarterly, monthly presentations can be done to bring about improvement in medical records.
11. Regular assessments can be made through an audit for randomly chosen files to ensure high standards.
12. The consent should be available in all the other languages spoken/written in India.
13. Hospital-wide standardization of the Discharge summary can be beneficial.
14. Colour coding of the files should be done for easy handling of the files at MRD.
15. Rewarding the best performing Department Unit could prove effective in bringing the required changes.

KEY LEARNINGS

In my span at the In-patient Pharmacy, I learnt how various pharmaceuticals & medical supplies were stacked and the criteria of differentiating between look-alike, sound-alike drugs, high-risk medication, costing criteria, and vaccines' storage. Also, I learnt about placing of pharmaceutical indents, their packing, billing, dispensing and discharge.

I learned about HIS (Hospital Information System) and Oracle, which Fortis Healthcare uses to manage its records.

Meanwhile, I observed the operations of the OPD and IPD billing departments along with the involvement of TPA desk, Financial Counselling section and Radiology department.

In the department of Quality management, I understood about audits that were carried to maintain and improve the Quality and delivery of the hospital services. While being engaged in the Medical Records Department, I carried out an audit of the patients' medical records, assessing their adherence to the SOP determined by NABH. This audit led to the formulation of an analysis. I prepared the presentation for the quality department for the quarterly meeting (April to June 2021) of the MRD committee of the organisation.

HIGHLIGHT - For the entire duration of my internship, I attended the morning meeting comprising all the Departmental Heads and the Zonal Director. They presented the previous days' reports, discussed issues, suggested ideas, and implemented those in their scheme of operational duties. I gained a fair idea of the overall process flow and operations in managing a healthcare setup.

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