Title

A Study on Medical Record Documentation Compliance with NABH 6th Edition at Rungta Hospital, Jaipur

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Introduction

Medical record documentation serves as a cornerstone of quality patient care, legal protection, operational efficiency, and hospital accreditation. The National Accreditation Board for Hospitals & Healthcare Providers (NABH) in its 6th Edition outlines stringent guidelines to standardize and enhance medical record keeping. These guidelines ensure continuity of care, patient safety, data integrity, and confidentiality.

Rungta Hospital, Jaipur—a growing multispecialty institution—aims to align with NABH standards to maintain high-quality services. However, gaps often exist between actual practices and compliance requirements. This study seeks to assess the current status of medical record documentation at Rungta Hospital in alignment with the NABH 6th Edition, identify gaps, and suggest areas for improvement.

Research Question

To what extent is Rungta Hospital, Jaipur, compliant with the NABH 6th Edition standards for medical record documentation?

Objectives

1. To assess the current level of compliance of medical records with NABH 6th Edition standards at Rungta Hospital.
2. To identify deficiencies and gaps in the documentation practices.
3. To evaluate staff awareness and training related to NABH documentation standards.
4. To provide recommendations to improve compliance and documentation quality.

Hypothesis

- Being a descriptive study there will be no Hypothesis in the test.

Material and Methods

- **Study Design:** Cross-sectional observational study

- **Study Location:** Rungta Hospital, Jaipur
- **Study Duration:** [Specify Duration – March 2025 to May 2025]
- **Study Population:** Inpatient medical records and hospital staff involved in medical documentation
- **Sample Size:**
  - 100 randomly selected surgical patient records
  - 5 staff members (doctors, nurses, and medical record department personnel)
- **Sampling Method:** Simple random sampling for records and purposive sampling for staff
- **Data Collection Tools:**
  - NABH 6th Edition Medical Record Audit Checklist
  - Structured questionnaire/interview schedule for staff
- **Inclusion Criteria:**
  - Inpatient records from the last 3 months
  - Staff with a minimum of 6 months experience in the hospital
- **Exclusion Criteria:**
  - Outpatient records
  - Incomplete or inaccessible records

Data Analysis Plan

- **Quantitative Data (Compliance Audit):**
  - Data entry using MS Excel/SPSS
  - Compliance scores will be calculated as a percentage of adherence to checklist items
  - Descriptive statistics: Mean, Standard Deviation, Frequencies

- **Qualitative Data (Staff Feedback):**

  Direct Personal Interview

Ethical Considerations

- Informed consent will be obtained from staff participants.
- Approval will be sought from the hospital's Ethics Committee.
- Patient confidentiality will be strictly maintained by anonymizing records.
- Data will be used solely for academic and quality improvement purposes.

Implications of the Research

- Identifies documentation gaps affecting quality and accreditation readiness.
- Helps hospital administration in prioritizing training and corrective actions.
- Supports development of standard operating procedures (SOPs) aligned with NABH norms.
- Provides a reference for other hospitals undergoing NABH compliance evaluation.

References

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