Abstract

Study objective: - The objective of the study is to evaluate compliance and non-compliance in the hospital and to assess whether the documentation is following the NABH standards.

Methodology: - The study is done in Surya Hospital, Jaipur, duration of the study is of 2 months. The data is collected from auditing the 226 active files, out of which this research sample size is 113 randomly of the patients from the nursing stations and the respective wards. The criteria are to match the quality indicators related to the patient record approved by the head of the quality department.

Key results: - 113 files audited, out of which admission requisition form compliance (78%), initial assessment of doctors' form non-compliance is 77.88%, the emergency form by doctors' non-compliance rate is of mainly concern which is 64.29%, doctor progress notes are 100% filled. nursing assessment compliance is 98.23% initial assessment by nurses is 92.86% and nurses' notes, clinical charts and vital sheets is 100%. In consents the general consents compliance is 89.38% and other required consent is 99.12%, anaesthesia consent is 100%. The compliance of the medication sheet is 100% except of the stop medication which is 98.82%. Surgery assessments, the procedures /surgical safety checklist / labour safety checklist is 98.82%, anaesthesia record (pre-op, intraoperative and post-op) compliance is 97.65% and compliance of operative notes (pre-op checklist and post op notes) is 97.65%. Nutritional assessment by dietician compliance is 95.4%.

Conclusions: - The purpose of this study is to present the compliance and non-compliances observed in the clinical audit of the active file. The clinical audit is the valuable tool to improve the qualitycare. Overall aim of the study is first,to evaluate compliance and non-compliance in the active file. Second, to assess if the documentation in hospital is following the NABH standards.

The result of this study shows some of the quality indicators are not matched with the standards. The audit demonstrated that consultant participation in documentation is the main requirement to match the standards. Although nursing staff's compliance rate is satisfactory, but it should be improved though. In this study there mentioned some of the recommendations which can help the organisation to improve the documentation. Key words: - Compliance, non-compliance, documentation, NABH

Acknowledgement

Dissertation is a journey which helps to learn and give practical knowledge and exposure of the industry. I want to express my gratitude here towards the people who help me during this period and without them this training or the project couldn't be possible.

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Abbreviations: -

NABH: - Nationall Accreditation Board for Hospitals and Healthcare Providers

CT: - Computed Tomography

MRI: - Magnetic Resonance imagining

ECG: - Electro-cardiogram

PICU: - Pediatric intensive care unit

NICU: - Neonatal intensive care unit

ER: - Emergency Room

RMO: - Resident Medical Officer

HOD: - Head of Department

AUDIT OF THE ACTIVE FILES IN SURYA HOSPITAL, JAIPUR

Chapter 1: -Introduction

Clinical audit is the process in which there is examining of the clinical records to figure out that the doctors and nursing staff offered in hospital comply with rules and regulations of the hospital.

Clinical audit is the valuable tool used to assess and evaluate the documentation procedure.

Active file means ongoing collection of record and forms of patient, which is required for keeping the records, it is assigned individually to the patients.

Active file audit means official inspection of the records or the ongoing file of the patients which is done by the quality department executives.

Documentation is the most important procedure required in the hospital for the current situation and for future purposes.

Proper filling of the documents or the patient file according to the established NABH standards.

The patient documentation includes the consultant forms, nursing forms, medication sheets, consents given by the patient or its attendants itself so they can't claim further for any mis-happenings.

The patients in the hospital come for the diagnosis and treatment. The hospital and patient both are responsible for every procedure and treatment. For having the written document and proof for the further procedures, hospital and the organisation requires some document for some written proof and to organise all the documents, organisation maintain and organise a file for all the documents. The files are being assigned to the patients individually for the purpose and these files are kept either in the nursing stations or the respective wards.

The regular audits or inspections of the files are required regularly and done by the quality department executives. The forms are filled in the patient file properly and thoroughly, these criteria are being checked in the audit. If the consultants, nursing staffs, surgeons, billing individuals and the responsible persons for the individual forms are doing their documentation properly.

The clinical audit is done in the context of quality improvement. It can be done by the external or the internal authorities for the organisation.

"Medical Audit" is a organised and planned programme in which there is objectively evaluation and monitoring the performance of the whole staff clinically, which figure out the opportunities where improvement is needed, and provides implementation by which solution is taken to sustain and make the required improvements.

1.1 Objective

To check and evaluate the compliances and the non-compliances in the active files

To assess if the documentation in hospital is following the NABH standards.

1.2 Research question

What are the compliance and non-compliances rate of the documentation in Surya Hospital, Jaipur?

How can hospital increase the compliance rate?

How can organisation improve the documentation of active files?

Chapter 2: -Review of literature

S. No.	Author	Title	Year	Study Description	Purpose	Conclusion
1	Diana McKey, Jo Gorrell , Alison Cornish , Chris Tennant	an audit of medical practice in first episode psychosis	2006	An active file audit was organised for the young people suffering with first stage psychosis (117 =files) over 1 year of treatment. Results: - Results of diagnosis – Schizophrenia (16%) drug induced psychosis (12%) , first episode psychosis (43%) affective psychosis (13%) and brief reactive psychosis (2%) . Only 4 of the 52 (8%) subjects undergoing neuroimaging had any abnormality, with only two of these requiring referrals. 3 of 33 (9%) electroencephalograms were abnormal, but without epileptiform activity. There was less documentation of the assessment of involuntary movements (4% of the sample) or weight (155 of sample).	Inspection of medical examination , diagnosis, and side effects monitoring and to consider the role of regular investigations in this group as recommended by national guidelines.	The low rates of clinically important abnormal findings in CT/ Magnetic resonance imaging and ECG re-open debate about the need for routine neuroimaging and electrophysiology in this population.
2	Tatiana Paim , Nancy Low – Choy ,	An audit of physiotherapists' documenta	2020	56 file audited, mean age = 79 years, no documentation on use of validated	To identify if physiotherapists is doing the	Gaps were found in physiotherapists documentation.

	Simone Dorsch	tion on physical activity assessment , promotion and prescriptio n to older adults attending out-patient rehabilitati on		tools to assess physical activity levels of older adults, prescription – 55/56 (98%) , goal setting regarding physical activity participation – 7 (12.5%) , advices of regular exercise document – 28/56 (50%) , formal referral was documented – 4/56(7%).	documentati on of the assessment, promotion, prescription of older adults physical coming for out -patient rehabilitatio n and assisting them in transition.	The collaboration between the health care system and community based physical activity program is imperative to facilitate the sustainability of an active lifestyle after discharge from rehabilitation program.
3	Roopa Lakhan pal, Jaclyn Yoong, Sachin Joshi	Geriatric assessment of older patients with cancer in Australia – a multicentr e audit	2015	Multicentre audit in (i)retrospective file review of initial consultations with an oncologist (ii)prospective audit of case presentations data was collected at 6 centres of oncology from October 2009 to March 2010. 251 files audited presence of comorbidities 92%, social situation living alone or with someone (80%) , social supports (63%) , presence of a geriatric syndrome (24%) , polypharmacy (29%) & creatinine clearance .	To determine the frequency of geriatric assessment in patients of age above 70 years in Australian medical oncology clinics	This is the first multicentre audit that reveals the low rates of GA in Australian medical oncology practice and describes the GA domains considered important by oncology clinicians.

Table – 4.1

Chapter 3: -Methodology

3.1 Study design: -

The study design of my dissertation is descriptive observational in which the information is collected regularly during my internship period from each floor by auditing the files in which I observed each form of the active patient's file. In my study I audited the file and observing the quality indicators whether it is filled and accurate.

3.2 Study setting: -

The study setting is Surya Hospitals located in Jaipur. It is 120 bedded super speciality hospital specialised in mother and childcare. The data of the thesis is being collected from the hospital.

3.3 Study population: -

The study population is 226 files. The 226 active files of the active patients are audited. The files audited from each private and general wards or from the nursing stations daily.

3.4 Study duration: -

The duration of the study is 25th April 2022 to 25th June 2022. The duration of my study is of 2 months including the auditing of the files and analysis of the data and presenting the study to the organisation mentor and suggest some measures to improve the non-compliances found during the auditing in the organisation.

3.5 Sample size: -

The sample size of the study is 113 files out of the 226 files audited. The data was extracted from the achieved data of the 226 files. The alternate file was considered from the whole data, which is just half of the resultant data.

3.6 Sampling technique: -

The files audited on the regular basis and randomly selected through the Microsoft excel alternatively from the audit sheet.

3.7 Data collection procedure: -

The data is collected by the quality indicators audit sheet approved and formed by the HOD of the department and checked the indicators in the active file regularly from the nursing stations, PICU, NICU and the respective wards.

3.8 Operational definition: -

The variables used in the research are compliance and non-compliance; compliance means the act of obeying an order, rule or request and noncompliance means failure to comply with something.

Chapter 4: -Data collection and analysis

- Data is collected by the quality indicators audit sheet to check from the patient files or records given by the HOD of the quality department.
- Data is collected by the observations and audit of the file regularly from the nursing station or the respective wards.
- After the regular data collection from the wards the data is being collected in the Microsoft excel.
- Data collected further analysed by the data collected was in variables 0, 1 and 3.
- The variable 0 was given to the non- compliance.
- The variable 1 was given to the compliance.
- The variable 3 was given to the not available in the document.
- The data in the excel sheet then analysed by the countif function in the excel, in which we got the compliance and non-compliance and the not available counts data.
- Then the received counts were divided by the sum of the compliance and non-compliance count and then multiply by the 100 to get the results in the percentage criteria.
- The obtained compliance and non-compliance in percentage data was then categorised as consultant documents, nursing documents, consents, medication sheets, surgery document.
- The categorised data then converted into the suggested bar graphs for the comparisons.

Chapter 5: -Results and discussions

Quality indicators	Compliance	Noncompliance
Provisional Diagnosis and treatment Details	78.76%	21.24%
Care Plan Documented & signed with name by RMO and clinician	77.88%	22.12%
Nursing care plan documented and signed	98.23%	1.77%
Time taken for ER Assessment Doctor	35.71%	64.29%
Time taken for ER assessment Nurse	92.86%	7.14%
Doctor Progress sheets	100.00%	0.00%
Nurses' notes, clinical charts & vital Sheet	100.00%	0.00%
Nutritional Assessment by Dietician	95.24%	4.76%
General consent Form	89.38%	10.62%
AnesthesiaConsent form	100.00%	0.00%
Procedure/ Surgery/Labour Safety checklist	100.00%	0.00%
Other required Consent forms	99.12%	0.88%
Anaesthesia Record (Pre-op, intraoperative & post-op)	97.65%	2.35%
Operative Notes (Pre-op Checklist & post-op notes)	97.65%	2.35%
Medication Dose , Frequency mentioned	100.00%	0.00%
SNDT of RMO/ Consultant	100.00%	0.00%
No use of error prone abbreviations	100.00%	0.00%
Stop medication signed by doctor with name	98.82%	1.18%

Table: - 5.1 Data compilation

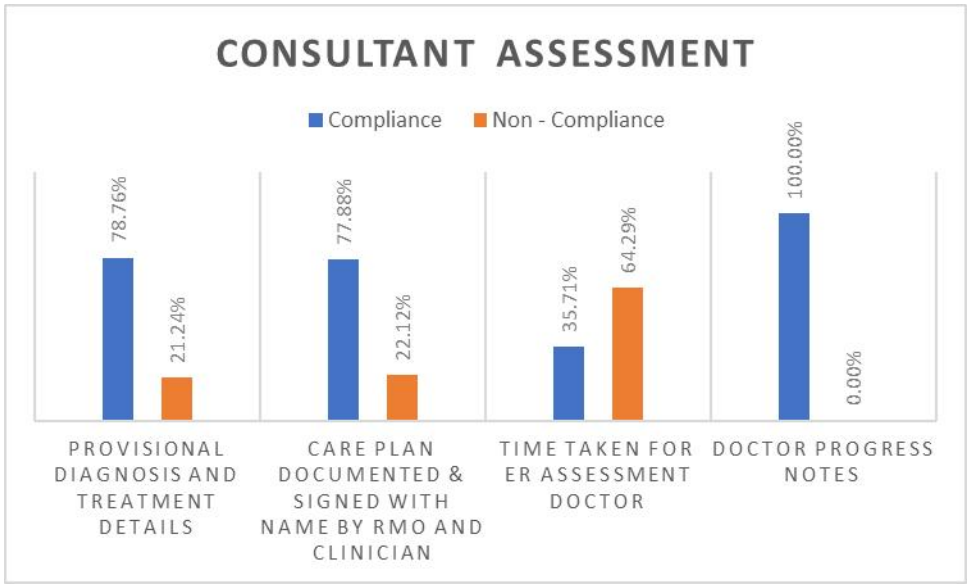

Figure: - 5.1 Consultant assessment

Consultant Assessment: -

- The above figure, compliance and non-compliance obtained from the audit.
- The audit of the provisional diagnosis and treatment details observed is the non-compliance rate is 21.24% and compliance is 78.76%, means out of 113 files 78.76% of the files were filled thoroughly by the consultants while the 21.24% were not filled in the admission requisition form.
- The care plan documented and signed with name by RMO, and clinician audit observed the non-compliance is 22.12% and the compliance is 77.88%, means the consultants didn't fill the initial assessment form of the patient properly.
- The time taken for ER assessment by the doctor in emergency form was not filled in 64.29% of the patient record which is of great concern in the documentation.
- The doctor progress notes were 100%, the legibility, use of capitals, signature with date, time, and name, all were maintained in 100 % of the patients' files.

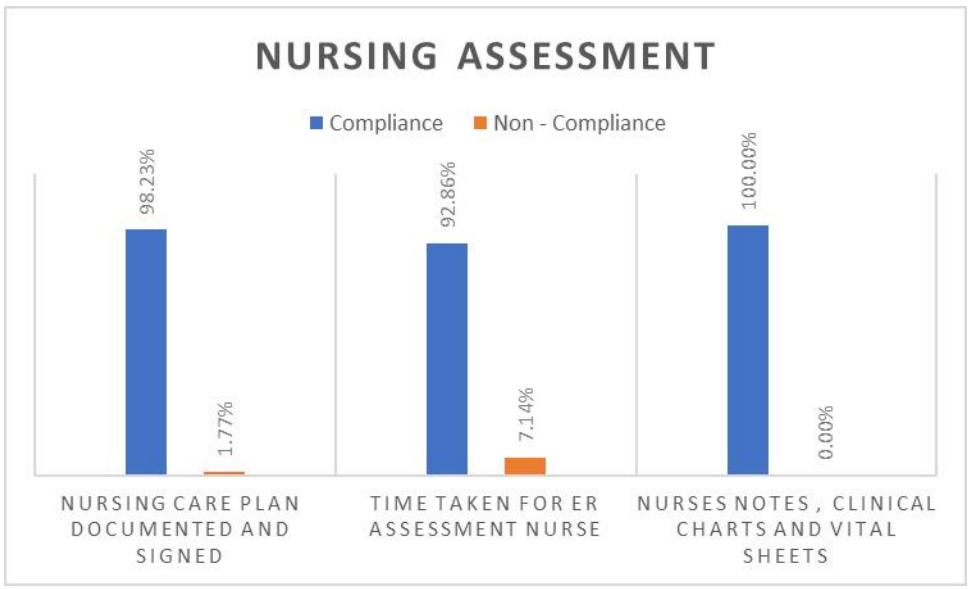

Figure: - 5.2

- The above figure is the assessments filled by the nursing staff.
- The nursing care plan documented and signed in the nursing assessment was 98.23%, which is satisfactory while 1.77% was not filled.
- The time taken for ER assessment nurse in the emergency form audit showing 92.86% of the compliance and 7.1% of the non-compliance.
- The nurse notes, clinical charts and vital sheets were filled 100%.

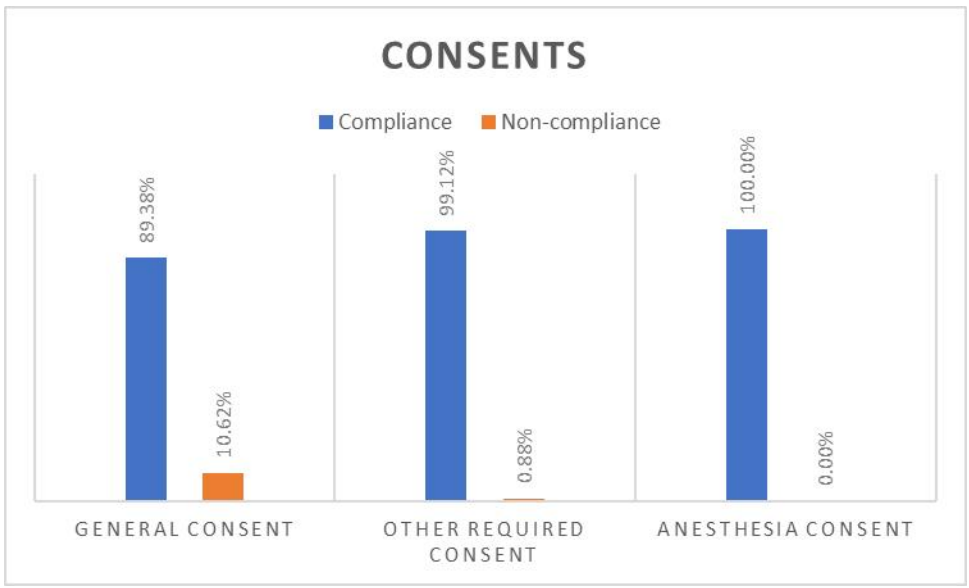

Figure: -5.3

- The above figure showing consent's compliance and non-compliance results.

- The consent form filling responsibility is of the billing department before admitting the patient.
- The 89.38% of the general consent in 113 files were filled and 10.62 % files were not filled thoroughly.
- The 99.12% of the other consents like covid consents, blood transfusion consents, any procedure consents were filled and 0.88 % of the files out of 113 were not filled completely.
- The anaesthesia consent was filled in 100 % of the patient's file in which the surgery required in the treatment.

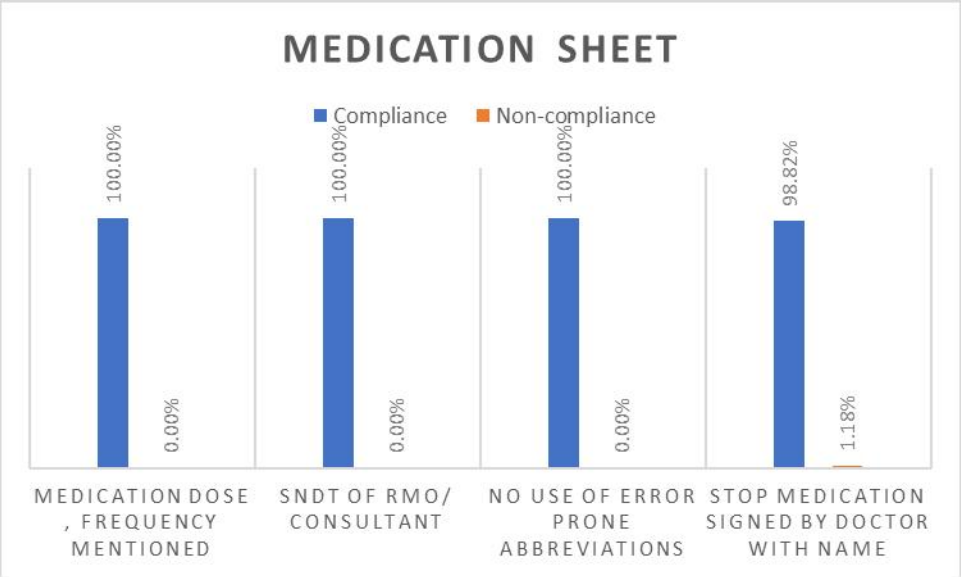

Figure: - 5.4

- The compliance in the medication sheet is 100% except in the stop medication signed by doctor with name.

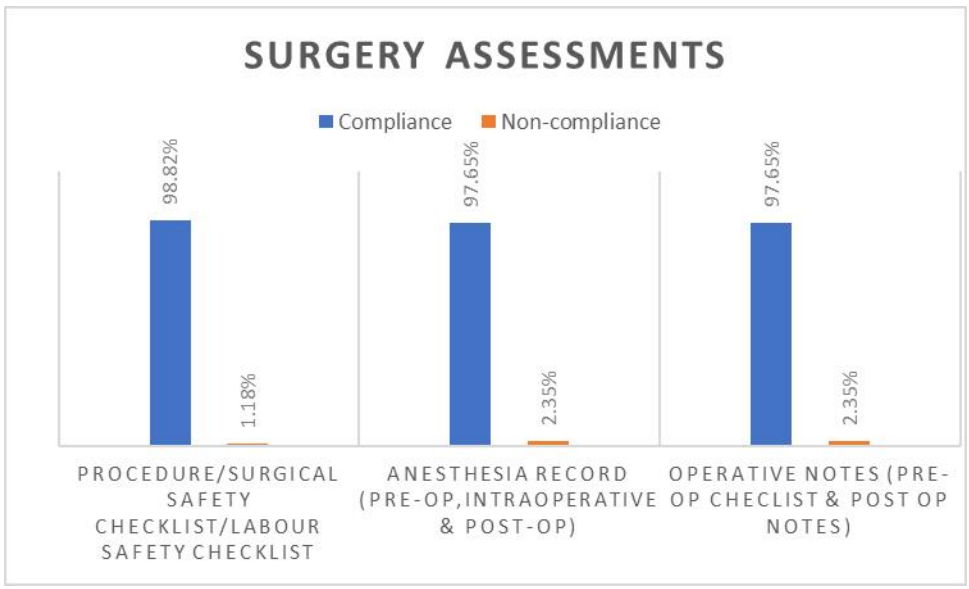

Figure: - 5.5

- The procedural / surgical safety checklist / labour safety checklist was filled in 98.82% of the files.
- The anaesthesia record was filled in 97.65 % of the files and was not filled in the 2.35% of the file.
- The operative notes (preoperative checklist and post operative notes) were filled in 97.65% of the file while 2.35 % of the form were not filled completely.

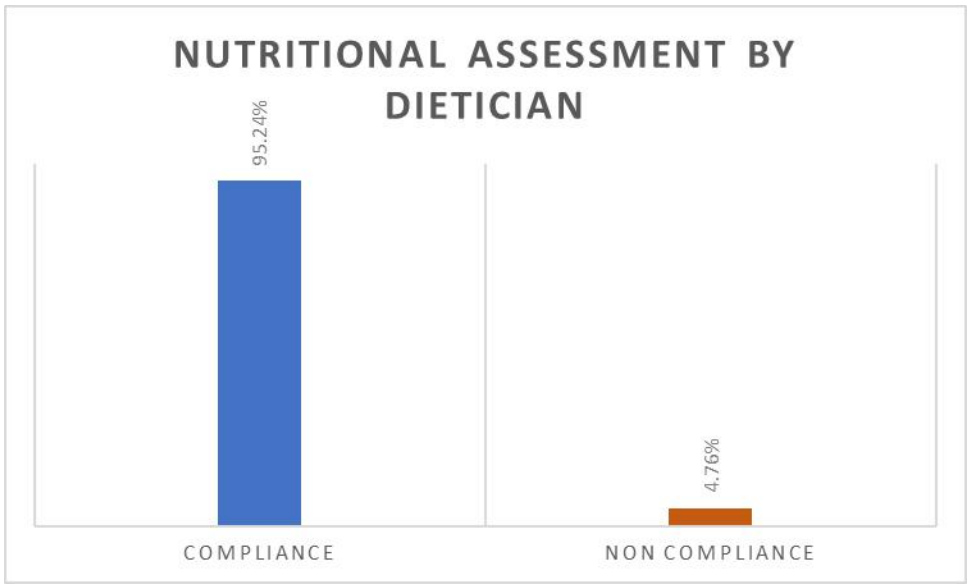

Figure: - 5.6

- Other forms like nutritional assessment by dietician were filled in 95.24% of the file and 4.76 % of the forms out of 113 files were filled.

- Overall result – 113 files audited, out of which admission requisition form compliance (78%), initial assessment of doctor's form non-compliance is 77.88%, the emergency form by doctors' non-compliance rate is of mainly concern which is 64.29%, doctor progress notes is 100% filled. nursing assessment compliance is 98.23% initial assessment by nurses is 92.86% and nurses' notes, clinical charts and vital sheets is 100%. In consents the general consents compliance is 89.38% and other required consent is 99.12%, anaesthesia consent is 100%. The compliance of the medication sheet is 100% except of the stop medication which is 98.82%. Surgery assessments, the procedures /surgical safety checklist / labour safety checklist is 98.82%, anaesthesia record (pre-op, intraoperative and post-op) compliance is 97.65% and compliance of operative notes (pre-op checklist and post op notes) is 97.65%. Nutritional assessment by dietician compliance is 95.4%.

Chapter 6: -Conclusion

Clinical auditing has an important part in providing efficient and accurate documentation for healthcare organization. The clinical auditing helps to find out the areas in which healthcare providers require improvement.

Quality healthcare provided by the organization depends on complete and accurate medical documentation in the clinical records always. The most suitable way to improve the medical documentation and level of growth of health care organization can only get by the medical records audits only.

The purpose of this study is to present the compliance and non-compliances observed in the clinical audit of the active file. The clinical audit is the valuable tool to improve quality care. Overall aim of the study is first, to evaluate the compliance and non-compliance in the active file. Second, to assess if the documentation in hospital is following the NABH standards.

The result of this study shows some of the **quality indicators are not matched with the standards**. The audit demonstrated **that consultant participation in documentation is the main requirement to match the standards.** Although nursing staff's compliance rate is satisfactory, but it should be improved though. In this study here mentioned some of the recommendations which can help the organisation to improve the documentation.

6.1 Recommendations

- The counselling should be done with the doctors about filling of the concerned forms, assessment, notes regularly.
- The junior resident should be assigned for the documentation.
- The advice should be given to the nursing in charges of the floor to give the constant reminders to the doctors to fill the assessment forms related to the consultants.
- The hands-on training about the importance of the documentation should be given to the newly joined junior residents and doctors.
- There should be proper record of the particular form which usually not getting filled properly and note the most non-compliance indicator.
- The training should be given to the new joining nursing staff about the documentation.
- The re-audits should be done regularly for the improvement of the documentation.
- The reward should be given to the staff who got 100% compliance documentation process.
- The constant reminder and training should be given to the billing team for documentation of the consents.