Audit of the active files in Surya Hospital

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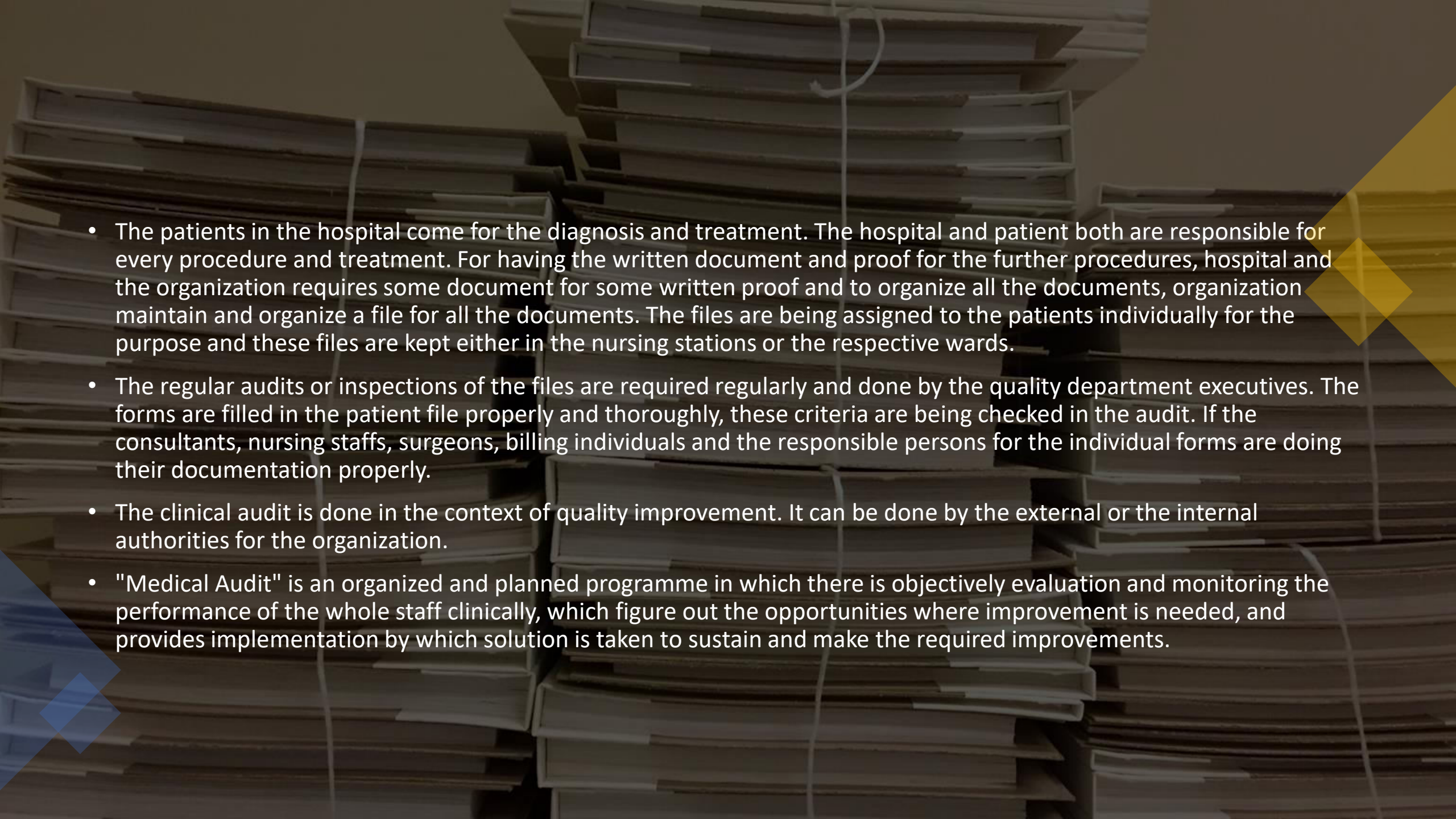
Introduction

- 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 organization requires some document for some written proof and to organize all the documents, organization maintain and organize 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 organization.
- "Medical Audit" is an organized 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.

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 organization improve the documentation of active files?

Aim of the study

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.

Methodology

- Study design: -
- Descriptive observational study
- Study setting: -
- Surya Hospitals, Jaipur
- Study population: -
- 226 active files
- Study duration: -
- 25th April 2022 – 25th June 2022

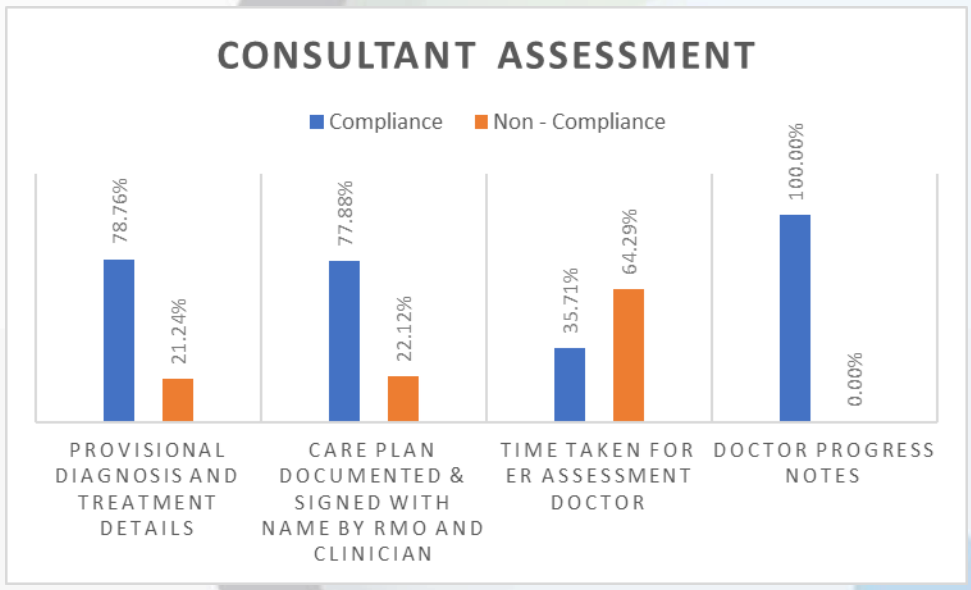
- Sample size: -
- Out of the 226 active files audited, sample was taken of 113 files which is just half of the file audited.
- Sampling technique: -
- The files audited on the regular basis and randomly selected through the Microsoft excel alternatively from the audit sheet.
- Data collection procedure: -
- The data is collected by the questionnaire 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.
- 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.

Literature review

S. No.	Author	Title	Year	Study Description
1	Diana McKey, Jo Gorrell , Alison Cornish , Chris Tennant , Alan Rosen	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).

2	Tatiana Paim , Nancy Low – Choy , Simone Dorsch , Suzzane Kuys	An audit of physiotherapists' documentation on physical activity assessment, promotion and prescription to older adults attending out-patient rehabilitation	2020	56 file audited, mean age = 79 years, no documentation on use of validated 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%).	To identify if physiotherapists is doing the documentation of the assessment, promotion, prescription of older adults physical coming for out -patient rehabilitation and assisting them in transition.	Gaps were found in physiotherapists documentation. 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.

Data analysis and interpretation



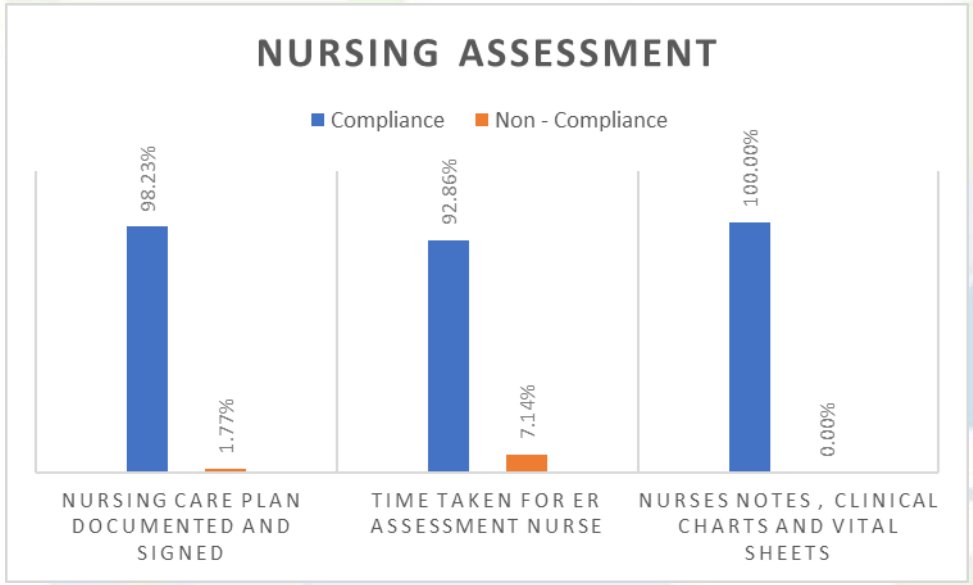
The above figure, compliance and non-compliance obtained from the audit.

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.

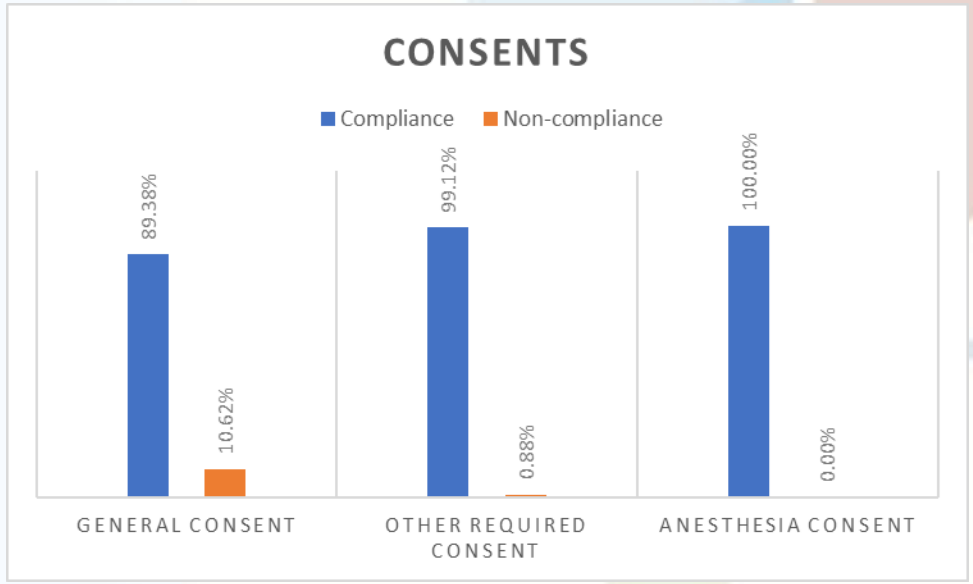


The above figure is the assessments filled by the nursing staff.

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%.



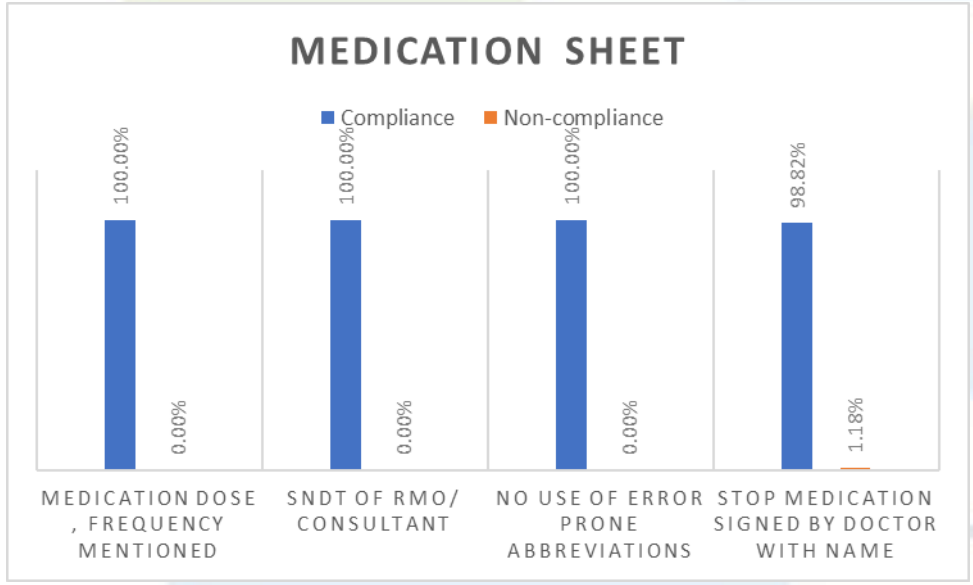
The above figure showing consent's compliance and non-compliance results.

The consent form filling responsibility is of the billing department before admitting the patient.

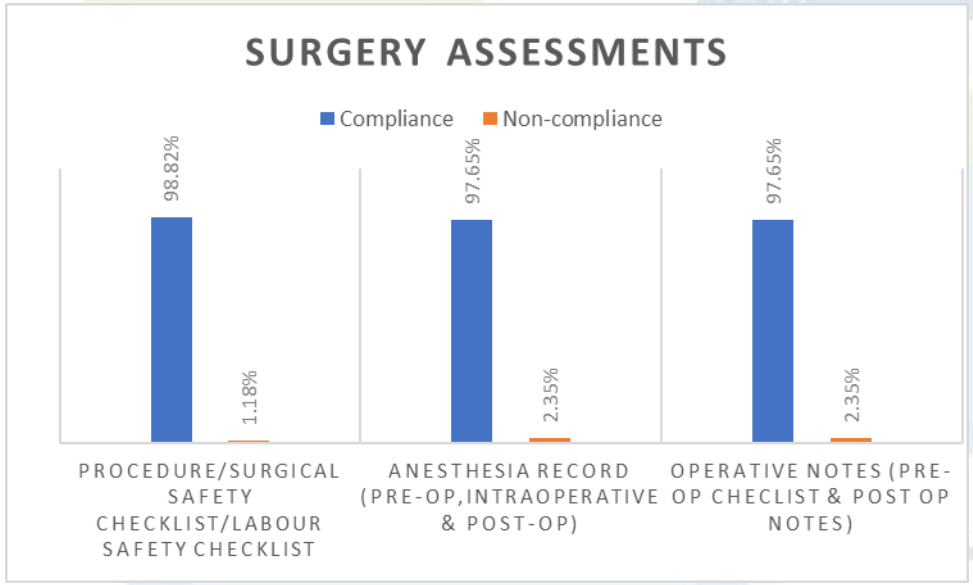
The 89.38% of the general consent in 113 files were filled and 10.62 % files were not filled thoroughly.

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.

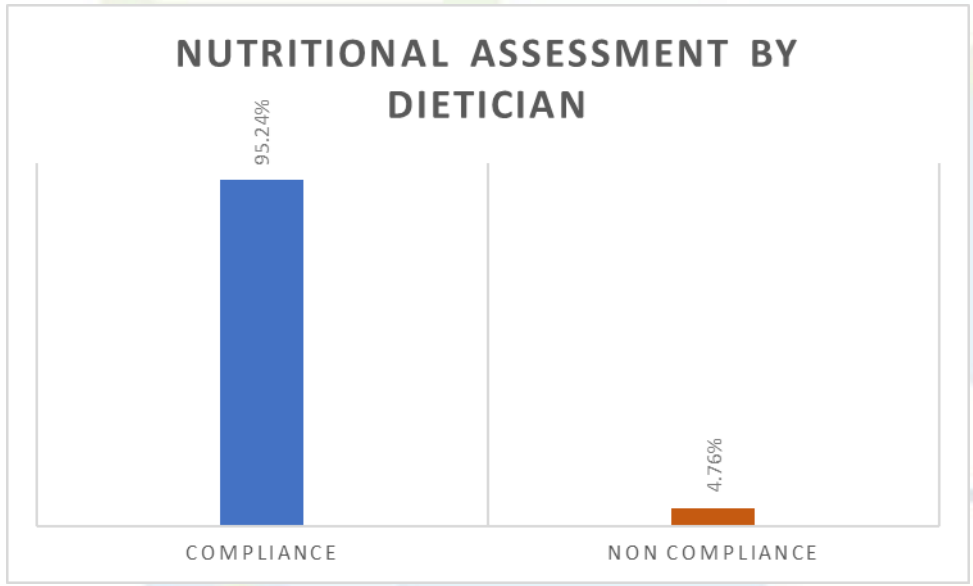
The anaesthesia consent was filled in 100 % of the patient's file in which the surgery required in the treatment.



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



The procedural / surgical safety checklist / labour safety checklist was filled in 98.82% of the files.
The anesthesia 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.



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.

Results

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%

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.

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.

thank you