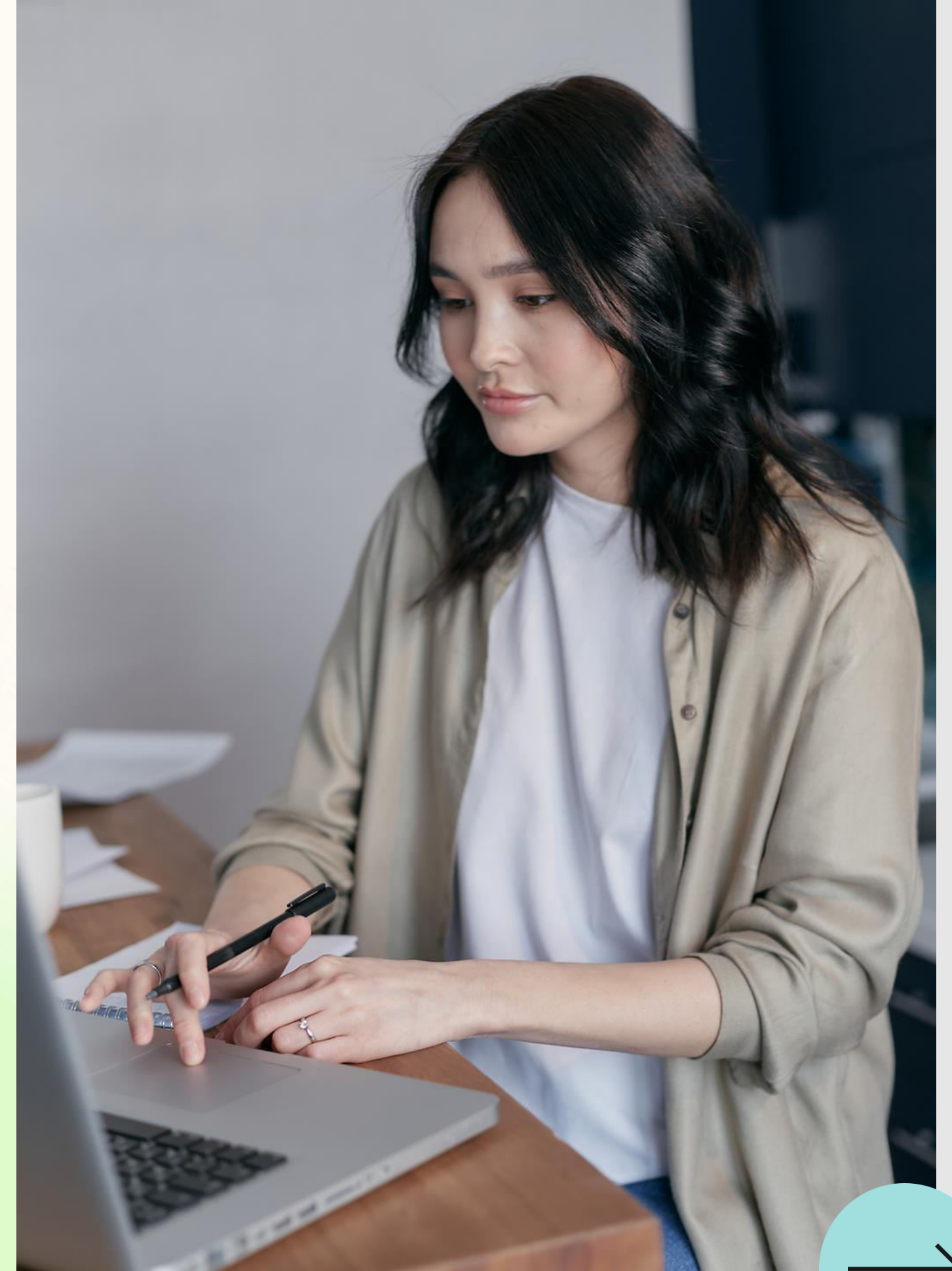


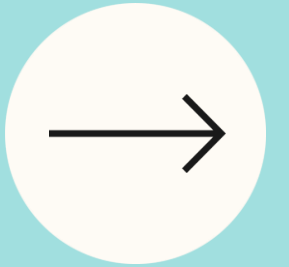
Assessment of Compliance Rates of In-Patient File Documentation As Per NABH Standards In Bansal Hospital, Bhopal

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MBA (2020-2022)

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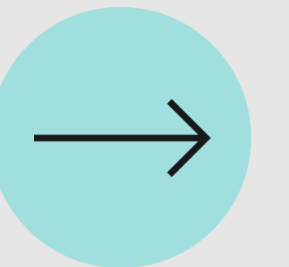
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“If it isn't written down, you didn't do it”



Introduction



- A MEDICAL RECORD is an organized and chronologically recorded document that contains information about the patient and his care while in the hospital.
- A clinical audit is a quality-improvement process which involves a systematic examination of patient care against predetermined standards/ guidelines and, if necessary, the implementation of practice adjustments
- Medical records administration includes the planning, regulating, directing, organizing, educating, advocating, and other administrative operations relevant to the growth, management, usage, and disposition of medical records
- The hospital's records also demonstrate that it is responsible for its operations, and they are a useful data source for clinical research, analytical reporting, and health informatics
- Maintaining a thorough record is critical not only for meeting licensing and certification requirements, but also for allowing a healthcare professional to prove that a patient received adequate care
- While doctors understand the importance of a health record in medical medicine and healthcare education, there's still growing acknowledgment that the database, as well as our existing model for managing medical data, is severely inadequate

Literature Review

Major non-compliances were reported for their non-conformity with the NABH standards.

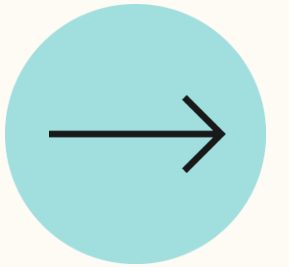
Awareness about the completeness of documentation on medical records was present only in certain areas of documentation

Documentation could be increased by education when reinforced with support of faculty members with regular feedback and also training regarding their charting quality.

Majority of the nursing staff had satisfactory knowledge, attitude & practice regarding the documentation process.

Intervention technique helped in increasing the compliance rate among the staff.

Challenges and Objectives



Research Question

- What is the compliance rate of documentation of IPD files documentation as well as rate of compliance of different departments in the hospital according to NABH standards?

Research Objectives

- To assess the compliance rates of the in-patient files documentation as per the policy proposed by the hospital.
- To carry out passive audit to compare the compliance rates for different departments in patient file documentation process.
- To identify the lacunae and suggest recommendations to overcome the gaps and implement the changes required for quality improvement.

Study Methodology

Research design: Descriptive Cross-sectional study.

Study setting : The study was conducted at Bansal multi-specialty Hospital, Bhopal, Madhya Pradesh with help of the Medical administration and Quality department.

Study population:

Inclusion criteria:

Patient files in the IPD department, and ICU (including NICU, HDU, CCU), only admitted patients were considered.

Exclusion criteria:

1. Patient discharged in less than 24 hours, mostly day care patients.
2. Active Patients, that is the patients who are currently admitted in the hospital and have not been discharged yet.

Study Approach:

1. **Sample size:** The sample size is taken to be 309 files (passive audit).
2. **Sampling technique:** Convenience sampling
3. **Duration:** 30th April 2022 to 10th June 2022.

Statistical tool: Microsoft excel was used for data cleaning and data analysis.

Data collection procedure:

The primary data was collected by preparing a checklist. The data was collected by passively auditing every file.

Results



Parameters regarding the Initial Assessment sheet (Doctor’s)

	Cardiology	Critical Care Team	CTVS	Gastroentology	Gynaecology	Haematology	Internal Medicine	Nephrology
	C	C	C	C	C	C	C	C
Time taken for initial assessment by doctor	49%	64%	36%	65%	17%	50%	59%	56%
Provisional diagnosis and treatment record	73%	100%	73%	81%	33%	50%	41%	85%
Care plan documented	96%	100%	100%	77%	33%	17%	82%	85%
Countersign by clinician	67%	64%	73%	90%	17%	17%	59%	63%
History sheet completely filled	93%	100%	82%	87%	100%	67%	82%	81%
	Neurology	Oncology	Orthopaedics	Paediatrics	Plastic surgery	Pulmonary medicine	Reproductive Medicine	Urology
	C	C	C	C	C	C	C	C
Time taken for initial assessment by doctor	33%	60%	17%	50%	40%	57%	16%	44%
Provisional diagnosis and treatment record	88%	90%	8%	17%	80%	71%	95%	78%
Care plan documented	76%	90%	100%	50%	100%	71%	49%	74%
Countersign by clinician	52%	80%	75%	50%	60%	43%	72%	63%
History sheet completely filled	74%	90%	92%	33%	100%	71%	100%	85%

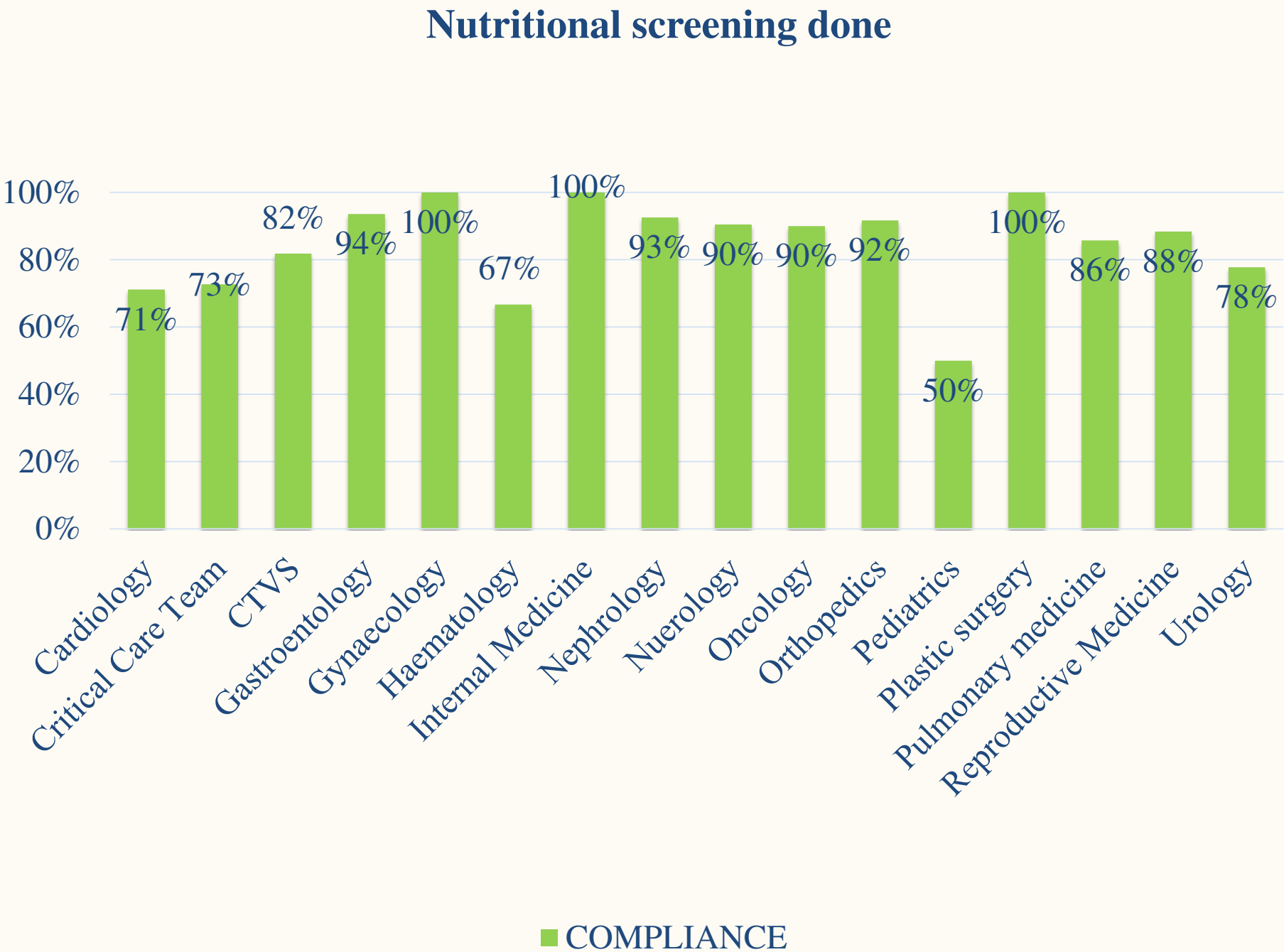
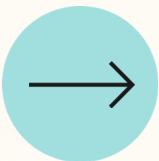
Nutritional Screening

This parameter, “Nutritional Screening Done” indicated if the nutritional screening sheet was added in the patient file and was completely filled and signed by the dietician. Absence of any lead to non- compliance.

Average showed that with most departments, the compliance rate was above 70% which is a good indicator.

Full compliance rates were seen with Internal Medicine, Plastic surgery department, and Gynecology.

The only department with 50% noncompliance rate was Pediatrics

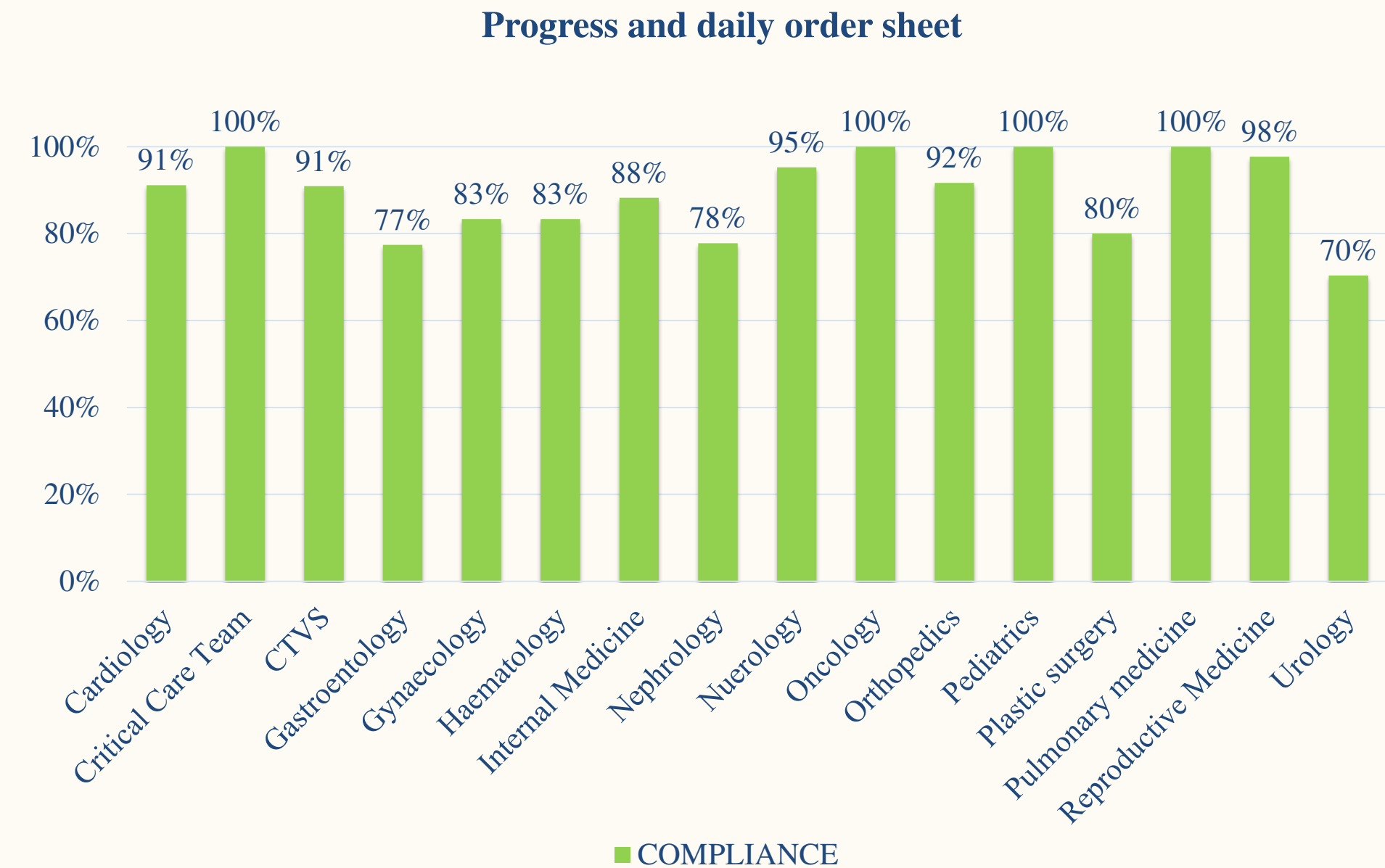


Progress and Daily Order sheet

This parameter, "Progress and Daily Order sheet", compliance was noted when All the progress sheets and daily order sheets were present in the patient's file, for every date till the time patient was admitted.

All of the departments showed pretty good compliance rate with all of them above 70%. Full compliance rate was seen in Critical Care Team, Department of Oncology and Department of Pediatrics.

The Department of Urology has 30% noncompliance among all of them.



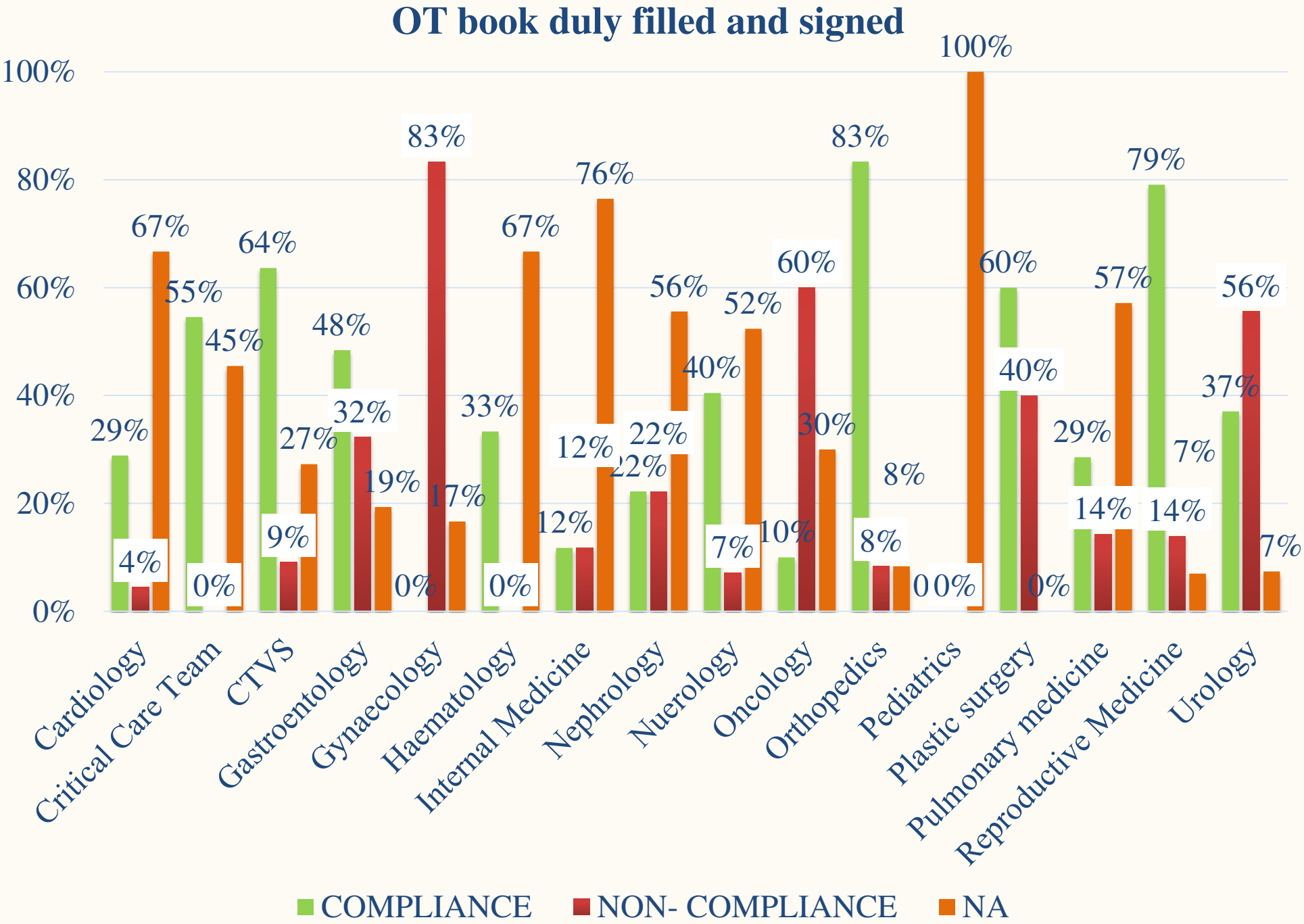
Parameters regarding Nursing documents

	Cardiology	Critical Care Team	CTVS	Gastroentology	Gynaecology	Haematology	Internal Medicine	Nephrology
	C	C	C	C	C	C	C	C
Nursing initial assessment	98%	100%	100%	97%	100%	100%	100%	100%
Nursing care plan documented and signed	93%	100%	91%	90%	100%	83%	82%	78%
All Nursing records signed	93%	100%	91%	90%	100%	67%	76%	89%
	Neurology	Oncology	Orthopaedics	Paediatrics	Plastic surgery	Pulmonary medicine	Reproductive Medicine	Urology
	C	C	C	C	C	C	C	C
Nursing initial assessment	95%	100%	83%	100%	100%	100%	95%	96%
Nursing care plan documented and signed	81%	80%	100%	83%	100%	100%	88%	89%
All Nursing records signed	86%	100%	83%	100%	80%	86%	91%	100%

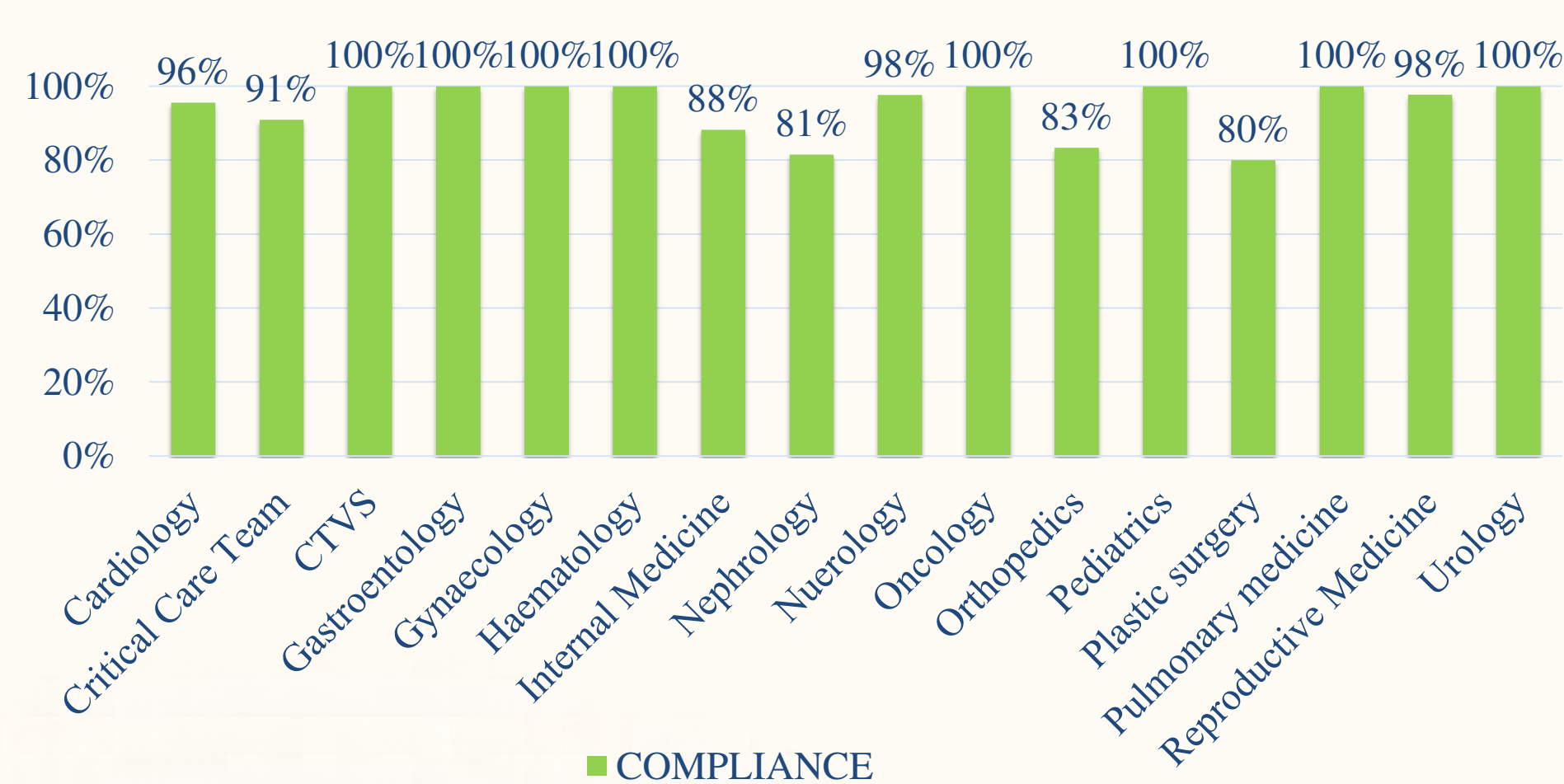
OT book duly filled and signed

This parameter “OT book duly filled and signed” indicates that all the information mentioned in the OT booklet has been filled by the doctor and the nursing staff, which includes patient details, doctor’s details, OT notes and procedural details.

NA (Not Applicable) means that patient did not undergo any surgical procedure.

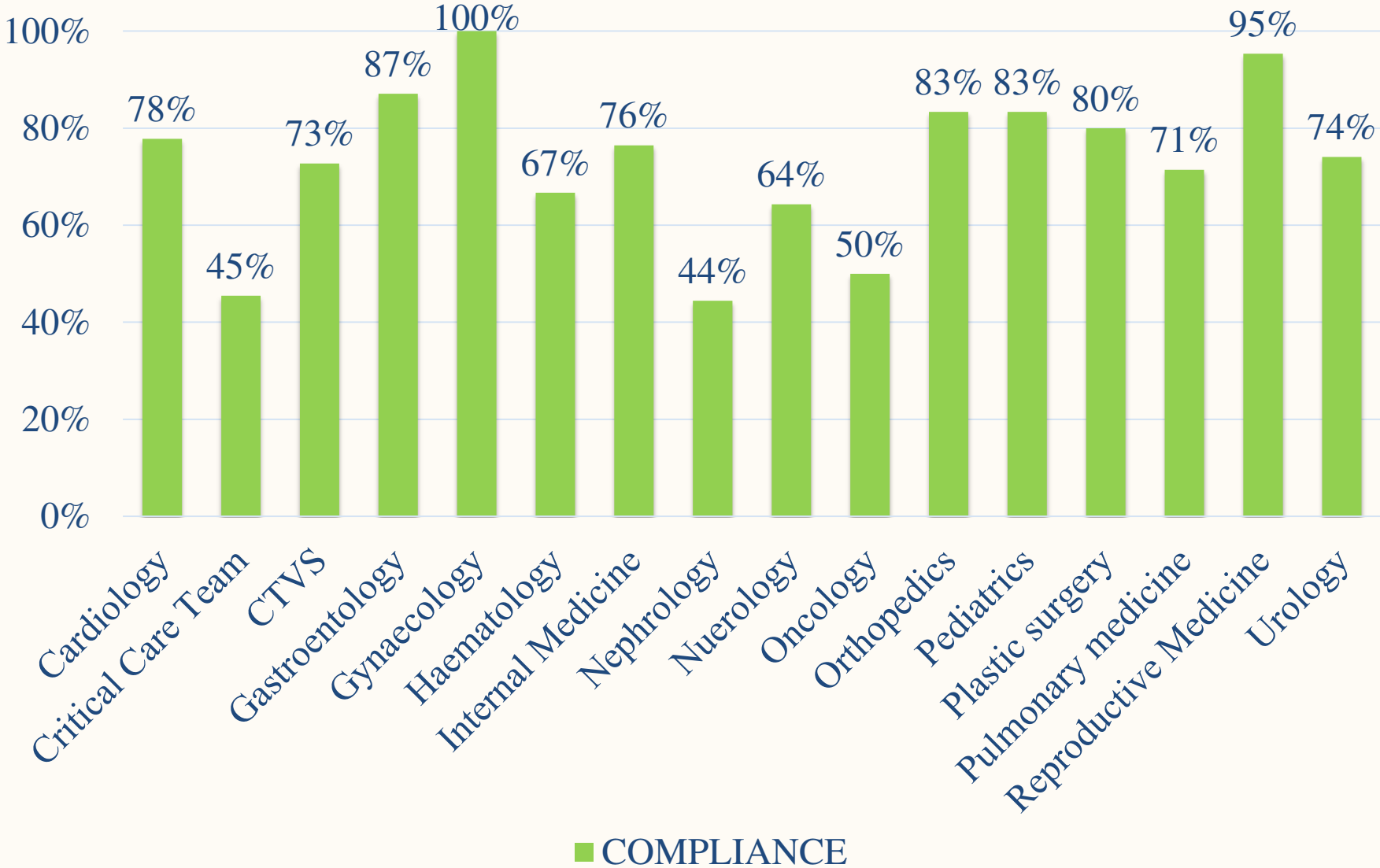


Consent form signed by patient/attender



Included forms, namely, admission consent form, surgical consent form, high risk form, blood transfusion form, anesthesia consent form, dialysis form, restrain form. Absence of signature in any of these forms (if applicable), lead to noncompliance.

Consent form filled & signed by doctor



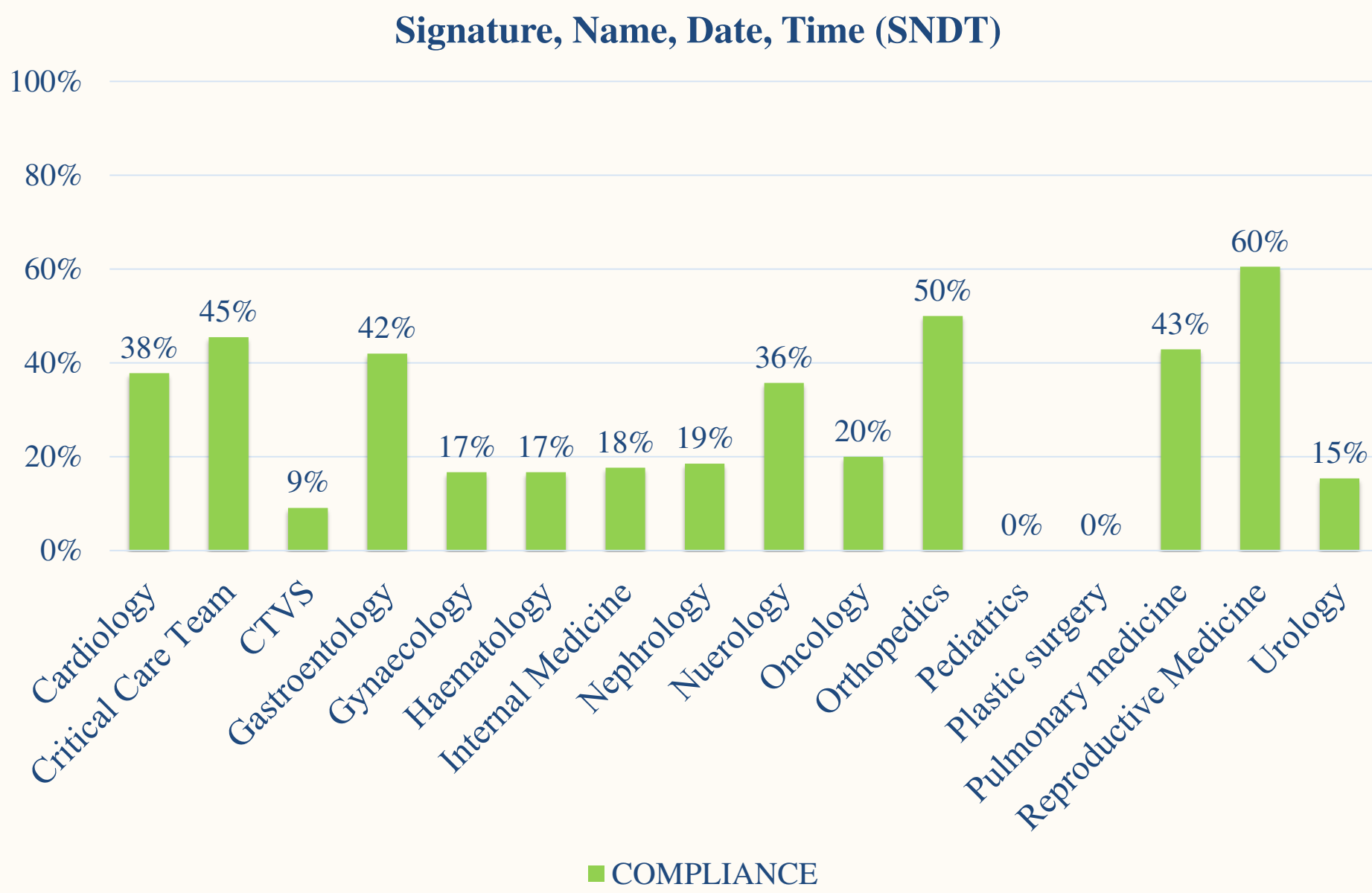
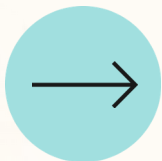
This includes, surgical consent form, high risk form, blood transfusion form, anesthesia consent form, dialysis form, restrain form and admission consent must be just signed by the doctor. If discrepancy is seen, it is marked as noncompliance.

Parameters regarding Medication Chart								
	Cardiology	Critical Care Team	CTVS	Gastroentology	Gynaecology	Haematology	Internal Medicine	Nephrology
	C	C	C	C	C	C	C	C
Frequency, route and dose of medicine mentioned	98%	100%	91%	100%	100%	100%	100%	96%
Legible prescription	96%	91%	73%	84%	83%	83%	76%	78%
Capital letters in Medication Chart	80%	100%	82%	74%	100%	67%	71%	78%
No Error Prone abbriviation in medication Chart	56%	82%	64%	74%	100%	67%	59%	70%
	Neurology	Oncology	Orthopaedics	Paediatrics	Plastic surgery	Pulmonary medicine	Reproductive Medicine	Urology
	C	C	C	C	C	C	C	C
Frequency, route and dose of medicine mentioned	93%	100%	100%	100%	100%	100%	100%	93%
Legible prescription	88%	70%	50%	100%	100%	100%	79%	67%
Capital letters in Medication Chart	83%	70%	50%	83%	100%	100%	93%	67%
No Error Prone abbriviation in medication Chart	64%	80%	50%	67%	80%	100%	86%	96%

Signature, Name, Date , Time

The last parameter in the study was “Signature, Name, Date , Time” commonly called as “SNDT”. The guidelines suggest the all the required places mentioned with these four parameters should be filled. Absence of any one of them leads to noncompliance.

This parameter showed highest noncompliance. Two departments showed absolute noncompliance.



Discussion



- A healthcare facility's bylaws or procedures should require medical personnel to complete patient data within a specific length of time, and those who don't ought to have their clinical qualifications revoked automatically.
- The above study shows a large discrepancy and clear weakness between the standards established and the findings observed in various departments



- If the average is calculated, it shows the **Department of Hematology has the least compliance, overall (63%)**, whereas, **The Critical Care Team had the highest compliance rate**, as per overall average, that is **84%**.
- If the individual parameters are observed, the highest compliance rates were seen for **“Nursing Initial Assessment (97%)”** and **“Frequency, Route, dose of medicine mentioned (97%).”**



- Whereas the lowest compliance rates were seen in **“SNDT (67%)”** followed by **“Time taken for Initial Assessment (57%)”**.
- For SNDT, the **highest noncompliance** rates were seen with **Department of Paediatrics**, and **Department of Plastic Surgery** (absolute noncompliance)
- While, for Time taken for Initial Assessment, the highest noncompliance was for Department of Reproductive Medicine (84%)

Conclusion

The study came to the following conclusions:

- Awareness of the completeness of medical records documentation was present only in some areas of recording, mostly with that related to the **nursing staff, and with medical prescription.**
- If observed according to different departments, some departments were more informed than the others, **especially The Critical Care Team and Department of Haematology.**



Recommendations



A root cause analysis should be performed to determine the cause of the lapse.



The need of good record keeping should be reinforced.



Rewarding the best department showing highest compliance will enforce a positive attitude, and further educating by emphasizing the importance of complete documentation of medical records should be done through regular trainings



The discharging ward in charge before passing on the file to MRD, should check for discrepancies or absence of information, and should get it completed within 48hours of discharge.



In MRD, screening of the discharged IPD file should be done on the day of reception. Incomplete files should be colour tagged and comments should be written, and should be returned to the concerned department



The quality department must do a daily audit initially to ensure higher compliance rates and informing the concerned authorities about the noncompliance found in the records.



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Thank You