Summer Training at
Sterling Hospital,
Ahmedabad

Audit of Medical Documentation of Patients Admitted in Sterling Hospital

By
Pranoti Dhomne

Under the guidance of
Mr. Rahul Sharma

MBA Hospital and Health Management
2015-2017

The IIHMR University, Jaipur
2016

INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

CERTIFICATE

TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Dr. Pranoti Dhomne** student of **MBA Hospital and Health Management** from the IIHMR University; Jaipur has undergone summer training at **Sterling Hospital, Ahmedabad** from 1st April to 31st May, 2016.

The candidate has successfully carried out the study designated to her during summer training and her approach to the study has been sincere, scientific & analytical.

The internship is in fulfilment of the course requirements.

I wish her all success in all her future endeavours.

Col. (Dr.) Ashok Kaushik
Dean (Academics & Student Affairs)
IIHMR University, Jaipur

Mr. Rahul Sharma
Assistant Professor
IIHMR University, Jaipur

sterling Hospitals
Because life matters

Ref.: SH/HRD/CERTI/6677-2016 03rd June, 2016

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Pranoti D Dhomne** has completed her internship in **Quality & Operations Department** from 01st April, 2016 to 31st May, 2016.

During her internship, we found her sincere, hardworking and proactive student.

We wish her all the best for her future endeavours.

With best wishes,

For **Sterling Addlife India Pvt. Ltd.,**

Sterling Addlife India Pvt. Ltd. Ahmedabad

Sangeeta Nair
Sr. Manager - HR

Acknowledgement

I, Dr. Pranoti Dhomne like to express my sincere thanks to Sterling Hospital, for giving me an opportunity for working on the project and for extending all possible support and guidance required for successful completion of the project and valuable learning which came along with the entire process.

All this could not have been fruitful without contribution of various people to whom I would like to express my gratitude.

First of all, I would like to thank **Dr. Nirav Patel, (Executive Corporate Quality &Academics), Ms. Sunidhi Padiyar (Manager Corporate Quality) ,** my guide and mentor at Sterling Hospital whose guidance and constructive feedback helped me improve quality of work to great extent.

I express my sincere gratitude to **Dr. Nikhil Lala (Centre Head, Corporate Head, Medical Services & Quality**, **Mrs**.**Sangita Nair (Senior Manager HR)** at Sterling Hospital, who gaveme chance to purpose my summer internship here and for their loving support throughout internship.

I extent my heartfelt gratitude to **Mr. Rahul Sharma**, **Assistant Professor**, Indian Institute of Health Management Research, for mentoring me guiding me through this study. I am thankful to him for his invaluable assistance and cooperation.

Finally, a special thanks to all the supporting departments of Sterling Hospital for their assistance and for providing me relevant information that assisted me to accomplish successful completion of my project.

Dr. Pranoti Dhomne

MBA (Hospital Management)

DECLARATION

I,**Dr. Pranoti Dhomne** hereby declare that the project work titled **'Audit of Medical Documentation of Patients Admitted in Sterling** Hospital'submitted in the partial fulfillment of the requirement for the 2nd year of MBA-Hospital Management, is a work done by me under guidance of our department faculty and Hospital authorities. This project is only and only STUDY purpose, not for publication or any other means. Use of any content of this project without permission of authorities will be considered illegal and actionable.

Dr. Pranoti Dhomne

MBA-HM

Contents

About Summer Training

MBA in Hospital management of Indian Institute of Health Management Research aims at preparing professionally trained managers of healthcare organization to meet the increasing need for managerial skills; it involves eight week summer training for the first year student to provide them firsthand experience of hospital environment.

As a part of this program, I had the privilege to undergo my summer training at the Sterling Hospitals, Ahmadabad to get a firsthand knowledge and experience about the functioning of the hospital.I worked through under the Hospital Operations Management Department and Quality Department from 1st April to 31st May.

Hospital Profile

Established as a multistage tertiary care hospital in 2001, Sterling Hospital is today the market leader in private chain of hospitals across Western India. It is owned and managed by Sterling Addlife India Ltd. Persisting on its corporate philosophy of patient centric approach, ethical medical practices, and world-class healthcare, Sterling has been offering a range of high quality medical and surgical care in a host of critical specialties such as Cardiology and CVTS Surgeries, Neurology and Neuro-Surgeries, Nephrology and Urology, Liver and Renal Transplant (Live and Cadaveric), GI Medicine and Surgeries, Haematology, Bone Marrow Transplant, Oncology and Onco-surgery, Critical Care and Emergency Trauma Care, Orthopaedic and Joint Replacement, Spine Surgery, Obesity Surgery, Neonatology as well as General Medicine and Surgery amongst others. Of the seven multi-specialty hospitals that Sterling has across Gujarat, Ahmedabad (290 beds), Vadodara (220 beds), Rajkot (190 beds) are tertiary care multi-specialty hospitals, while Gandhidham(119 beds) are high-end secondary care set-up. Besides that, Sterling operates a satellite centre at Mehsana. The Ahmedabad centre, which is the prime healthcare provider, is one-of-its-kind across the state with 290 beds, 7 major operation theatres and over 115 ICU beds. Over the years Sterling Hospitals has gained astounding success in the provision and advancement of tertiary healthcare in Gujarat. Its Pathology Department was ranked 2nd in India and 11th globally by EQAS, BIO-Rad (USA) in Immunoassay Quality Assurance. For three consecutive years, between 2007 and 2009, Sterling Hospital was honoured as the Best Hospital, and it garnered the title yet again for the fourth time in the year 2011. The Ahmedabad centre of Sterling has become the first hospital in Gujarat to be accredited by the National Accreditation Board for Hospitals and Healthcare Providers (NABH) for excellence and quality in healthcare. Above that, its Pathology Laboratory has become the first corporate hospital laboratory in Gujarat to get accreditation from the prestigious National Accreditation Board for Testing and Calibration Laboratories (NABL), reiterating high quality testing and diagnostics capabilities of the hospital. Sterling Hospital, Vadodara, which the Group took over, is also the first corporate hospital to be

accredited by NABH in South Gujarat. It is the quality of service of Sterling that brings patients from across Gujarat, Rajasthan, Madhya Pradesh, Maharashtra and also from the world over. Today, comfort, care and quality cure has become the hallmark of Sterling Hospital. This coupled with its special team of doctors, hi-tech equipment infrastructure and superior post-operative care facilities have earned the Group an enduring trust of patients, medical associations and doctors alike.

Vision

To be a 'Preferred Choice' provider for 'Ethical' 'Superior' 'Holistic' health care solutions. To be 'Humane' 'Viable' & 'Patient Centric'.

Mission

- Excel and above all ' Be ethical and honest'- never violate your conscience.
- We make a difference in everything we do.
- We do everything on or before time.
- We deliver quality- do more than what the client expects.

Department in Sterling Hospital

Specialties

- Anaesthesiology
- Dentistry
- Dermatology
- ENT
- General Surgery
- Internal Medicine
- Microbiology
- Oncology
- Orthopaedics
- Ophthalmology
- Gynaecology& High Risk Pregnancy
- Pathology
- Psychiatry

- Radiology
- Trauma

Super Specialties

- Arthroscopy & Joint Replacement Surgery
- Bariatric Surgery
- Bone Marrow Transplant
- Cardiology
- Cardio-Vascular & Thoracic Surgery
- Diabetes & Endocrinology
- Gastroenterology & GI Surgery
- Haematology-Oncology
- HIV & Infectious Diseases
- Kidney Transplant
- Liver Transplant
- Neonatology
- Nephrology
- Neurosciences
- Neurosurgery
- Onco Surgery
- Paediatrics
- Paediatric Surgery
- Plastic, Cosmetic & Reconstructive Surgery
- Pulmonology & Critical Care
- Rheumatology
- Spine Surgery
- Stereotactic & Functional Neurosurgery
- Urology
- Vascular Surgery

LAYOUT OF HOSPITAL

Neuro ICU, Stroke ICU, Stem cell Transplant	8th floor
VIP suite, Haematology, Oncology.	7th floor
Blood Bank, CCU2,Endoscopy, OPD (Haematology), Stem Cell Transplant.	6th floor
Transplant Unit, Paediatric ward, NICU, PICU, Physiotherapy Department, Transplant Coordinator office.	5th floor
Infection Control Department ,General ward, Semi Special ward, Special room, Deluxe room.	4th floor
General ward, Semi Special ward, Special room, Deluxe room.	3rd floor
OT,SICU	2nd floor
OT, Dermat , CVTS, MICU, SICU, Cathlab, Transient care Unit, CSSD.	1st floor
Radiology & Pathology ,OPD, Pharmacy, Emergency &Casulaty , IP Billing, GICU, CCU1, Emergency OT, ER Waiting Area	Ground floor
OPD1, OPD2, OPD Billing, Cafeteria, Auditorium, IT Department, Health Check up, Biomedical Waste Department, Laundry Department, MRI, Maintainace Department, Biomedical Gas Department, House keeping Department.	Basement

ABSTRACT

Title

Audit of Medical Documentation of Patients Admitted in Sterling Hospital.

Objectives

- To evaluate the quality of medical notes documented in patients file.
- To identify the deficiencies and shortfalls in medical record documentation.

Material & Methodology

- **Study Design:** Descriptive study.
- **Setting:**Sterling Hospital, Ahmadabad.
- **Duration of Study:** 2 months.
- **Sample Size :** 300
- **Sampling Technique :** Simple Random Sampling

Methodology

The retrospective audit was conducted in Sterling Hospital Ahmedabad from 1st April 2016 to 31st may 2016. Out of 1900 patients admitted during this period, 300 case notes were randomly selected and subjected to audit. The clinical notes were broadly analyzed for documentation of sixteen parameters. Each parameter's documentation was to be noted down as yes for data present in the file, no for data absenteeism and missing for the data which is not mentioned in the documentation and not applicable for data which is not applied to that category.

Data Analysis

Statistical analysis were done using bar diagrams

Result

Over all, only 15.7% filled were fully completed whereas rest were somewhere lacking some of the criteria to be fulfilled.

Conclusion

Documentation of important clinical information is poor even in the charts of patients in tertiary care hospital. Higher Standards of recording in internal medicine are called for, since the quality of record does not only affect the individual patient, but also the qualities of medical care in general. All clinical departments and hospitals should carry out detailed studies into the contents of their medical notes.

INTRODUCTION

"Medical audit is systematic review and evaluation of records and other data to determine the quality of the services "

Medical audit and clinical audit are often used interchangeably, but clinical audit might be considered to cover all aspects of clinical care. It complements and may partly overlap financial audit, utilisation review, and management of resources; its focus is the process and results of medical care rather than the use of resources. Medical audit is more systematic, quantified, and formal than traditional clinical ward rounds, meetings, and case presentations but shares with these the objectives of better patient care and education. (1)

"Documentation of patient care is frequently the Achilles heel of Clinical services. Proper documentation of clinical record is of paramount importance".

The hospitals are the healthcare organizations which provide medical care in the form of diagnosis and treatment. Good medical care needs maintenance of complete and accurate medical records. This need is generally enforced as a licensing or certification prerequisite for hospital care providers. There is a separate department in medium sized and big hospitals as Medical Records Department (MRD). The medical records can be stored manually and electronically.To audit the records a tool was prepared and the complete documentation process of the concerned specialities was studied. All the important details were taken care of while making the tool. The clinical papers that went in to each patient admission, to their operation details, paper work during their stay and discharge was understood. (2)

"Within the nightmare of a malpractice suit brought against a clinicians, a solid documented chart in one's hand is universally recognized as one of the critical elements of the best defence".

The absence of complete documentation in patient medical records can have a negative effect on statistical databases, financial planning, clinical preparedness, and gross revenue for the healthcare organization. It is for this reason that every healthcare organization should be focused on ensuring accuracy and completeness in clinical documentation, at any cost. Documentation improvement is not a new concept in healthcare, but rather an evolving trend.

From a clinical perspective, we have seen movements away from postponing care until patients are severely ill and in need of hospitalization to preventive medical care. Along with this trend, we have seen fewer, but more severe inpatient admissions and an increase in outpatient admissions over the past decade. Second, from an information management viewpoint, there has been an increasing trend toward computerization of medical records. The government has responded to this trend by implementing privacy and security protections. Hence to maintain proper medical record documentation so as to maintain the quality is of upmost importance.

The aim of the current study is to evaluatethe quality of medical notes writing in a medicalunit of a tertiary care hospital. This would help in identifying the deficiencies, mistakes and shortfallsin medical records documentation. Finally waysand means are to be suggested so as to improveand overcome the deficiencies. The purpose of clinical audits is essentially to improve the quality of healthcare services by systematically reviewing the care provided against set criteria.

RESEARCH METHODOLOGY

An audit was conducted in Sterling Hospital,Ahmedabad .It included patient casenotes admitted during 1st April to 31st May 2016..All the case notes were collected from nursing station. 1900 patients admitted during this period from which, threehundred case notes (sample size) were selected from the pile in simple random manner (usingrandom table) and were subjected to audit. Thepatient's information's was entered into a pre-designed audit pro-forma having all the relevant details. A single observer who would assess it as per agreed standard, analyzed the patient's chart and filled the proforma.

- **Study Design:** Descriptive study.
- **Setting:** Sterling Hospital, Ahmadabad.
- **Duration of Study:** 2 months.
- **Sample Size :** 300
- **Sampling Technique :** Simple Random Sampling

Sixteen parameters were assessed in the contents of medical notes. This included documentation of the following:

1. ER assessment completed within 5 minutes (by ER Doctor)
2. Admission on history completed within 01 hours (by MO)
3. Nursing assessment is complete within 02 hours
4. Plan of care with preventive aspects documented and counter signed by the consultant (within 24 hours)
5. SNDT (where ever applicable in History sheet)
6. Any Error prone abbreviations and illegible handwriting
7. SNDT (where ever applicable in treatment sheet)
8. Treatment orders counter signed by the consultant

9. Consultant notes are complete
10. Pain assessment
11. Nutrition assessment
12. Re assessment notes (progress notes) by nurses and MO
13. SNDT (wherever applicable in all assessment sheets)
14. Signed by patient and relative
15. Signed by consultant /team member
16. Risk and benefits documented

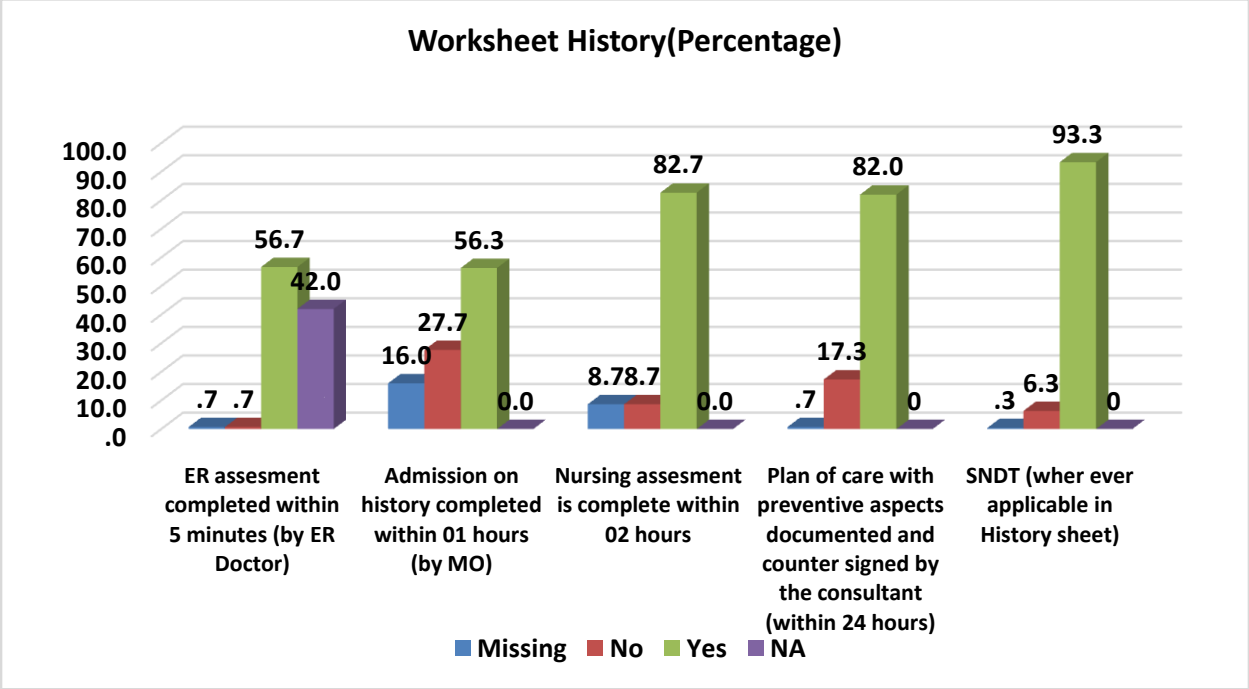
We maintaineda structured sheet for investigation to be written inchronological order. Investigations were graded asper completeness of flow sheet and documentation

The clinical notes were broadly analyzed for documentation of sixteen parametersdepending on the completeness and quality of documentation. Each parameter's documentation was to be noted down as yes for data present in the file, no for data absenteeism and missing for the data which is not mentioned in the documentation and not applicable for data which is not applied to that category.

This is a descriptive study (audit) hencethe frequency and percentages were determined.

DATA ANALYSIS

Observations & Result



Worksheet History					
	ER assesment completed within 5 minutes (by ER Doctor)	Admission on history completed within 01 hours (by MO)	Nursing assesment is complete within 02 hours	Plan of care with preventive aspects documented and counter signed by the consultant (within 24 hours)	SNDT (wher ever applicable in History sheet)
Missing	2	48	26	2	1
No	2	83	26	52	19
Yes	170	169	248	246	280
NA	126	0	0	0	0

Interpretation Graph 1

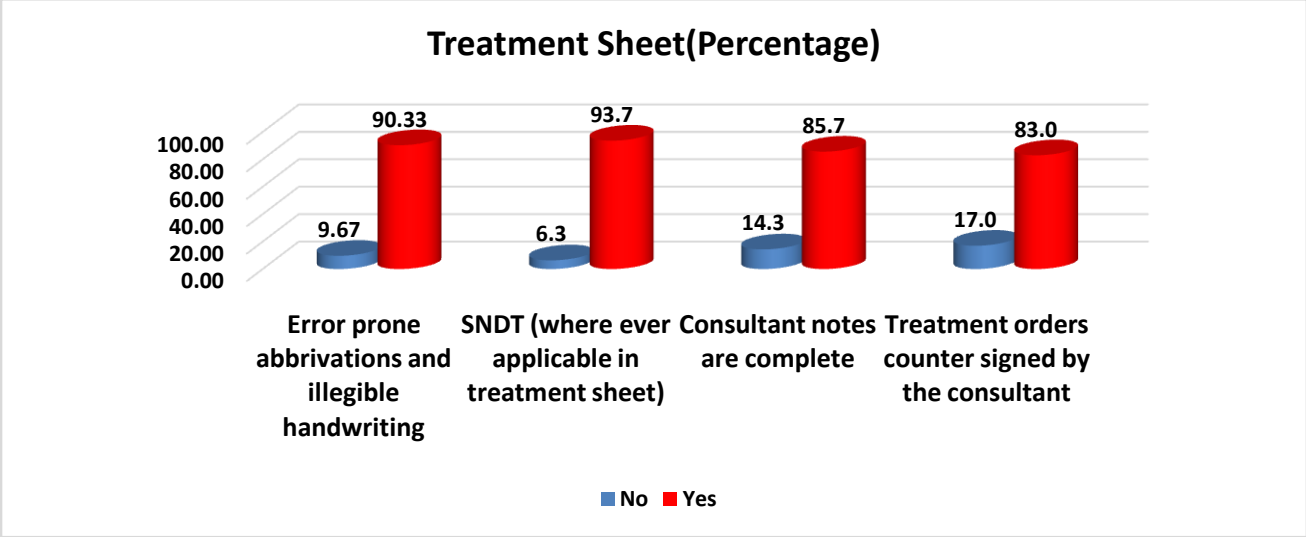
From the above we can see that in 56.7% (n=170) files ER assessment was completed within 5 minutes, 42% (n=126) were not admitted to ER & 7% (n=2) data was missing and 7% (n=2) was incomplete.

Onlyin 56.3% (n=169) files , history was recorded within 1 hr of admission, in 16% (n=48) data was not documented & 27.7% (n=83) files , didn't match this criteria.

Nursing assessment was done within 2 hrs in 82.7% (n=248) files where as 8.7% (n=26data was incomplete and 8.7% (n=26) data was not documented .

Also Plan of care with preventive aspects were documented and counter signed by the consultant within 24 hrs was recorded in 82% (n=246)files , 0.7% (n=2) data was missing , 17.3% (n=52) were incomplete.

93.3% (n=280) files were recorded with sign and date applicable in the history sheet, 0.3% (n=1) data was missing and 6.3% (n=19) data was incomplete.



	Error prone abbrivations and illegible handwriting	SNDT (where ever applicable in treatment sheet)	Consultant notes are complete	Treatment orders counter signed by the consultant
No	29	19	43	51
Yes	271	281	257	249

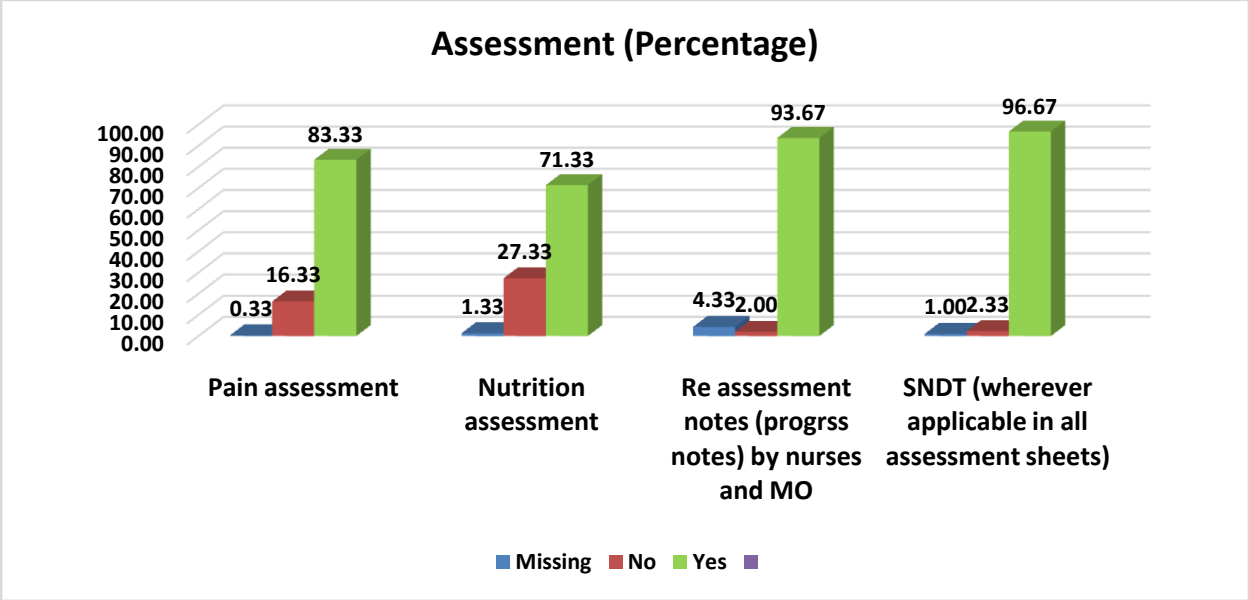
Interpretation Graph 2

In Treatment sheet, 90.33% files were without any error prone abbreviation in treatment sheet and 9.67% files were error prone.

93.7% files were recorded with sign and date whereas 6.3% were incomplete.

Consultant noted found to be complete in 85.7% files whereas 14.3% were incomplete.

83% treatment orders countersigned by the consultant and 17% files were not signed.



	Pain assessment	Nutrition assessment	Re assessment notes (progrss notes) by nurses and MO	SNDT (wherever applicable in all assessment sheets)
Missing	1	4	13	3
No	49	82	6	7
Yes	250	214	281	290

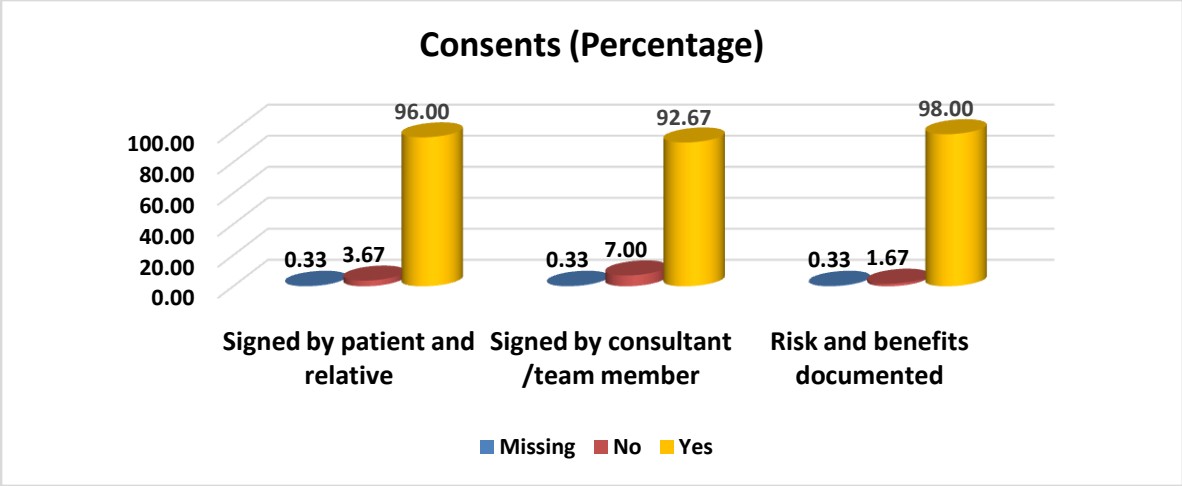
Interpretation Graph 3

In assessment sheet, 83.33% files were recorded with pain assessment , 0.33% were missing and 16.33 % were incomplete.

Likewise, in nutrition assessment 71.33% files were in efficient manner , 1.33% were missed and 27.33% were incomplete.

93.67% files were completed with reassessment notes while 4.33% were missed and 2% were incomplete.

96.67% were completed with sign and date whereas 1% files missed this data and 2.33% files were without sign and date.



	Signed by patient and relative	Signed by consultant /team member	Risk and benefits documented
Missing	1	1	1
No	11	21	5
Yes	288	278	294

Interpretation Graph 4

In Consent sheet, 96% consents were signed by patient and relatives, 0.33 % files missed this data and 3.67 % were not signed.

92.67 % files were signed by consultant or team member 0.33 files missed this data and 7% files were not signed.

In 98% files, risk and benefits were documented where as in 0.33 % the data was missed and in 1.67 % it was not mentioned.

Result

Over all, only 15.7% filled were fully completed whereas rest were somewhere lacking some of the criteria to be fulfilled.

Conclusion

Documentation of important clinical information is poor even in the charts of patients in tertiary care hospital. Higher Standards of recording in internal medicine are called for, since the quality of record does not only affect the individual patient, but also the qualities of medical care in general. All clinical departments and hospitals should carry out detailed studies into the contents of their medical notes.

LIMITATIONS& RECOMMENDATIONS

Limitations

- Less study duration
- Single handed study

Recommendation

There should be regular check of the records by the floor co coordinator at the floors to see if the clinical details are filled or not. Clinician should be made reminded again and again about the importance of maintaining the records and especially the areas where they tend to skip regularly. Regular training of clinicians to emphasize the importance.

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APPENDIX

Self Administered Checklist

1. ER assesment completed within 5 minutes (by ER Doctor
   (i)Yes (ii)No (iii)Missing (iv) Not Applicable.
2. Admission on history completed within 01 hours (by MO)
   (i)Yes (ii)No (iii)Missing
3. Nursing assesment is complete within 02 hours
   (i)Yes (ii)No (iii)Missing
4. Plan of care with preventive aspects documented and counter signed by the consultant (within 24 hours)
   (i)Yes (ii)No (iii)Missing
5. SNDT (wher ever applicable in History sheet)
   (i)Yes (ii)No (iii)Missing
6. Any Error prone abbrivations and illegible handwriting
   (i)Yes (ii)No (iii)Missing
7. SNDT (where ever applicable in treatment sheet)
   (i)Yes (ii)No (iii)Missing
8. Treatment orders counter signed by the consultant
   (i)Yes (ii)No (iii)Missing
9. Consultant notes are complete
   (i)Yes (ii)No (iii)Missing
10. Pain assessment
    (i)Yes (ii)No (iii)Missing
11. Nutrition assessment
    (i)Yes (ii)No (iii)Missing
12. Re assessment notes (progrss notes) by nurses and MO
    (i)Yes (ii)No (iii)Missing
13. SNDT (wherever applicable in all assessment sheets)
    (i)Yes (ii)No (iii)Missing

14. Signed by patient and relative

    (i)Yes (ii)No (iii)Missing

15. Signed by consultant /team member

    (i)Yes (ii)No (iii)Missing

16. Risk and benefits documented

    (i)Yes (ii)No (iii)Missing

Abbreviations

ER – Emergency Room

MO – Medical Officer

SNDT – Sign & Date