Indoor Patient Care in Shalby Hospital: A Study

By

Khushboo Srivastava

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2018-2020

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TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr Khushboo Shrivastava,student of MBA Hospital and Health Management from The IIHMR University Jaipur has undergone internship training at Shalby Hospital ,Jaipur from 2/02/2020 to 2/04/2020.

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

The internship is in fulfilment to the course requirements.

I wish her all success in all her future endeavours.

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Certificate By Scholar

This is to certify that the dissertation titled indoor patient care in Shalby Hospital , a study and submitted by Dr KhushbooShrivastava ,enrolment number 0761 under the supervision of Dr Nutan Jain for award of MBA in Hospital and Health Management in the university carried out during the period from 2/02/20 and 2/04/20 embodies my original work and has not formed the basis for the award of any degree, diploma associateship, fellowship titles in this or any other institute or other similar institutions of higher learning

Dr Khushboo Shrivastava

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Signature

Table of contents

Indoor Patient care in Shalby Hospital: A Study

Introduction

The Clinical Establishment Act Standard for Hospitals (Level 1A and 1B) define *inpatients* as those who are admitted and stay overnight or more, and they are referred as inpatients. Patient safety is a fundamental aspect of Universal Health Coverage. Safe and high-quality healthcare are the most important factors for the strengthening health care systems and ensuring effective universal health coverage (UHC) under Sustainable Development Goal 3: ensure healthy lives and promote health and well-being for all at all ages (1). Unsafe care leading to death is one of the 10 leading causes of death and disability in the world (1). In high-income countries, it is estimated that one in every 10 patients is harmed while receiving hospital care. The harm can be caused by a range of adverse events, with nearly 50% of them being preventable (1).

International Patient Safety Goals given by Joint Commission International (JCI) in 2019 clearly pins downs the patient care related goals.

- Goal One: Identify patients correctly.
- Goal Two: Improve effective communication.
- Goal Three: Improve the safety of high-alert medications.
- Goal Four: Ensure safe surgery.
- Goal Five: Reduce the risk of health care-associated infections.
- Goal Six: Reduce the risk of patient harm resulting from falls.

Standardization of Health Care Services

According to a study by Rozich JD et al, when the patterns of healthcare services are widely variant , the clinical outcome suffers, and patient safety is compromised (2). According to an article by AK Jha, an external and independent body which checks objective criteria to ensure that hospitals are following evidence-based practices to maximize patient outcomes must be employed (3). Some external accreditation systems in various countries are as follows:

United States of America

There are various organizations in the United States that perform accreditation and establish standards for healthcare delivery. These agencies include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), the American Medical Accreditation Program (AMAP), the American Accreditation HealthCare Commission/Utilization Review Accreditation Commission (AAHC/URAC), and the Accreditation Association for Ambulatory Health Care (AAAHC).

Europe

The United Kingdom piloted the continent's first accreditation programme in 1980. Despite the widespread participation of private hospitals in particular, this voluntary scheme is only one of several initiatives the government has developed to encourage better health care. English accreditation has been exported on an experimental basis to Finland, Portugal and Sweden, which have all developed the model to a limited degree without making it mandatory.

Only three European countries run their own accreditation systems. In Belgium, planning needs form the basis for national standards, which are then modified and administered locally. France subjects all public and private services to an external review aimed at improving safety as well as quality. Scotland is developing separate accreditation programmes for clinical priorities such as cancer, strokes and mental health.

Many other European governments have passed health care laws that are designed to improve organizational and clinical quality, fall short of full accreditation

Australia

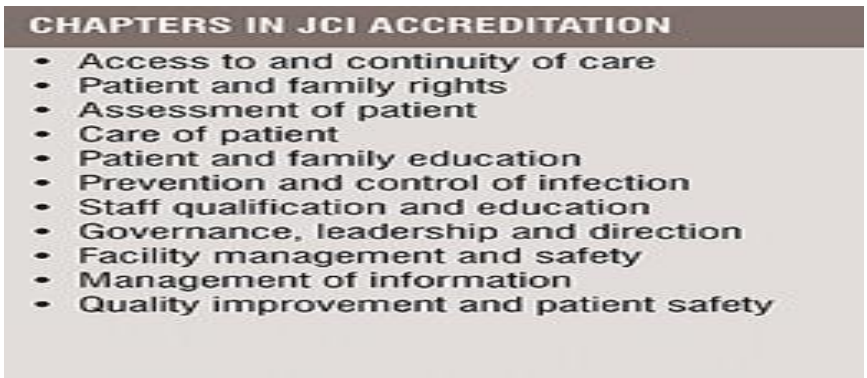
HQAA has Deemed Status Authority by the Centres for Medicare and Medicaid (CMS) to accredit long lasting, effective and quality home medical equipment, and orthotics. HQAA has accreditation standards designed for various healthcare providers and related organizations

Asia

Joint Commission International (JCI) which is the international arm of the American JCAHO is very popular in the region. NIAHO- ISO certification developed by the TUVHS America program combines two independent sets of standards — ISO 9001 Quality Management standards and Hospital Conditions and Participation standards set by the Medicare program in the US. This new system focuses largely on the administrative processes . it is still subject to approval. Only then it will be able to accredit hospitals internationally.

Popular Accreditation Systems in India

JCI is a not for profit organization. Joint Commission International accredits eight types of health care providers: hospitals, medical colleges, mobile health care facilities, clinical pathological laboratories, home care facilities, long term care facilities, medical transport organizations, and primary care.



In JCI, there are 565 standards divided into 197 core standards that must be met to achieve accreditation and 368 other standards that lead organisations to best practice levels. These standards are further divided into 1033 measurable parameters, which focus on aspects such as patient safety, patient rights, facilities, and physicians' credentials besides policies and procedures of the organisation. To get accredited a hospital will have to fully meet most of these parameters and the remaining ones at least partially.

National Accreditation Board of Hospitals

National Accreditation Board for Hospitals & Healthcare Providers (NABH) is a constituent board of Quality Council of India (QCI). It has been set up to establish and operate accreditation programmes for healthcare organizations. The NABH board, which is being supported by all stakeholders including industry, consumers, government, have full functional autonomy in its operation(qcin.org/NABH)

Complying with patient safety is a daunting task more so in the absence of a uniform regulatory framework. Introduction of NABH in 2006 has been a landmark event which provided us with a patient safety framework of global standards.

Application procedure

- Application for accreditation
- Acknowledgement and registration of application
- Appointment of principal assessor for the purpose of pre assessment and on-site assessment of the Health Care Organization(HCO)
- Pre assessment of HCO within three months of submission of application
- Final assessment of HCO within six months of pre assessment and submission of the assessment report by the assessment team
- Scrutiny of assessment report by NABH accreditation committee
- Issuance of accreditation certificate

Outline of NABH Standards

Patient centric standards

Access, assessment and continuity of care

Care of Patients

Management of medication

Patient Rights and Information

Hospital Infection Control

Organization centred standards

Continuous Quality Improvement

Responsibility of Management

Facility management and Safety

Human Resource Management

Information Management System

Indoor patients department are of one of the important unit to maintain quality and safety measures. The patients and their attendants stay while they are in trouble and therefore, compliance of quality standards is important. Compliance with the NABH guidelines in a corporate hospital which caters to urban population which mostly pays via TPA or self-finances its treatment is utmost necessary.

Review of literature

Promoting patient safety in India : Situational analysis and the way forward

July 2014: The National Medical Journal of India 27(4):217-23

Source PubMed ,

Authors – Rajan Madhok, Sonali Vaid et al

The authors studied five international case studies and drew a roadmap for India to address the challenges of implementation and promotion of patient safety culture.

The policy framework constitutes the first challenge. There is not enough commitment or planning for an overall mandate on healthcare accreditation policies. Initiatives such as the NABH and other accreditation programmes are facing a question mark on their very existence because of the perception that some accreditations can be easily procured. As for the Clinical Establishment Act, it focuses more on structures and processes than outcomes, and hence, does not offer a way forward at the moment. Independently validated and objective reporting of patients' concern does not exist. No organization is ready to report its data publicly Reporting of incidents related to patient safety is seen as an act of complaining as most of the times a report is seen as a means of inflicting punitive measures to the wrongdoer . There follows a vicious cycle that discourages reporting or owning mistakes.

The second challenge is the absence of leadership by the organized professions. There appears to be inadequate sense of responsibility or urgency in the mind of the policymakers. Although individually, some doctors are bringing to light the cause of patient safety, the quality officers generally find that doctors are the most reluctant participants. The response of the Indian Medical Association to the 'Satyamev Jayate' programme, i.e. its demand for an apology from the actor, Aamir Khan, for raising issues pertaining to malpractice, shows how far behind the times the organized profession is.

The lack of pressure to change, the modus operandi related to safe care practices by the healthcare organizations is the third challenge. Patients are attracted by the perceived quality of service, rather than the actual clinical quality and standards of patient safety. They are strongly influenced by the 'brand name' or personal knowledge of the medical staff. As for the 'sellers' market, where the demand is higher than the supply in most places, there is no incentive for organizations to change. Even where financial incentives have been introduced, for example, the 20% extra payment for public-sector patients receiving care at NABH-accredited hospitals, the money is either not utilized, or does not suffice for setting up the infrastructure required for quality improvement. Consequently, the staff members concerned with quality feel undervalued, as they do not directly generate any revenue. In fact, it is believed that they cost money. Sadly, the monetary impact of inefficiency and complications due to unsafe care do not concern healthcare providers since they pass on the cost to the consumers anyway: 'complications generate revenue!' according to the proponents of this theory ; cost–benefit ratio of working with such a misguided agenda is actually against investment in safety related processes.

The fourth challenge is that the issues of patient safety and quality improvement are barely emphasized in education and training, if at all. Coupled with this is the absence of holistic development and promotion of professionalism in medical education. Much of medical education is based on learning by rote and there is limited development of the faculty of critical thinking. This is reflected in a lack of capability when students attempt to learn about the scientific basis of quality improvement.

The way the care of patients is organized and delivered in India constitutes the fifth hurdle. Given the shortage of trained nurses, the stand-in nurse is usually a family member. The latter is called upon to perform nursing tasks such as monitoring the patient's temperature as well as the fluid intake–output, and even administer Ambu bag ventilation in some cases. However, even with the best intentions in the world, a patient's relative cannot be a substitute for a nurse, and the chance of unsafe.

Problems in communication, both formal and informal, constitute the sixth concern. As a result of these problems, which are often due to the paternalistic system of healthcare, patients and carers are not given adequate information. This is compounded by poor record-keeping and minimal documentation. The absence of teamwork and group practice means that individual physicians practise in isolation (9).

Effective quality measures include the process, structure and outcome of all aspects associated with improved patient care. Quality indicators are of prime importance in improving health structures, processes, and outcomes. Quality indicators act as the foundation for improving process quality of patient care. The need for a standardized, objective and easily measurable quality indicators is mandatory.

National accreditation board for hospitals and healthcare providers (NABH) standards: a study

Current medical issues 2017;volume 15 ;issue 3;page 231-36
Authors Samuel N J Davis, Sonia Valas

According to this article, accreditation benefits all the stakeholders in a healthcare organization namely:

Patients – Accreditation results in high quality of care delivery and safety. Patients in any part of the world have an equal right to receive high quality safe care and NABH is a right step in that direction. They are made aware of their rights and patient satisfaction is constantly evaluated.

Accreditation thus helps in maintaining a patient centric approach in healthcare.

Hospitals-It showcases the commitment of hospital to quality assurance and patient safety. It also keeps the hospital at par with other healthcare organizations and gives it a competitive edge over other organizations.

Staff– Accreditation ensures that the hospital staff works in an environment with continuous learning process and uniform policies.

Empanelment – Accreditation provides an alternative system of empanelment by insurance and third-party administrators.

According to the **Technical Report of National Consultation Workshop on Patient Safety** held in 2010 there was a key role of a Patient Safety committee in ensuring safe working

practices in a hospital. The objectives of such a committee were to ensure safety of patients and to minimize medical errors.

Patient safety committee monitored the following aspects at the hospital
Author: Mandeep et al
Source Journal of national accreditation board for hospitals and healthcare providers 2014, volume 1,issue 2, pg. 52-55

Timely shifting of patients from casualty to wards so that the treatment could be initiated swiftly. Availability of duty doctors in the wards at all times to ensure management of emergencies. Interdepartmental references to be attended in time. Increasing awareness among doctors about patient safety practices. They did a descriptive study by providing a questionnaire to 10 doctors and 40 nursing staff to collect information regarding knowledge and attitude towards NABH accreditation. The study concluded that the level of knowledge of the hospital staff and doctors improved after training regarding NABH accreditation.

Accreditation ushers in a substantial change in nursing care protocols. Nurses are being the forefront of healthcare deliverance and they have to change their day to day routine significantly to inculcate changes and flawless execution of protocol expected from them.

To assess the effectiveness of plan teaching program the NABH accreditation on newly recruited staff nurses at Krishna Hospital, Karad;
Journal of Evolution of Medical and Dental Sciences; December; 2015; volume 4; issue 103; page no. 16830-34.
Author : Kavita sanjay kapurkar

A study was conducted among 35 nurses working in a single accredited hospital in Malappuram district, Kerala with the intention of assessing the effects on the NABH accreditation on nursing professionals.. This study was conducted by using simple random sampling method with validated self-administered questionnaire. A Likert's 5-point scale charting regarding the retraining schedules, work stress, improvement in working conditions, increased workload following implementing NABH protocol. The study concluded that majority of newly recruited nurses have 19% average knowledge and 18%have average practice towards NABH guidelines. Knowledge and practice behaviour of the nurses between pre-test and post-test was highly significant.

Medical records and issues in negligence: an article

Source: Indian Journal of Urology 2009 July -September;25(3) 384-88

Author Thomas Joseph.

It is particularly important that documentation of care is being provided by the treating doctor be done. Record keeping has come a long way from the initial days when stacks of papers were kept in a dilapidated room. It has evolved into a science in itself. In the current scenario it is especially important that the treating consultant keep such records such as diagnosis, treatment, consent forms etc for his or her own safekeeping. It will also help in future evaluations of the patient's medical condition, research purposes, prognosis and follow up. Medical records are definitely an important constituent of the management of a patient. The importance of documentation of the patient's medical care report cannot be undermined for a couple of important reasons.

An important reason is that it helps the medical practitioner in the scientifically evaluating the patient profile, analysis of the treatment results, and to plan future treatment programmes. It also helps in policy formulations by the political and bureaucratic stakeholders for planning of medical care.

Along with this medical recordkeeping is important from the medico legal angle. In such situations the need arises when the patient has filed for malpractice against the treating consultant and the healthcare organization. In such a situation of alleged negligence, documentation is the only reliable the evidence for deciding on the sentence on the doctor. The increasing foray of medical insurance is another reason for the essential practice of medical record keeping by the treating physician and the healthcare organization. Medical records are crucial for reimbursement of the expenses borne by the patient. Incomplete record maintenance will have unfavourable financial implications to the patient. Sadly, record keeping is not given due importance in most medical centres even though its importance is so obvious.

"Poor records mean poor defence; no records mean no defence". Medical records include a variety of documentation of patient's history, clinical findings, diagnostic test results, preoperative care, operation notes, post-operative care, and daily notes of a patient's

progress and medications .It is important to have a duly filled consent form to document the patient's concurrence with the procedures. A duly filled surgical consent form could safeguard the operating surgeon in case of an allegation of negligence. Similarly, anaesthesia consent form also protects the treating doctors against any false allegation.

It is important that the prescription should be legible with the name of the patient, date, and the signature of the doctor in its proper place. Doctor could be sued if the nurse or the pharmacist give out wrong drugs or wrong dosages. A patient could misuse an undated prescription (15).

Study Questions

1. Is there compliance by the healthcare providers to NABH indicators related to admission of patients in ward?
2. What are the most neglected safety aspects during indoor patient care?
3. What could be the possible reasons for non-compliance to the NABH indicators.

Study Objectives

1. To find out about the status of compliance to NABH guidelines during documentation of admitted patient details.
2. To find out the areas in healthcare where caregivers are the most negligent and to train them accordingly.
3. To identify the areas where more chances of adverse events can take place in the ward in and to prevent them.

Methodology

The study was undertaken at Shalby hospital, Jaipur. It is a fully equipped multispecialty hospital with 237 beds with 23 operational critical care beds for intensive care units.

The following steps were followed to conduct the study:

Step 1: Review of the patient safety guidelines

Step 2: Audit of a total of 30 files of indoor patients who were admitted in Shalby hospital Jaipur for more than 24 hours was done within two months period. In order to reduce the bias, the following methods were adopted

- Case files were selected from different workstations in the hospital to ensure participation of all the departments.

- Case files were selected at different time of the day so that files which are send to different departments at a particular time only would also be included in the sampling.

Step 3:Audit checklist included the following parameters in terms of Yes or No:

A. Initial assessment by doctors

- Was the assessment done within 20 mins. of admission
- Chief complaints documented
- History of present illness documented
- Vitals documented
- Investigations advised
- Dietary advice documented
- Consultant name, signature with date and time

B. Plan of care completed (by consultant)

- Care plan documented
- Provisional diagnosis made
- Consultant name, signature with date and time

C. Nutritional screening

- Height, weight, BMI recorded
- Diet prescription documented

D. Nursing care plan completed 24 hours in hospital

- Assessment staff name, date, time, signature and shift recorded
- Nursing notes

E. Consent form

- General consent available and complete
- Informed consent available and complete
- Surgery consent available and complete
- Patient and witness name, signature, date and time documented

- Doctor name signature with date and time documented

F. Medication administration record

- Drug name in capital letters
- Frequency, route, dose and time
- Doctor name, signature with date and time
- Nurse name, signature date and time

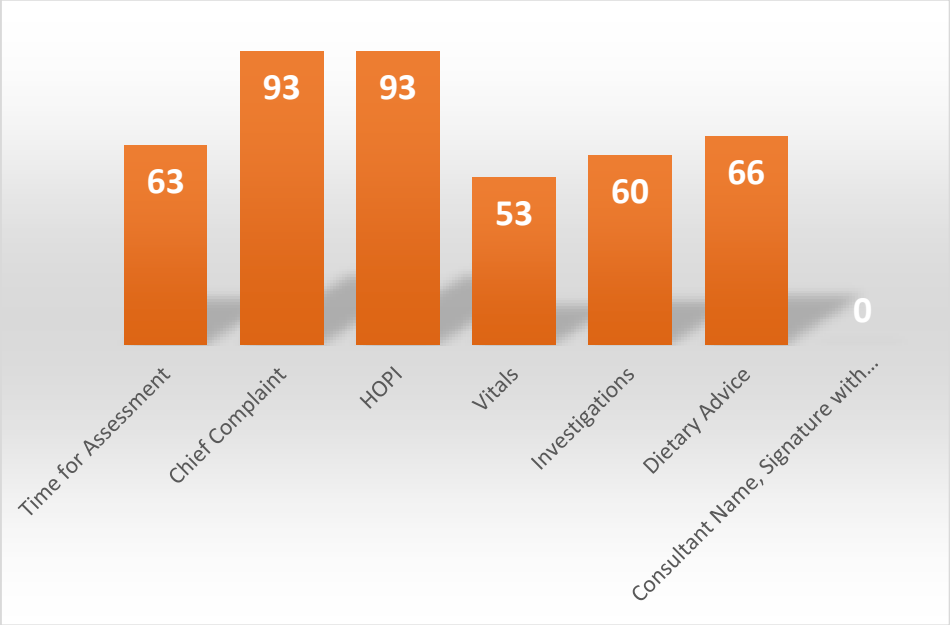
Results

An important fact was that the quality assurance team was very recently formed in the hospital. The post of quality manager was filled recently. The NABH indicators were started to be implemented as this study was carried out. The results are presented in terms of key indicators as mentioned in the methodology.

A. Initial assessment by doctors

The results revealed that of 30 case files, chief complaints and history of present illness were fond documented in a majority (93 per cent) of files. Dietary advice was found in 66 per cent case files followed by time assessment (63 per cent) and investigations advised (60 per cent) respectively. Vitals documentation was also found in about one-half of the files. None of the files had consultant's name, signature with date and time (Fig 1).

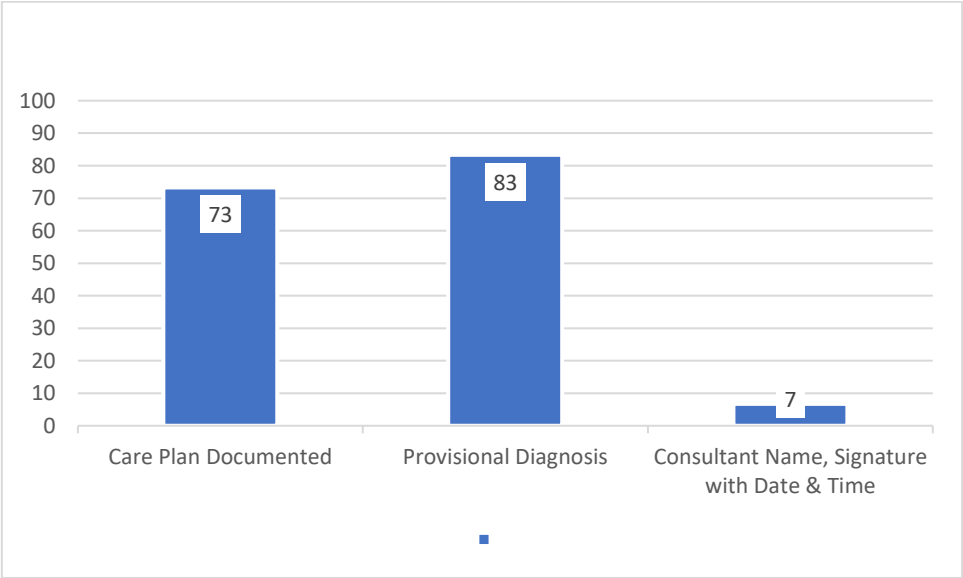
Fig 1: Percent Distribution of Case Files by Initial Assessment by Doctors



B Plan of care completed (by consultant)

According to Fig 2 it is very clear that consultants or doctors made provisional diagnosis in 83 per cent of the case files but care plan was found documented in 73 per cent of the files. A few (seven percent) files had Consultant's name, signature with date and time.

Fig 2: Percent Distribution of Case Files by Plan of Care



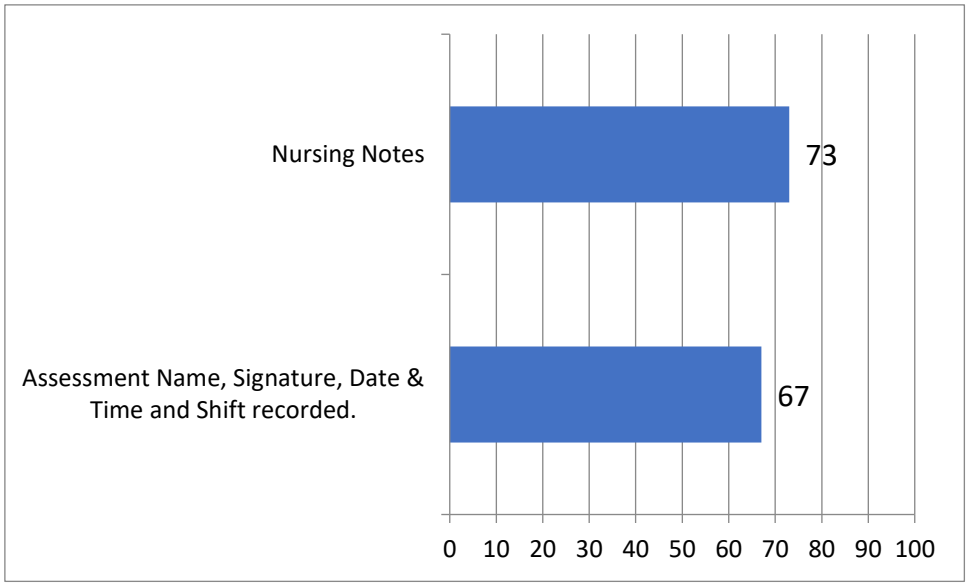
C. Nutritional screening

The results revealed that in 37 per cent files nutritional screening was recorded in terms of height, weight, body mass index, and diet prescription.

D. Nursing care plan completed 24 hours in hospital

Assessment staff name, date, time, signature and shift was found recorded in 67 per cent case files in relation to the nursing care plan which needs to be completed 24 hours in hospital. Nursing notes were observed in 73 per cent case files (Fig 3).

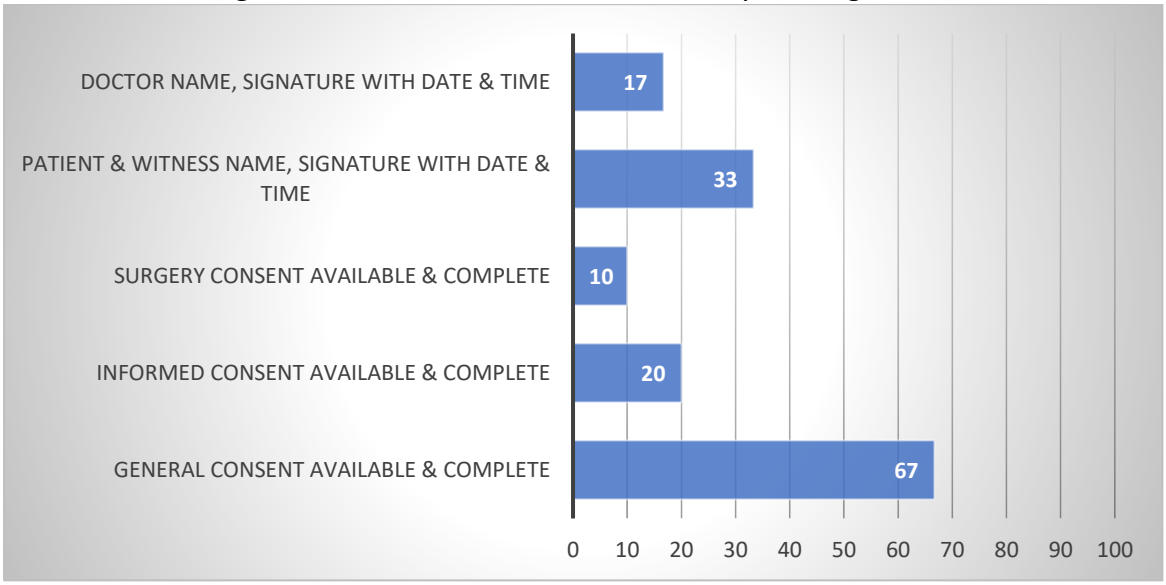
Fig 3: Percent Distribution of Case Files by Nursing Care Plan



E. Consent form

The Fig 4 shows that complete general consent was available in 67 per cent case files. In one-fifth of the case files informed consent was also available and found to be completed as well but surgery consent was found to be available in 10 per cent cases only. Patient and witness name, signature, date and time documentation was in 33 per cent case files. As mentioned above, in nursing care plan as well doctor's name, signature with date and time was available in 17 per cent cases only.

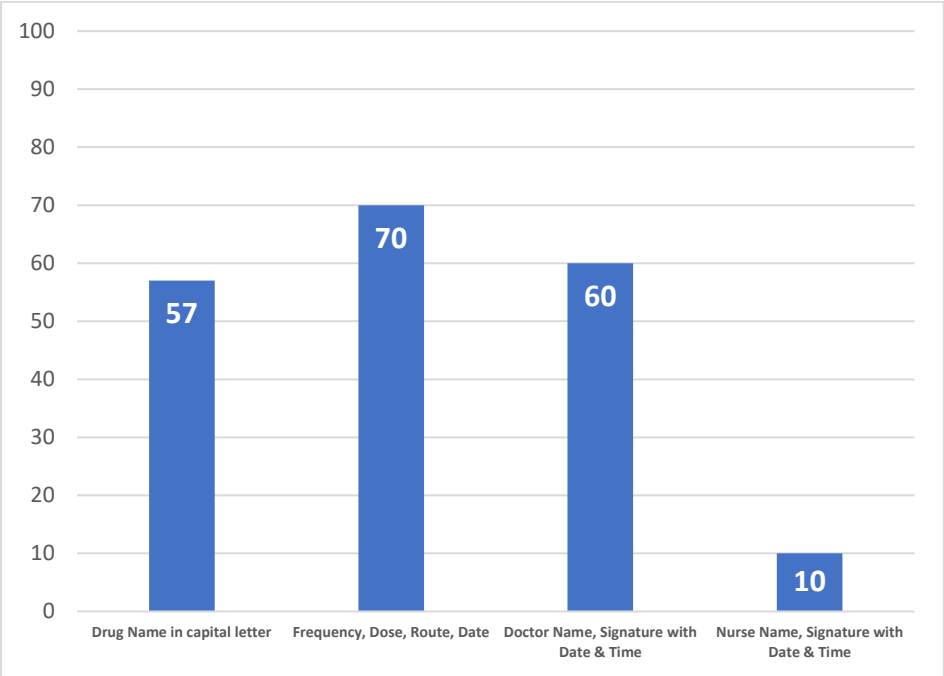
Fig 4: Percent Distribution of Case Files by Nursing Care Plan



F. Medication Administration Record

Of 30 case files, 57 per cent files had drug name in capital letters. Frequency, route, dose and time was also found recorded in 70 per cent files. On the contrary of above findings, doctor name, signature with date and time was found in 60 per cent case files but only 10 per cent files had nurse name, signature with date and time (Fig 5).

Fig 5: Percent Distribution of Case Files by Medication Administration Record



The results point out that the compliance to the NABH is partial. The doctors, nursing and nutritionist are complying to the indicators in most of the parameters. Some parameters such as consent form verification, doctors' signatures have extremely less compliance.

This type of non-compliance to verification of case file entries, making medication entries in small case letters and incomplete documentation of surgical and informed consent form could lead to adverse events or have medicolegal implications. Poor compliance to documentation of nutritional screening could also lead to adverse event.

Discussion

The fact that Shalby hospital, Jaipur is a large corporate hospital with more than 200 beds and an urban outreach makes one look at the adherence to NABH guidelines in a different light. The hospital has a brand image to maintain. At the same time, it is pitching for medical tourism as Jaipur is a favoured tourism destination. Hence, the strive towards NABH accreditation. There were some lacunae in compliance with NABH guidelines.

There was low rate of documentation by doctors and nursing staff. The low rate of documentation was observed in patient related vitals, nutritional status entry ,verification of case files ,nutritional screening and filling of consent forms. Deviation from the standard method of entry of medication in capital letters was also observed. All these areas of non-compliance could lead to generation of an adverse event. This would cause a major breach in patient safety practices. For example a patient with renal disease could get a high protein diet or a hypertensive patient could get a high salt diet which could lead to an adverse event.

Improper documentation of either surgical consent form or informed consent form could have medicolegal implications for the concerned doctor and organization.

Conclusion

Compliance with NABH guidelines is an external accreditation system to ensure patient safety and quality practices in the healthcare organization.

Adherence to the NABH guidelines is not very satisfactory in the hospital at present despite the hospital already undergoing pre assessment level NABH approval. The areas with better compliance were documentation of history taking with 93% compliance followed by provisional diagnosis with 83% compliance and documentation of plan of care with 73% compliance. Compliance with nutritional screening was also found to be poor.

Compliance was poorer in the document verification parameter than the others. Proper filling of the surgical consent form and other informed consent form was also complied with poorly. Prescription writing was another area with lesser compliance than the other.

Illegible handwriting could result in wrong dosage or wrong medication administration to a patient. This could result in an adverse event. Poor documentation of vitals could also lead to overlooking of the patient's critical condition. This could also result in an adverse event. Missing dietary advice by the nutritionist could result in wrong kind of diet for a patient, for example a patient with renal disease could get a high protein diet which could lead to an adverse event.

The results clearly indicate that the consultants ,nursing staff and other supportive staff such as dieticians need training in compliance with NABH guidelines. Regular training will improve the compliance of the healthcare providers with documentation of patient findings, nutritional screening, capitalization of medication names. The consultants should be trained in verifying the case files properly with their name, signature date and time. The nursing staff should also receive training for the same. Training should be imparted for proper filing and verification of consent forms.

This study highlights the status of compliance to NABH indicators in Shalby Hospital ,Jaipur. This highlights the need of a quality assurance department in the hospital on a regular basis and its effective functioning.

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