DISSERTATION

At

Shri Ram Murti Smarak Institute of Medical Sciences, Bareilly

Report on

Medical Record Review Audit as a Method for Developing Safe Patient Care

By

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PG/19/015

Health IT Management

Under the guidance of DR. B.S. SINGH

POST GRADUATE DIPLOMA IN HOSPITAL AND HEALTH MANAGEMENT

2019-21

International Institute of Health Management Research

New Delhi

COMPLETION OF DISSERTATION

The certificate is awarded to **Mr. Anmol Sharma** in recognition of having successfully completed his 3 months dissertation with effect from April 5, 2021 and has successfully completed his Project on **"Medical Record Review Audit as a Method for Developing Safe Patient Care"** At **Shri Ram MurtiSmarak Institute of Medical Sciences** in**Quality Assurance Department**.

He comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning.

We wish him all the best for future endeavors.

Nishi Bhardwaj

Organization Mentor

Miss Nishi Bhardwaj,

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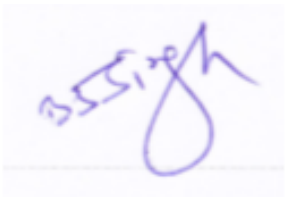
TO WHOMSOEVER IT MAY CONCERN

This is to certify that ANMOL SHARMA student of PGDM (Hospital & Health Management) from International Institute of Health Management Research, New Delhi has undergone internship training at SRMS IMS Hospital from 05/04/21 to 04/07/21.

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

The Internship is in fulfillment of the course requirements. I wish him all success in all his/her future endeavors.



Dr B.S Singh
Associate Professor
IIHMR, New Delhi

Mentor

IIHMR, New Delhi

Certificate of Approval

The following dissertation titled **"**Medical Record Review Audit as a Method for Developing Safe Patient Care" at **"SRMS IMS Hospital"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **PGDM (Hospital & Health Management)** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Name Signature

_____ _____

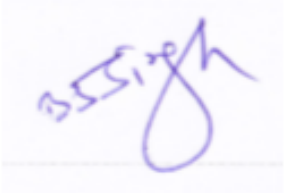
_____ _____

_____ _____

CERTIFICATE FROM DISSERTATION ADVISORY COMMITTEE

This is to certify that **Mr. ANMOL SHARMA,** a graduate student of the **PGDM (Hospital & Health Management)** has worked under our guidance and supervision. He is submitting this dissertation titled **"Medical Record Review Audit as a Method for Developing Safe Patient Care"** at "SRMS IMS Hospital" in partial fulfillment of the requirements for the award of the **PGDM (Hospital & Health Management).**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.



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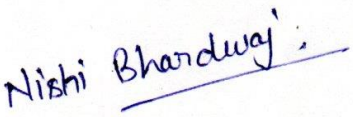


Miss. Nishi Bhardwaj

Assistant Manager

SRMS IMS, BAREILLY

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "Medical Record Review Audit as a Method for Developing Safe Patient Care" and submitted by Mr. Anmol Sharma Enrollment No. PG/19/015 under the supervision of Dr. B.S Singh for award of PGDM (Hospital & Health Management) of the Institute carried out during the period from 5th April 2021 to 4th June 2021 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Signature

FEEDBACK FORM

Name of the Student: Anmol Sharma

Dissertation Organization: SRMS IMS(Shri Ram MurtiSmarak Institute of Medical Sciences)

Area of Dissertation: Quality Assurance Department

Attendance:90%

Objectives achieved: Interprets and implements quality assurance standards in hospital to ensure quality care, Review's quality assurance standards. studies existing hospital policies and procedures, and interviews hospital personnel and patients to evaluate effectiveness of quality assurance program.

Deliverables: The Candidate had successfully completed research on Medical Record Audit for Developing Safe Patient Care for the hospital.

Strengths: Hardworking , Quick Learner.

Suggestion for improvement: He should learn more about NABH Standards 5th edition.

Suggestion for Institution(course curriculum, industryinteraction,placement,alumini): None

Nishi Bhardwaj.

Signature of the Officer-in-Charge/ Organization Mentor (Dissertation)

Miss.Nishi Bhardwaj

(AssistantManager- Quality AssuranceDeptt.)

Date:17/6/21
Place: Bareilly

ACKNOWLEDGEMENTS

My Institute - International Institute of Health Management Research (IIHMR), Delhi deserves the foremost appreciation for providing me the opportunities to understand my capabilities. I would like to thank one and all in the IIHMR team for providing me a platform for my professional career as well as for helping me boosting up all my capabilities and making me confident enough to work for health care organizations. I would like to thank Dr. Anandhi Ramachandran (Associate Professor) and Dr. B.S Singh (Associate Professor and Mentor) for their continuous support.

I acknowledge the tremendous contribution of my guide in completion of the project right from the word goes. I would like to render my sincere thanks to Dr. R.P SINGH (MEDICAL SUPRINTENENT) for providing me the opportunity to complete my dissertation. Also, I would like to express my sincere and deep thanks to Miss. Nishi Bhardwaj (Assistant manager) and whole quality team who helped me in every possible way and provided me best possible resources to complete my internship. I extend my words of thanks to all the staff for always being so cooperative and facilitating me. I am extremely grateful to my parents for their love, prayers, caring and sacrifices for educating and preparing us for our future. I'd want to offer my heartfelt gratitude and appreciation to the institute's personnel for their time and attention. My gratitude and appreciation also go to my class mates who assisted me in designing the project and to those who volunteered to assist me with their skills.

Finally, I'd want to express my gratitude to everyone who helped me accomplish the research work, whether directly or indirectly.

List of Contents:

List of Tables:

List of Images:

List of Graphs:

ORGANIZATION PROFILE

Shri Ram Murti Smarak Trust

In the years 1990, in commemoration of the memory of the Veteran Fighter for Liberty, real Gandhian, ex-parliamentarian, former U.P. Minister Late Ram Murti Ji, a Public Charitable Trustee, the Shri Ram Murti Smarak Trust was created.
The major purpose of the trust is to provide and promote engineering, technology, medicine, science and management training and research.
SRMS Trust aims to raise the masses regardless of colour, caste and faith.
enhancing health & medical education through promoting social values - social services via the promotion of technical and professional training Confidence social and charitable activities
Scholarships of Rs. 3 crores are available to deserving students.
50 exceptional students from India's premier institutes will be awarded an All India Talent Scholarship of Rs. 50 lakhs.
Since 1990, I've been debating and writing stories.
Eminent individuals are recognised with the Ram Murti Pratibha Alankaran Award and a monetary prize of Rs. one lakh.
Free Vocational Training in X-Ray, ECG Technician, Computer Hardware & Software, Machine Fitting, EPABX, Plumbing, Electrician, and Nursing Assistant Course for Underprivileged Youth
SRMS Hospital on Wheels provides door-to-door screening and treatment for blindness, deafness, diabetes, tuberculosis, malnutrition, hypertension, cancer, and support services for healthy mothers and babies.
SRMS Janhit Chikitsa Yojna for free treatment of six patients per day.
Rural Health Camps, Free Pharmacy, Free Cataract Eradication Program
Free 400 beds in SRMS Hospital as part of the government's NRHM (National Rural Health Mission) health programme.
Primary Health Care Centers in the SRMS
SRMS Samudayik Swastha Yojna costs Rs. 365 per year for a couple's treatment up to Rs. 50,000.
SRMS Charitable School, RTI Ladies Circle India
Health Education in the Community
Outreach Program on Campus

Scientific Test Series of the SRMS

Smart Class Room on Wheels
Institutions that use the SRMS Mobile Telemedicine Bus SRMS College of Engineering and Technology, Bareilly, was founded and is operated by the Trust.
Bareilly, SRMS College of Pharmacy -2000
Bareilly SRMS Institute of Medical Sciences Hospital - 2002
2005 SRMS Institute of Medical Sciences, Bareilly
Bareilly SRMS School of Nursing – 2006
Bareilly SRMS College of Engineering, Technology, and Research - 2008
Bareilly R.R. Cancer & Research Centre – 2008
2011 SRMS Institute of Paramedical Sciences, Bareilly
2011 SRMS International Business School, Lucknow
Unnao, SRMS College of Engineering & Technology – 2011
Lucknow SRMS Charitable School - 2015
SRMS Functional Imaging & Medical Centre, Lucknow – 2015 (Equipped with PET CT 3.0 Tesla MRI, dual Source CT Scan, Gamma Camera, Dexa scan, Digital Mammography, etc.)
Bareilly, SRMS College of Nursing - 2017
Bareilly, SRMS Goodlife (A Wellness Center) – 2018
Unnao, SRMS Hospital - 2018
2018 SRMS College of Law, Bareilly
Unnao, SRMS College of Nursing & Paramedical Sciences -2018
Lucknow, SRMS Step2Life (A Rehabilitation & Physiotherapy Centre) –2019

Shri Ram Murti Smarak Institute of Medical Sciences Hospital

Shri Ram Murti Smarak Institute of Medical Sciences (SRMS IMS) is currently a well-recognized leader in medical care, education, and research. Shri Ram Murti Smarak Trust created the Institute under the guiding principles of Shri Dev Murti Ji, Managing Trustee and founder, to honour and advocate his father Late Shri Ram Murti Ji's inspirational beliefs. A visionary and a missionary, respectively. The Trust's imaginative enthusiasm is to serve society as a whole by creating not just competent professionals, but also devoted doctors and better citizens who will contribute to society. The Institute is spread out across 30 acres of land in a spacious, pollution-free setting. It's on the 13.2-kilometer Bareilly-Nainital Road in Bareilly. Teaching, studying, patient treatment, and living are all possible on the campus. On July 4, 2002, Shri Ram Murti Smarak Institute of Medical Sciences opened its most modern 975-bed, centrally air-conditioned, Multi-Super Specialty, Tertiary Care, and Trauma Hospital. The hospital contains 600 teaching beds where students seeking their MBBS may be taught and trained. The care of patients on these beds is provided at no cost to them. The hospital is well-equipped to deliver high-quality education and training to students in a variety of departments. Students are exposed to a range of patients during their clinical training in order to become competent in the area of medicine. Students are also exposed to the behavioural and management abilities necessary to become a full medical practitioner in today's environment during their training.

When it was founded, the institution was the only medical centre in the region with the greatest range of medical specialties delivering superior medical services under one roof. The institute's mission has been to deliver world-class medical facilities to patients in need of clinical and diagnostic assistance since its beginnings. The institution has well-established Pre-Clinical, Para-Clinical, and Clinical divisions, all of which are staffed by experienced and certified doctors. Radiotherapy, Cardiac Sciences, Renal Sciences, Neuro Sciences, and Plastic Surgery departments are also fully operational. These departments see around 1200 patients every day in the OPD and have an average occupancy rate of 85 percent to 90 percent. Every month, over 200 cardiac interventional procedures, over 400 dialysis, over 50 radiotherapies, and over 600 major operations are conducted in various surgical departments.

Mr. Dev Murti
(Chairman)

Mr. Aditya Murti
(Director Administration)

Vision

- “To be partner in building India a world leader in Medical Education & Health care.”
- “To establish & develop world class self-reliant institute for imparting Medical and other Health Science education at under-graduate, post-graduate & doctoral levels of the global competence.”
- “To serve & educate the public, establish guidelines & treatment protocols to be followed by treating hospitals.”
- “To develop and provide professionally qualified doctors for augmenting the nations human resources through Bio-Medico-Socio-Epidemiological scientific research.”
- “To provide quality & affordable health care facilities and services to all sections of the society.”

Mission

- “To Strive incessantly to achieve the goals of the Institution.”
- “To impart academic excellence in Medical Education.”
- “To practice medicine ethically in line with the global standard protocols.”
- “To inculcate high moral, ethical and professional standards among students and to improve their overall personality as well as inculcate compassionate behaviour.”
- “To evolve the Institution to the status of a Deemed University.”
- “Our Students – Our Assets.”
- “Our Staff – Our Means.”

Values

- Integrity
- Excellence
- Fairness
- Innovativeness

Key Specialties:

OPHTHALMOLOGY
GENERAL MEDICINE
OBSTETRICS AND GYNAECOLOGY
PULMONARY MEDICINE
ORTHOPEDICS
OTORHINOLARYNGOLOGY AND HEAD AND NECK SERVICES
GENERAL SURGERY
PAEDIATRICS
DENTAL
PHYSIOTHERAPY
CARDIOLOGY
ONCO-SURGERY
PLASTIC SURGERY
UROLOGY
NEUROLOGY
GASTROENTEROLOGY
GASTRO SURGERY
NEPHROLOGY
NEUROSURGERY
RADIOLOGY SERVICES
SPECIALIZED LABORATORIES
EYE DONATION
NUCLEAR MEDICINE

1. Abstract

- The medical records department is owned by the hospital. A medical record for patient care services is a clinical, administrative and legal record. The record covers the patient's history, the physical condition, the examination, the therapeutic process. Indoor patients are informed of the appropriateness, quality and treatment. The medical audit is a systematic and careful review of the quality of current practise comprising diagnostic and therapeutic treatment methods, resource utilisation, outcomes and quality of life for patients, to improve the quality of care for patients. The issue of inquiry is: What is the present level of hospital staff practises for direct patient care when it comes to documenting hospital records? The study's main aim is to conduct a medical documentation audit on the hospital's medical records to improve the quality of healthcare in hospital; secondly, to identify the documentation practises for hospital medical personnel, and lastly, to compare the difference between compliance with patient records and standard hospital compliance. The goal of the research is to make sure all healthcare records are kept to the highest level while ensuring that the quality and accuracy of clinical records are continuously improved. In order to comprehend and identify the difficulties, the descriptive research was conducted. The location of the research was the Shri Ram Murti Medical Science Institute In-Patient Department, which took a total of two months to conduct the audit and to prepare the report. The obtained data were secondary, and the discharge cases in the medical records department were available. The usage of technical sampling is comfortable to sample. The strategy employed is to check the files and monitor the patient's medical records. To retain the quality indicators, a systematic checklist (audit tool) is employed. Approx. 400 case files sample size. IPD's Intensive Care Unit (ICU), Ophthalmology, General Surgery, Obstetrics and Gynecology, Pediatrics, Psychiatry, Medical Record Files, Download Files have been picked for their inclusion Criteria. Criteria for exclusion Because of covid-19, emergency and active files are excluded from the research. As well as the conclusions determined from the study, it has also been shown how vital it is that manuscripts are to be used with a computerized prescription and that the results show the performance of the different departments in the recording of records practices.

2. ABBREVATIONS

- NABH: - National Accreditation Board for Hospitals & Healthcare Providers
- QCI: - Quality Council of India
- HCO: - Health Care Organization
- MRD: - Medical Records Department
- NCR: - National Capital Region
- ENT: - Ear, Nose, Throat
- FGH: - Fairfield General Hospital
- ICU: - Intensive care unit
- CCU: - Critical care unit
- ITU: - Intensive treatment unit
- IPD: - Inpatient department
- OPD: - Out Patient Department
- IMS: - Intercontinental Medical Statistics
- BI- Business intelligence
- MLC-Medicolegal Case
- ICD-International Classification of Disease
- LAMA-Left Against Medical Advice

3. DISSERTATION REPORT

3.1 Introduction

Quality Assurance: All procedures that are part of quality assurance are analysis, evaluation, monitoring, assessment and testing. Quality is defined as doing all possible to fulfil and satisfy the aspirations and wants of people we represent, as well as doing things correctly the first time. Clinicians who prefer to assess their own (or their colleagues') findings do so as a means of objective reflection. Auditing is a sort of examination when it is done on a consistent and regular manner. An evaluation is a one-time measurement of the impact of a service on health indicators. Surveillance is a type of evaluation that is performed on a regular basis. An evaluation is the collection and examination of ad hoc data about healthcare provision by administration. Continuous assessment is monitoring. Quality management is to ensure that qualitative standards are met. There may be a multiple purpose of a quality assurance programme, each of which may differ. A quality assurance programme can help avoid issues, diagnose and repair such problems, and encourage higher standards of healthcare in order to achieve its aims. They can try to eliminate or rehabilitate the poor, increase the average level of practise, reward greatness, or employ a few of those aims. In a quality assurance programme, the procedures utilised can be as highly focussed as the detection and response to specific patient and physician isolated occurrences such as surgical disorder.

Quality in healthcare defined in different ways.

"Quality" in healthcare services means all the medical organizations that are committed to meeting their customers' demands, be they the patient, payer, admitting physician, employer, or internal customer.

"Quality at the correct moment does the right things for the right people and always does them well."

Quality may include technical care quality, non-technical services such as the wait time of the customer and the attitude of the personnel, as well as programmatic components such as policy, access, infrastructure and management.

Quality Management: Quality management is the element that defines and implements quality policy in the overall management function. It comprises strategic planning, distribution of resources and other quality systematic actions such as quality planning, operations and assessments.

Dimensions of quality

Technical performance: the extent to which healthcare staff and facilities fulfil technical quality expectations (i.e., adhere to standards).

Efficacy: the extent to which care outcomes are obtained. Effectiveness:

Efficiency: The ratio of service output to related service production expenses.

Access: the level of geographical, economic, societal, organizational or language obstacles to which health services have been unrestricted.

Interpersonal ties between the providers and customers: trust, respect, secrecy, cortesy, sensitivity, sensitivity, good listening and communication.

Amenities: physical look, cleanliness, comfort, privacy and other characteristics vital for customers.

Relevance: Client choices, insurance plans or treatments as suitable and practical.

Choice: Customer choice, insurance plan, or treatment, as suitable and practical. The physical appearance of the facility ,comfort, cleanliness, privacy, and other aspects that are important to clients.

Quality management principles in healthcare

Principle 1 - Focus on patients: Our healthcare system depends on patients and therefore should comprehend the patients' present and future needs, satisfy the demands of patients and seek to surpass their demands.

Principle 2 — Leadership: Leaders build an organization's unity of purpose and management. They must develop and maintain an internal climate in which individuals may actively participate in attaining the goals of the business.

Principle 3 – Employee participation: The essence of an organisation is people at all levels, and their full participation allows their strengths to be utilised to benefit an institution.

Principle 4 – Process approach: When operations and related resources are handled as a process, a desired outcome is attained more effectively.

Principle 5—Management System approach: The identification, understanding and management of connected processes as a system helps the company achieve its objectives effectively and efficiently.

Principle 6 - Continuous improvement: the organization's permanent goal should be a continuous improvement of its entire performance.

What is quality exactly?

There are several ways of describing healthcare quality.
In healthcare the term 'quality' is stated as a whole, whether that client is a patient, a payer, an admissible doctor, an employer and an internal customer, in order to satisfy the client's demands.
"At the appropriate time, and every time and every time, to do the best with the appropriate people," is how quality is stated.
Quality may contribute to the technical quality of care and nontechnical components of the provision of services like the waiting times of the client and the attitudes of workers..

Quality Assurance teams aim to meet the increasing needs of customers for quality of service.
• Help patients improve their treatment standards.
• To assess the competence of the medical workers to be an incentive to keep up to date so that any errors may be avoided.
• Pay attention to the problems and aid in correcting the issues responsible for the hospital administration.
• Help in legislative function.
• Restricting unwanted operations.
• Lower medical error number.

Medical Records

The Department of Medical Records focuses on patient care documentation. It does not immediately deal with reviews or standards of care offered to real therapy. The department of Medical Records assists several medical staff committees through the provision of medical record data to ensure that all professionals comply with patient care documentation rules. In order to give crucial information to conduct research, statistical data on the use of hospital services, mortality and morbidity profiles, and to assess the performance of clinical facilities, Medical records play a significant role in the operation of any hospital. There are certainly many things to come in terms of quality services for the patient, which are carefully structured and handled in the Medical Records department. The hospital or medical practitioner's medical records should be held. It is confidential and cannot be shared without the patient's permission. All patients are entitled to access and receive a copy of their records As long as the patient has signed records for accompanying any application from the legal representation, the legal representative of the patient is entitled to such documents. Other medical care providers are entitled access patient records if they participate directly in patient care and treatment. Minor parents also have access to medical records for patients In specific circumstances such as road traffic accidents, medical malpractice, insurance claim etc., the medical records are typically requested before the courts For research reasons impersonal records were utilized as the identity of the patient is not disclosed. Although the name is not divulged, the research team remains secretive to patient records and is concerned that the information is secret. The necessity to govern medical research has recently been realised to effectively limit the way this sort of study is conducted. For the use of patient data an ethical evaluation is needed Record Management Problem The institution/hospital has several issues to maintain the records properly. The outmoded form must be constantly revised

Maintenance staff trained at all times are required. Storage of inactive records at a suitable place is required. Record retention needs to be determined. Destroying the unwanted records Storage records include two steps. A. Removal of records that are active to an inactive file. B. Unimportant records are destroyed and disposed of. The paper documents may contain various types of hazards such as old-age paper, color changes from white to yellow may be present, dirt and dust may be present, insects and fungal products are a major hazard to records, when paper is folded down, dampness and water leakage may be weak in the plating, and even destroy the paper. Medical records are properly preserved Collect and categories all the records according to the various paragraph.

What is case file?

A case file is referred to as medical papers detailing a medical condition of a patient, clinical observations, laboratory test results, pre- and postoperative treatment, progress and medications. Taking notes accurately, the doctor will decide if the treatment is appropriate or not. India is likewise in its infancy as regards its appreciation of the need of proper record keeping. The health care provider and the patients benefit from a strong medical record. It's crucial to properly document the patient's therapy for the prescribing doctor. It has become a discipline to keep medical records. For all medical negligence cases, the accuracy of patient reporting is vital. The doctor can only verify the surgery correctly by keeping track of it. The only dependable source of information are frequently medical papers.

What is Case file audit?

In simplest terms, case or medical file audit is a record analysis that identifies what is being performed properly and what needs to be improved. Medical report audits may be conducted by an impartial body or by employees of an organization, depending on the goal. External audits are often undertaken to assess existing treatment procedures to measure continuity of care, although third-party audits are typically performed to review enforcement. The approach aims to enhance patient care and results by systematically reviewing treatment against clear standards/criteria and making any practical modifications if necessary. The medical record enables the doctor and other health professionals to examine and plan for the immediate treatment of the patient and to follow through on their medical care.

From chapter 10 of NABH 5th edition accreditation:

Information Management System (IMS)

Its aim is to guarantee that the appropriate information is made available to the appropriate person at the right time. Management of the information system in hospitals involves management of all information modalities that employees, patients, visitors and the public in particular interact. A true and clear medical record is maintained for each patient by the organisation. The organisation is successful in dealing with several areas of the medical record such as contents, employees authorised to enter and record retention. For approved care providers, the health records is available. The medical files are checked regularly. The administration of data and information must be focused towards meeting the needs of the organisation, supporting great patient care. Verified, secure and accurate provision of the information requirements at the correct time and location. Privacy, integrity and safety of records, data and information are preserved. Preserved medical information confidentiality is crucial and is protected across all platforms for processing information, storage and distribution. Material management also comprises frequent assessment, evaluation and withdrawal of outdated information to ensure that employees, patients and visitors do not become confused. This chapter talks about the importance of medical record keeping and also with the help this chapter any hospital can follow the stated standards in this chapter and apply it to achieve desired goals and have good medical record keeping practice.

3.2 Literature Review

Today in India every hospital has an aim to get an NABH accreditation, NABH 5th edition talks about the hospital should carry out review of medical records, in NABH 5th edition in chapter-10 it was mentioned that medical records should be reviewed at regular intervals.

Standard IMS.7-Medical audit (The organization carries out a review of medical records.)
Core a) “The medical records are reviewed periodically.”
(Should be defined by HCO, Active daily basis, Passive monthly basis)
Commitment b) “The review uses a representative sample based on statistical principles. “
(simple random, sample size based on discharges, total number of in patients)
Commitment c) “The review is conducted by identified individuals. “
(Ex: MRD technicians, Quality team members etc)
Commitment d) “The review of records is based on identified parameters.”
(Timeliness, legibility, completeness)
Commitment e) “The review process includes records of both active and discharged patients.”
Commitment f) “The review points out and documents any deficiencies in records.”
(Missing forms, in complete operation notes, absence of signature, date, time, name)
Commitment g) “Appropriate corrective and preventive measures are undertaken.“
(Preventive actions shall be informed to the relevant staff)

Verma, S., Midha, M., & Bhadoria, A. S. (2020) [1]. "Facts and figures on medical record management from a multi super specialty hospital in Delhi NCR" it is a study of the medical records department of a multi super specialty secondary care hospital in NCR. In this work, primary data was acquired by direct observation and retrospective study of MRD documentation. The quality control section acquired secondary data from books, journals, academic publications, and the internet. Methodology that is used in the study is descriptive analysis in this study they found that the hospital has released an extensive medical records handbook that includes the goal, the scope, the hierarchy structure, the job description, the regulations, the procedures, and the processes. The MRD has a well-documented medical record flow mechanism, however after examining the flow of patient data from November 2016 to February 2017, it was discovered that only 276 files were received in MRD in November 2016, with 0.72 percent of files not being received. Furthermore, 71 patients (23.67 percent) needed over 31 days to get files in MRD. Only 237 files were received in MRD out of 286 patients released in January 2017, compared to 10.14 percent files not received. Furthermore, 28 patients (9.80 percent) required over 31 days to get files in MRD. Only 206 files were received at MRD in February 2017, out of 268 patients released, and 22.39 percent of files were still missing as of March 11, 2017. The results from this study indicate that, after release of patients, there is no effective monitoring/tracking method to monitor the data from ward/billing to MRD.

Mr. AO Alalade, Dr. Neha Jinsiwale and Anuradhai Arungunasekaran. (2020) [2]."Improving the Quality of Clinical-records: Audit and Literature Review". Research paper talks about that Medical records are comprehensive records of a patient history and treatment. Medical records are essential for communication between health care providers, as well as patient safety and treatment continuity. They are records that are used to defend patients who have filed complaints or allege clinical negligence. paper concluded that Medical records are critical medical or legal papers that are required to provide patients with adequate health care. It is critical to adhere to standards in order to demonstrate that patients receive acceptable treatment. These also give information for scientific research and quality-improvement efforts. Every health care practitioner has a responsibility to keep accurate medical records.

Azzolini, E., Furia, G., Cambieri, A., Ricciardi, W., Volpe, M., & Poscia, A. (2019) [3]. "Quality improvement of medical records through internal auditing" in this research paper author's talks about the importance of internal auditing of medical records, it was also mentioned in the paper that importance of assessing the quality of medical records cannot be overstated. Also, it is the first research to examine the effectiveness of internal audit as a technique for improving medical record quality in a hospital context. The programme was conducted out in a third-level teaching hospital. Using a random sample technique, two retrospective evaluations of the quality of medical records were performed by trained ad hoc review teams. A 48-item evaluation grid split into 9 domains was used to measure quality: Patient Medical History and Physical Examination; Daily Clinical Progress Notes; Daily Nursing Progress Notes; Drug Therapy Chart; Pain Chart; Discharge Summary; Informed Consent; General; Patient Medical History and Physical Examination; Daily Clinical Progress Notes; Daily Nursing Progress Notes; Drug Therapy Chart; Pain Chart; Discharge Summary; Surgical Record; A departmental audit system was devised after the first evaluation of 1.460 medical records. Following the internal auditing of 1.402 medical records, the second evaluation was performed. And When compared to the first analysis, the second study revealed a considerable improvement in all parts of the medical chart, with an increase of all scores

above 50%. The differences revealed between the first and second analyses for each component of medical information are significantly significant (p0.01). the study concluded that Internal audits are not merely measures, but also important to help the business meet its targets and assess the quality of clinical treatment and achieve high professional performance.

Danladi Garba, Kabiru & Yahaya, Idris. (2018) [4].”SIGNIFICANCE AND CHALLENGES OF MEDICAL RECORDS” the paper stated the importance of medical records in any particular hospital cannot be overstated; they are the key instrument for achieving maximal goals, and they are equally helpful to patients and healthcare professionals. Medical records are a critical component in ensuring that hospitals function smoothly and efficiently. They aid clinical decision-making, offer documentation of policies, and assist hospitals in litigation. The importance and problems of medical records in general were revealed in this research. The necessity of information for the proper treatment of all patients is self-evident. The real cost of gathering data to assist hospitals is not always quantifiable, and its worth in this scenario is unquantifiable. As a result, medical records are necessary to guarantee that patient information is stored and used in a systematic manner. The paper concluded that the necessity of information for the proper treatment of all patients is self-evident. The real cost of gathering data to assist hospitals is not always quantifiable, and its worth in this scenario is unquantifiable. the goal is to offer better treatment for the patient by meticulously recording every aspect of his or her condition.

Singh, Prerna. (2018) [5]. “Analysis of Health Record Documentation Process as Per the National Standards of Accreditation with Special Emphasis on Tertiary Care Hospital"The aim of this research is to analyse gaps in patient file documentation and evaluate patient file conformity rates for surgery versus medical patient records. And second to assess the patient file documenting procedure in accordance with the National Accreditation Standards. The research was carried out at Delhi's X Hospital. There was a total of 200 patient files and the major data were collected in the nursing, nursing and crucial areas by validating patient files. Following that, a documentation review audit was created (in accordance with the NABH target elements) that took into account the critical features of documentation in health records. The files were checked with the parameters in the audit tool. Three possibilities were presented for the assessment of compliance: complete compliance, partial compliance and non-compliance. The compliance percentage (percentage) was then calculated for each medical record form. Data were examined and evaluated as well as serious non-compliance with the NABH criteria were reported to doctors, nurses and paramedics. Advice has also been given. This aided in lowering the proportion of noncompliance. This article found that the medical record follows patient care systematically and is an important part of the quality of therapy. Interactivity and continuity of treatment between physicians and other patient care workers, Precise and cautious requested auditing and payments, extensive analysis of regularity and quality of care, assessment and collection of data relevant for research and education. A carefully drafted medical record can ease many of the problems associated in the filing of claims and can, if required, even act as a legal document to support the care provided.

Singh, Madhav & Patnaik, Saroj & Sridhar, Bhandaru. (2017)[6]”Medical Audit of Documentation of Inpatient Medical Record in a Multispecialty Hospital in India”. The article discusses the medical records that enable healthcare workers to arrange and evaluate

treatments for the patient. Search was carried out at a multi-specialty hospital to conduct a medical examination of medical records to evaluate whether the actual documenting approach complies with the policy. The objective of this article is to audit the hospital medical records of a multispecialty facility for medical purposes. Determine whether the present documentation technique complies with hospital policy. And to Identifying the gaps in the same and proposing some potential remedies the research's design is a descriptive research. The research area includes medical stations, gynaecology and obstetrics ward, surgery station, ear, nose and throat station, eye ward, paediatric station, skin ward and psychiatric station. All hospital medical data for selected wards for the previous 12 months were systematically sampled randomly. Thirty-two case sheets were sampled, 40 of each department. The information collected was primary and source of release was for less than 12 months in the Medical Records section. This was a quantitative method to data collecting. Survey and observation approaches were applied. An organised checklist with 26 checklist elements, with few of the quality indicators as a standard used during the research. Findings were that Gynaecology and paediatric records have not been confirmed to be suitable. Findings from the paper is that the recording of psychiatry and dermatology was considered appropriate in accordance with the policy given out. Care in the surgical department was not planned according to the established routine.in conclusion Medical records are official documents which are technically valid and should include a complete description of care data or contact info for each patient. Medical records at hospitals are highly vital and crucial. These documents are essential for legal and future planning of hospital medical care

Farooqui, Iqbal & Pore, Prasad & Doke, Prakash & Kumar, Amit. (2017) [7].”Change in completeness of medical records after NABH process in a teaching hospital”. Researcher talks about Comprehensive therapeutic records are the bedrock of the quality and productivity of long-term care during hospitalisation and subsequent follow-up visits, since they can provide a complete and accurate chronology of drugs, events, and future care plans. A poor therapy record might indicate a lack of resources and fragmented clinical treatment. It can also be used to support claims of irresponsibility and extortion. The aim of the study is to investigate the integrity of medical records in relation to the necessary fields that should be included further, evaluate every department in respect of record completeness. Last to Assess and analyse the completeness of medical records before and after a procedure. In the end a total of 340 IPD data were examined, with 170 in each of the three groups. The completeness of IPD records was determined to be 78.75 percent in September, pre-intervention, and increased significantly to 87.75 percent in December, post-intervention (p-value 0.01). The completeness of records rose from 6.5 percent to 45.7 percent, according to Wong et al. After intervention, Dima et al found a 73.6 percent increase in completeness. The pre- and post-intervention periods were separated by ten months, whereas our trial had a two-month separation. According to Owen et al, discharge reports had the highest percentage of completeness (44.4%), while admission notes had the lowest percentage (22.9%). last thoughts the completeness of medical records at the hospital is improved through a few initiatives related to NABH accreditation.

Esposito P, Dal Canton A. (2014) [8]. “Clinical audit, a valuable tool to improve quality of care: General methodology and applications in nephrology”.in this article author talks about the importance of clinical audit, the assessment and improvement of the quality of care delivered

to patients is critical in everyday clinical practise as well as in health policy planning and finance. Various tools, such as event analysis, health technology evaluation, and clinical audit, have been created. The paper concluded that the Control, and hence the proper allocation of resources, is becoming a critical concern in the administration of Health Care Systems. The research shows that awareness of the clinical audit must continue to be extended and its methodical execution encouraged both nationally and locally to become a feature of the expertise of each health professional, along with other quality improvement initiatives. It is important to understand from the study that clinical auditing is an integral part of the continual improvement in quality. The comparison of clinical practise and standards results in the formulation of initiatives aimed at improving the quality of daily care.

Raza, Maiedha. (2012) [9].” Good Medical Record Keeping”. The paper talk about Good medical record keeping is essential in clinical practice. Medical notes are not only valuable as learning tools, but they are also necessary for patient safety and communication between the members of a multidisciplinary team in medical and legal circumstances. The General Medical Council wishes to maintain 'excellent' notes in a clear, chronological, and exact order. The General Medical Council. The main aim was to assess retention of medical note according to the recommendations that have been set. The method utilised is a modern assessment with 100 percent accuracy as standard of the stable medical records of Fairfield General Hospital (FGH). A poll was also conducted with perspectives on medical recordkeeping. The findings were Three of the KPIs (written date, patient name and hospital numbers) reached 100 per cent, improving standards throughout the three audit cycles. The poll shows that 60 percent of the cohorts did not read the regulations for note-keeping and did not appreciate the quality of their medical notes. The paper concludes that studies show that there is scope for improvement for medical note keeping, and audits can assist boost standards. It also emphasises the necessity to make progress in teaching medical care to doctors.

Bali, A., Bali, D., Iyer, N., & Iyer, M. (2011) [10].” Management of medical records: facts and figures for surgeons” the main objective of this study is Maintain accurate surveillance Medical investigation Cases of insurance, medical malpractice, payment for workers, and criminal cases. medical/dental, paramedical or other schooling. For medical and statistical auditing, the various element of record maintenance has been explained. Medical records are one of the main aspects on which virtually every medical-juridical fight is won or lost. If appropriately stated, the physician receives a notice that the therapy is right. Despite being aware of the necessity of retaining the record in India, it is still in the early stages.in conclusion the research concluded Medical records play a key role in the care of patients. For two essential reasons, it is necessary for the physician and the health care system to keep patient records correctly. Firstly, it assists the patient to assess properly and to organise the protocol for their therapy. Secondly, in situations of medical malpractice, the judicial system is mostly based on documentation proof. Medical records should thus be written appropriately and maintained in accordance with the patient's and the doctor's interests.

Thomas J. (2009) [11]. “Medical records and issues in negligence” in his Research indicated different record-keeping systems. The manual procedure involving books and papers is the conventional technique of record keeping adopted in most hospitals across India. Manual record keeping has major constraints, including the necessity for extensive storage space and

problems with records recovery. However, it is legally more acceptable as documentary proof since records without detection are difficult to manipulate. The Medical Council of India Regulations of 2002 the subject of medical record keeping was addressed and answers numerous medical record problems. The key concerns addressed are, keep interior records for three years from the start of therapy in standard proforma (Section 1.3.1 and Appendix 3) second, Patient or approved attendant requests for medical records and documentation should be recognised and published within 72 hours (Section 1.3.2).third, Keep a register for certificates with full medical certificate information issued with at least one patient identity mark and signature (Section 1.3.3).last Computerized medical records for rapid recovery should be made (Section 1.3.4).in this article he also talks about summoning of these medical records in the court he mentioned about that Medical records can be accepted as revised in 1961 by the Court, pursuant to Section 3 of the Indian Evidence Act of 1872. These are deemed helpful evidence by the courts since the evidence is acknowledged to be authentic and unbiased during a patient's treatment. There is no legal value for medical records written after a patient's discharge or death. The whole line should be marked and reprinted with date and time in the case of revision. Medical record keeping is a specialised field in larger teaching and company hospitals with individual officers in medical records dealing with these problems.

Gurudatta. S. Pawar, Jayashree.G. Pawar (2009) [12] “Facts of Medical Record Keeping - The Integral Part of Medical and Medico Legal Practice”. It was mentioned in the paper that Medical records are an essential component of any medical practise or career. These records are crucial for the doctor, the patient, and society at large, especially in instances such as medical crises, negligence cases, and medical research. They assist the treating physician in proving that he or she utilised adequate care and competence while treating the patient in today's world of consumer awareness and lawsuit suites. The role of the responsible doctor is to maintain and preserve them in an appropriate and systematic manner. They also provide a medical record for the part of the province and the country as a whole, which is essential for formulating health policy. Data may be made available to the treating clinician immediately, which can save lives in critical medical situations such as medication hypersensitivity and unresponsive patients. Furthermore, in this digital age, every effort should be taken to computerise medical records that are reasonably well safeguarded for the sake of security and retrieval. Eliminating paper-based documents will save space and time. Keep in mind that having accurate and well-maintained documents can save you from problems and claims. not just once, but on a regular basis.

3.3 Methodology

Each file should be revised in accordance with the NABH standards and each file consisting of patient information, the patient health record. Patient medical records are obtained from hospital. A list of tests is used in order to analyse the entire patient report and the checklist includes standards defined by NABH that are checked on the basis of an observation audit, after the analytical lacuna identified during the examination is detected, as well as suggestions to improve the quality of treatment at Shri Ram Murti Smark. Two months of study time are used, 400 files are collected and analysed by checklist, 1 was awarded for each complete parameter and 0 was provided for the incomplete parameter. The maximum scoring for a single file can be 12 because the main checklist has 12 specified parameters. In addition, the completion percentage determined using the simple percentage calculation approach is complete for observing the number of case files. Finally the final product was drawn with the help of the Power BI application. And after the audit is completed the results will be drawn.

Data and Methods:

Study Design: Observational Cross-Sectional Study

Study Area: Study was conducted in SRMS IMS HOSPITAL

Sampling Method: Convenience Sampling.

Duration of the Study: 2 Month (5-04-2021 to 4-06-2021)

Tool: Observation & Checklist

Sample size:400 discharge case files.

Serial No	Parameter
1	Face sheet
2	Admission advice form
3	OPD prescription vitals information
4	OPD prescription Drug allergy
5	OPD Prescription medication in capital letter
6	IPD prescription Medication chart of nurse in Capital letter
7	IPD prescription Treatment/progress record
8	Plan of care properly written
9	Overall prescription in capital
10	Nursing assessment form
11	Staff hand over record
12	MRD IPD checklist

Table1:Key Parameters selected from Checklist:

Case files must contain all these documents:

1. Face Sheet:

A face sheet is a paper that summarizes the details of a patient quickly. Patient preferences and preferences, together with contact information, a brief medical history and the degree of functioning of the patient may be shown on the face sheets.

2. Admission Advice Form:

The grounds for the patient being admitted to the hospital or other hospital, the baseline state of the patient and the initial directives for the patient's treatment are all recorded in admission notes. On-service notes, progress notes (SOAP notes), pre-operative notes, post-operative notes, procedur notes, postpartum notes and discharge notes are instances of the medical practitioners' usage of these notes.

3. General Consent Form:

A paper signed before the medical procedure by a patient confirming that the patient accepts the procedure and is aware of any possible dangers. The major objective of the permission form is to demonstrate that the operation has been accepted by the patient.

4. Consent for Surgery/Operation:

Surgical consent is defined as giving your doctor permission to operate on you, and it is not always in writing. It is considered a criminal offence if this consent is not given for a surgery. Informed consent goes beyond general consent because it includes being fully informed of all potential consequences that may arise during the procedure. To perform any surgery, a physician requires both types of consent.

5. Consent for Administration of Anaesthesia:

The anaesthesia provider must get informed permission for anaesthesia since he is the only one who can deliver the relevant anaesthetic information and explain the dangers involved. The anaesthesiologist may document it with a handwritten note on the surgical consent form or on a separate anaesthesia consent form.

6. Consent for Minor Procedures/Invasive Investigation:

The patient must express his willingness for the invasive investigation and the doctor must obtain consent from a competent patient after explaining what he is going to do and the implications of what he is going to do.

7. Investigation chart

A patient's investigation chart contains information like as demographics, vital signs, diagnoses, prescriptions, treatment plans, progress notes, difficulties, vaccination dates, allergies, radiological pictures, and laboratory and test results

8. Initial Assessment Sheet including Plan of Care

Initial assessment defines as al actions that contribute to identifying the patient's current clinical status, including history collection, physical examination, and laboratory testing. And it should include plan of care sheet for the patient

9. Treatment and Progress Record

Treatment records comprise any documents, including test results, pertaining or resulting from or related to the patient's medical treatment, history or condition, in a hospital or in a laboratory, invoice, billing or other documents.

Progress notes serve as a written record in patient care, enable medical professionals to compare the previous status with present status, to provide results, views and plans

for doctors and other staff members and to provide retrospective assessment of case information for various parties.

10. Pre-Anaesthetic Check up

The process of clinical examination that occurs before the administering of anaesthetic for surgical and nonsurgical procedures is known as pre-anesthesia checkup. The major objectives of this work is to analyse, diagnose, and treat known and undiscovered co-morbidities that directly or indirectly impair patient perioperative care.

11. Preoperative order

It is a series of questions and assessments that must be completed as part of your safe care prior to surgery. What can I anticipate? On the day of surgery, your nurse in the Preoperative Holding or Preparation room will make sure that you have completed all of your obligations.

12.Surgical safety checklist

A surgical safety checklist is a way for a team of operating room workers (nurses, surgeons, anesthesiologists, and others) to communicate and discuss essential facts regarding each surgical case.

13. Dept. of Anaesthesia (Anaesthesia Record)

The anaesthetic record is a chronological record of the events that occurred during the patient's treatment. It's a lasting record of what happened. It acts as a permanent record of the anaesthetic and how the patient's physiologic reactions were induced. The anaesthetic record is a "page in the clinician's textbook" where he or she records the unique account of one patient's treatment.

14. Post- Operative Orders by Anaesthetist

Postoperative care is regarded as the treatment you receive after an operation. The type of postoperative care you need depends on the kind and medical history of the operation. The treatment of pains and wounds is often covered. Postoperative care starts immediately after surgery. The doctor is responsible for these orders.

15. Operation Notes

is a crucial document that documents a patient's procedure, what was discovered during sur gery, and the surgeon's post-operative recommendations

16.Postoperative care

The treatment you receive following a surgical treatment is known as postoperative care. The sort of postoperative care you require is determined on the procedure you underwent. And these orders are given by physician.

17.Vitals Chart

Vital signs replicate essential body functions, as well as your heartbeat, respiratory rate, temperature, and blood pressure. Your health care supplier might watch, measure, or monitor your important signs to envision your level of physical functioning.

18.Sugar Chart

A blood sugar chart shows you how to keep your blood sugar levels in check throughout the day, especially before and after meals. They enable clinicians to set goals and track the progress of a diabetic treatment plan.

19 Intake/Output Chart

The intake and output chart is a method for documenting and sharing information on the following subject matters: Whatever the patient consumes, particularly fluids, whether or not through the gastrointestinal system (enterally) or intravenously (parenterally) Whatever the sufferer excretes or gets rid of.

20-medication sheet

A medication sheet is a legal record of the pharmaceuticals given to a patient by a health care practitioner at an institution.

21-venous access documentation

Any means of entering the circulation through the veins to give intravenous therapy (e.g., medicine, fluid), parenteral nourishment, acquire blood for analysis, or offer an access point for blood-based therapies such as dialysis or apheresis is referred to as venous access.to keep record of it we use venous access documentation

22-Nursing Assessment Form

A nursing assessment form is used by registered nurses to evaluate patients and their symptoms.

23-Nursing Care Plan

A nursing care plan includes all pertinent information concerning a patient's diagnosis, treatment objectives, and nursing instructions.

24-Nurses Record

Nurses' records on the nursing care given to the patient, including their assessment of the patient's progress.

25-Investigation Flow Chart

When patient in ward and he went for different test ,all those records will be recorder and written down as investigation, and in a sequential manner

26. Nutritional Assessment and Reassessment Form

The systematic process of collection and evaluation of data to conclude that an individual's influence is known as the nutrition assessment, concerning the type or cause of nutritional health issues. A qualified clinical dietitian will periodically examine nutritional needs to identify changes in the state of the patient and reactivity to nutrition management.

27. Investigation Report-

When a formal complaint is filed or an event happens, an investigation report is a document that outlines the results of the inquiry. This is where the investigators keep track of the concerns, assess the evidence, and come to a decision.eg: lab, Xray, CT Scan, USG, ECG etc.

28. Discharge summary

A report commissioned by a hospitalised patient's attending physician that outlines the admitting diagnosis, diagnostic procedures conducted, treatments received while hospitalised, clinical course while hospitalised, prognosis, and plan of action following discharge with specified time to followup.

29. Nursing staff shift hand over record

Each patient's bedside receives a handover, which includes patients, parents, and caregivers. The nurse who is now responsible for the patient's care passes the baton to the nurse who will be responsible for the patient's care in the future.

30.patient referral/transfer request form-

During an emergency call to a facility or a patient transfer between health care institutions or programmes, the Transfer Form is used to provide important, accurate clinical patient care
information.

31.death declaration certificate

The most often issued certificate is medical death certificate, usually referred to as the death certificate. A doctor, a medical examiner or a coroner can make a statement. After the death of a patient.

32.death summary

The Discharge Summary becomes a Death Summary when a patient passes away. Transcribing a Death Summary may be difficult, especially when the death is plainly unexpected and involves a kid. The dictator's tone of speech often reveals sorrow, whereas the doctor is more matter-of-fact about it in other circumstances. Death Summaries, thankfully, are one of the less prevalent report kinds. Only the sections Final Diagnoses and Hospital Course should be included in the death summary. The dictator will occasionally deliver a narrative description with no headers.

33. MLC report

In all medicolegal instances, a doctor prepares an injury report (wound certificate, medicolegal certificate, medicolegal case [MLC]). A medicolegal report is a type of injury report.

34.consent for moderate sedation-

The goal of this document is to provide patients the chance to understand and consent to conscious sedation

35.high risk consent (if applicable).

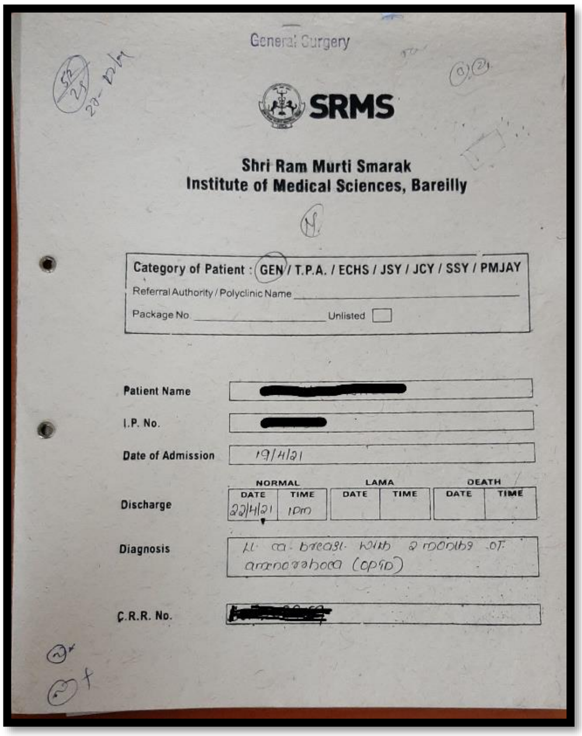
A high-risk informed consent procedure ensures authentic informed consent in difficult instances while also providing some protection for the surgeon, powerfully connecting professional duty with justifiable self-interest.

36.blood transfusion consent (if applicable)

Only after supplying information is a formal consent in the language that the patient / receiver understands best obtained. the dangers of red blood cell and plasma transfusions, as well as alternatives apprised about the advantages, hazards, and alternatives accessible well enough in advance of planned medical or surgical operations

37.LAMA(Left Against Medical Advice)

If patient leaves the hospital against the advice of a Doctor that document is knows as LAMA



General Surgery

SRMS

Shri Ram Murti Smarak
Institute of Medical Sciences, Bareilly

Category of Patient : GEN / T.P.A. / ECHS / JSY / JCY / SSY / PMJAY
Referral Authority / Polyclinic Name
Package No. Unlisted

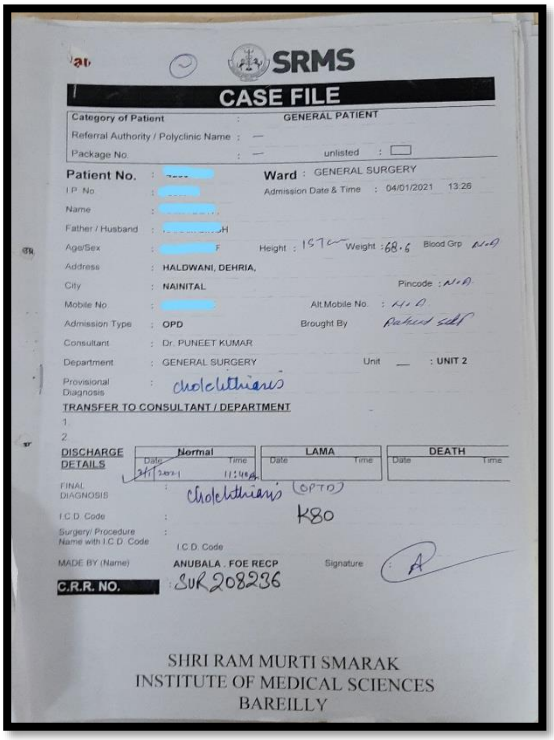
Patient Name [redacted]
I.P. No. [redacted]
Date of Admission 19/4/21

	NORMAL		LAMA		DEATH	
Discharge	DATE	TIME	DATE	TIME	DATE	TIME
	22/4/21	1pm				

Diagnosis

C.R.R. No. [redacted]

Image1: case file



SRMS

CASE FILE

Category of Patient : GENERAL PATIENT
Referral Authority / Polyclinic Name : —
Package No. : — unlisted :

Patient No. : [redacted]
Ward : GENERAL SURGERY
I.P. No. : [redacted]
Admission Date & Time : 04/01/2021 13:26
Name : [redacted]
Father / Husband : [redacted]
Age/Sex : [redacted]
Height : 157 Weight : 68.6 Blood Grp : N/A
Address : HALDWANI, DEHRIA,
City : NAINITAL Pincode : N/A
Mobile No. : [redacted] Alt Mobile No. : N/A
Admission Type : OPD Brought By : Patient self
Consultant : Dr. PUNEET KUMAR
Department : GENERAL SURGERY Unit : UNIT 2
Provisional Diagnosis : cholelithiasis

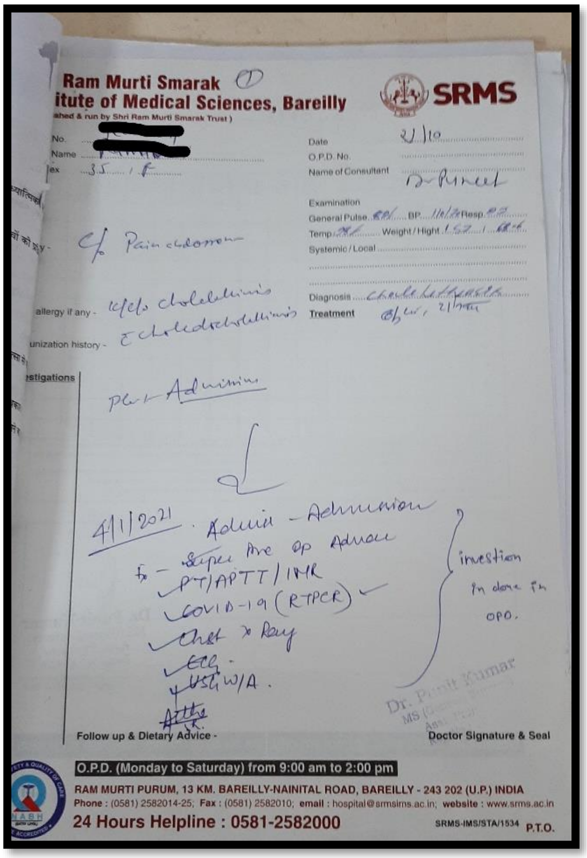
TRANSFER TO CONSULTANT / DEPARTMENT
1.
2.

DISCHARGE DETAILS	Normal		LAMA		DEATH	
	Date	Time	Date	Time	Date	Time
	7/1/2021	11:49				

FINAL DIAGNOSIS : cholelithiasis (OPTD)
I.C.D. Code : K80
Surgery/ Procedure Name with I.C.D. Code : I.C.D. Code
MADE BY (Name) : ANUBALA . FOE RECP Signature
C.R.R. NO. [redacted]

SHRI RAM MURTI SMARAK
INSTITUTE OF MEDICAL SCIENCES
BAREILLY

Image2:face sheet



Ram Murti Smarak
Institute of Medical Sciences, Bareilly

SRMS

No. [redacted]
Name [redacted]
Sex 35 / F

Date 2/1/0
O.P.D. No.
Name of Consultant Dr Puneet

Examination
General Pulse BP
Temp. Weight / Hight
Systemic / Local

C/o Pain abdomen

Allergy if any
Immunization history

Diagnosis cholelithiasis
Treatment

Investigations

Plan Admission

4/1/2021 Admission
PT/APTT/INR
COVID-19 (RTPCR)
Chest X Ray
ECG
USG W/A

investigation done in OPD.

Follow up & Dietary Advice - Doctor Signature & Seal

O.P.D. (Monday to Saturday) from 9:00 am to 2:00 pm
RAM MURTI PURUM, 13 KM. BAREILLY-NAINITAL ROAD, BAREILLY - 243 202 (U.P.) INDIA
Phone : (0581) 2582014-25; Fax : (0581) 2582010; email : hospital@srmsims.ac.in; website : www.srms.ac.in
24 Hours Helpline : 0581-2582000 SRMS-IMS/STA/1534 P.T.O.

Image3: OPD manuscript prescription prescription

Shri Ram Murti Smarak
Institute of Medical Sciences, Bareilly
Established & run by Shri Ram Murti Smarak Trust

SRMS

Patient No. [redacted] Consultation Date 12/4/2021
Patient Name [redacted] Department Ophthalmology
Age,Sex [redacted] Doctor Name Dr. Neelima Mehrotra OPD DAYS : (सोमवार,बुधवार)

Vitals :
Chief Complaints :
DOV
Clinical Findings :
O RAPD, OU AC SHALLOW

Parameter	Right Eye	Left Eye
Vision	PL+, PR ACCURATE	6/24P
IOP	14.6	20.6

Diagnosis :
E MSC
Investigation : —
General Advice:
CATARACT SURGERY, BP, RBS, RTPCR FOR COVID19
Drug Allergy:
NOT KNOWN
Treatment / Rx.— Date12/4/2021

MOXIFLOXACIN 0.5%W/V+KETOROLAC TROMETHAMINE 0.4%W/V (MOXIPLUS E/D 5 ML) 21 1 Drop

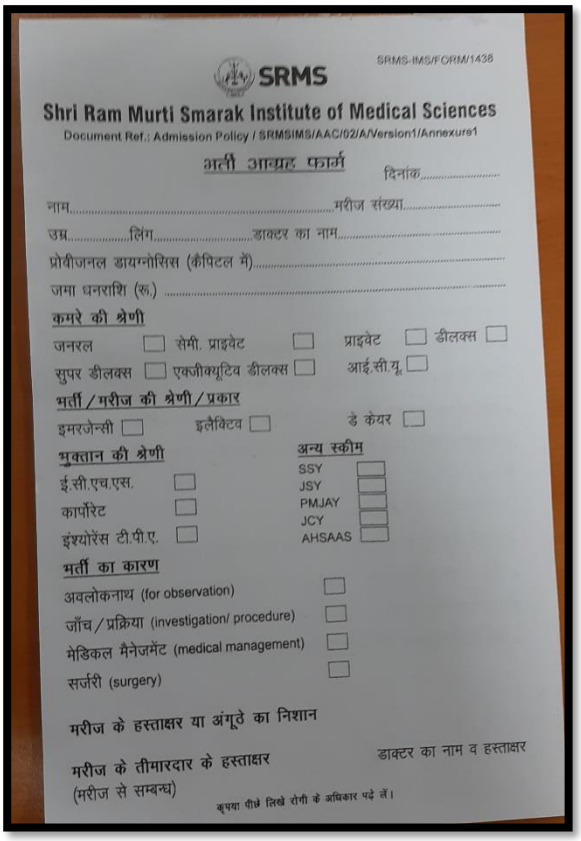
Admission Advice - Date:12-4-2021 , CATARACT SURGERY

Right : Left :

Dr. Neelima Mehrotra
Professor
(OPHTHALMOLOGY)
Reg No. : 40906

O.P.D. (Monday to Saturday) from 9:00 am to 2:00 pm
RAM MURTI PURUM, 13 KM. BAREILLY-NAINITAL ROAD, BAREILLY - 243 202 (U.P.) INDIA
email : hospital@srmsims.ac.in; website : www.srms.ac.in
24 Hours Helpline : 0581-2582000

Image4: OPD computerized



SRMS-IMS/FORM/1438

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Shri Ram Murti Smarak Institute of Medical Sciences

Document Ref.: Admission Policy / SRMSIMS/AAC/02/A/Version1/Annexure1

भर्ती आग्रह फार्म

दिनांक.....

नाम.....मरीज संख्या.....

उम्र.....लिंग.....डाक्टर का नाम.....

प्रोवीजनल डायग्नोसिस (कैपिटल में).....

जमा धनराशि (रू.) .....

कमरे की श्रेणी

जनरल ☐ सेमी. प्राइवेट ☐ प्राइवेट ☐ डीलक्स ☐

सुपर डीलक्स ☐ एक्जीक्यूटिव डीलक्स ☐ आई.सी.यू. ☐

भर्ती / मरीज की श्रेणी / प्रकार

इमरजेन्सी ☐ इलैक्टिव ☐ डे केयर ☐

भुक्तान की श्रेणी

ई.सी.एच.एस. ☐

कार्पोरेट ☐

इंश्योरेंस टी.पी.ए. ☐

अन्य स्कीम

SSY ☐

JSY ☐

PMJAY ☐

JCY ☐

AHSAAS ☐

भर्ती का कारण

अवलोकनाथ (for observation) ☐

जाँच / प्रक्रिया (investigation/ procedure) ☐

मेडिकल मैनेजमेंट (medical management) ☐

सर्जरी (surgery) ☐

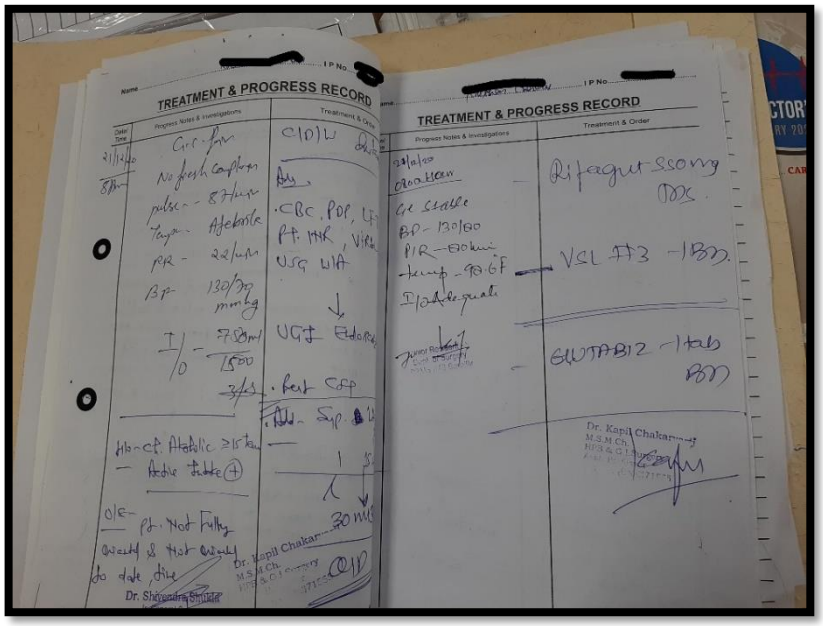
मरीज के हस्ताक्षर या अंगूठे का निशान

मरीज के तीमारदार के हस्ताक्षर (मरीज से सम्बन्ध)

डाक्टर का नाम व हस्ताक्षर

कृपया नीचे लिखे रोगी के अधिकार पढ़ें लें।

Image5:admission advice form

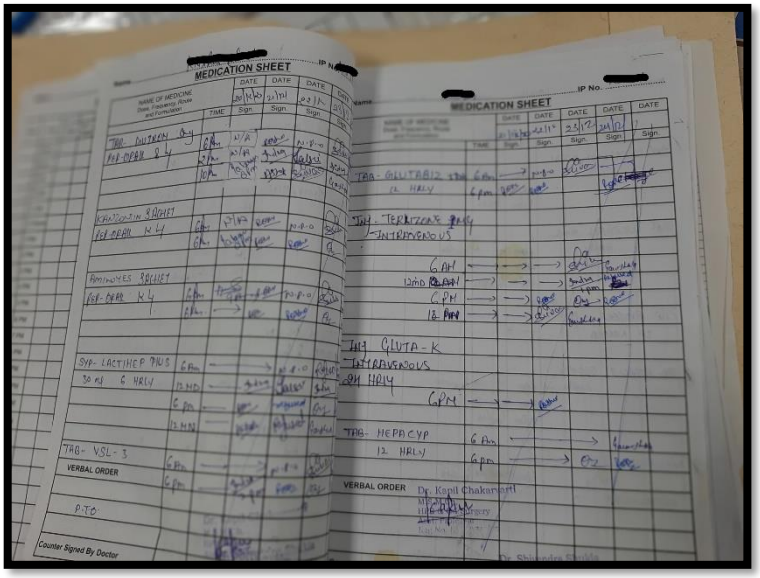


TREATMENT & PROGRESS RECORD

Progress Notes & Investigations

Treatment & Order

image6:Treatment and progress record



MEDICATION SHEET

IP No.

Name

DATE

TIME

Sign.

TAB. GLUTABIZ 1Tab 6PM 12 HRLY

INJ. TERRIZOAR 2mg INTRAVENOUS 6PM 12 AM

INJ GLUTA-K INTRAVENOUS 20H HRLY 6PM

TAB. HEPACVP 6PM 12 HRLY 6PM

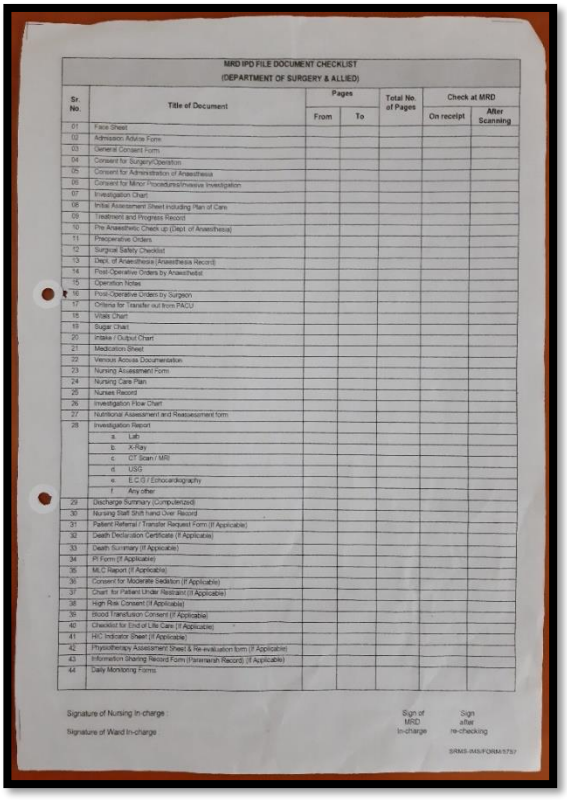
VERBAL ORDER Dr. Kapil Chakarwarti

TAB- VSL-3 VERBAL ORDER

P.T.O.

Counter Signed By Doctor

Image7: Medication sheet



MRD IPD FILE DOCUMENT CHECKLIST

(DEPARTMENT OF SURGERY & ALLIED)

Sr. No.	Title of Document	Pages From	Pages To	Total No. of Pages	Check at MRD On receipt	Check at MRD After Scanning
01	Face Sheet					
02	Admission Advice Form					
03	General Consent Form					
04	Consent for Surgery/Operation					
05	Consent for Administration of Anaesthesia					
06	Consent for Minor Procedures/Invasive Investigation					
07	Investigation Chart					
08	Initial Assessment Sheet including Plan of Care					
09	Treatment and Progress Record					
10	Pre Anaesthetic Check up (Dept. of Anaesthesia)					
11	Preoperative Orders					
12	Surgical Safety Checklist					
13	Dept. of Anaesthesia (Anaesthesia Record)					
14	Post-Operative Orders by Anaesthetist					
15	Operation Notes					
16	Post-Operative Orders by Surgeon					
17	Criteria for Transfer out from PACU					
18	Vitals Chart					
19	Sugar Chart					
20	Intake / Output Chart					
21	Medication Sheet					
22	Venous Access Documentation					
23	Nursing Assessment Form					
24	Nursing Care Plan					
25	Nurses Record					
26	Investigation Flow Chart					
27	Nutritional Assessment and Reassessment form					
28	Investigation Report					
	a. Lab					
	b. X-Ray					
	c. CT Scan / MRI					
	d. USG					
	e. E.C.G / Echocardiography					
	f. Any other					
29	Discharge Summary (Computerized)					
30	Nursing Staff Shift hand Over Record					
31	Patient Referral / Transfer Request Form (If Applicable)					
32	Death Declaration Certificate (If Applicable)					
33	Death Summary (If Applicable)					
34	PF Form (If Applicable)					
35	MLC Report (If Applicable)					
36	Consent for Moderate Sedation (If Applicable)					
37	Chart for Patient Under Restraint (If Applicable)					
38	High Risk Consent (If Applicable)					
39	Blood Transfusion Consent (If Applicable)					
40	Checklist for End of Life Care (If Applicable)					
41	HIC Indicator Sheet (If Applicable)					
42	Physiotherapy Assessment Sheet & Re-evaluation form (If Applicable)					
43	Information Sharing Record Form (Paramarsh Record) (If Applicable)					
44	Daily Monitoring Forms					

Signature of Nursing In-charge

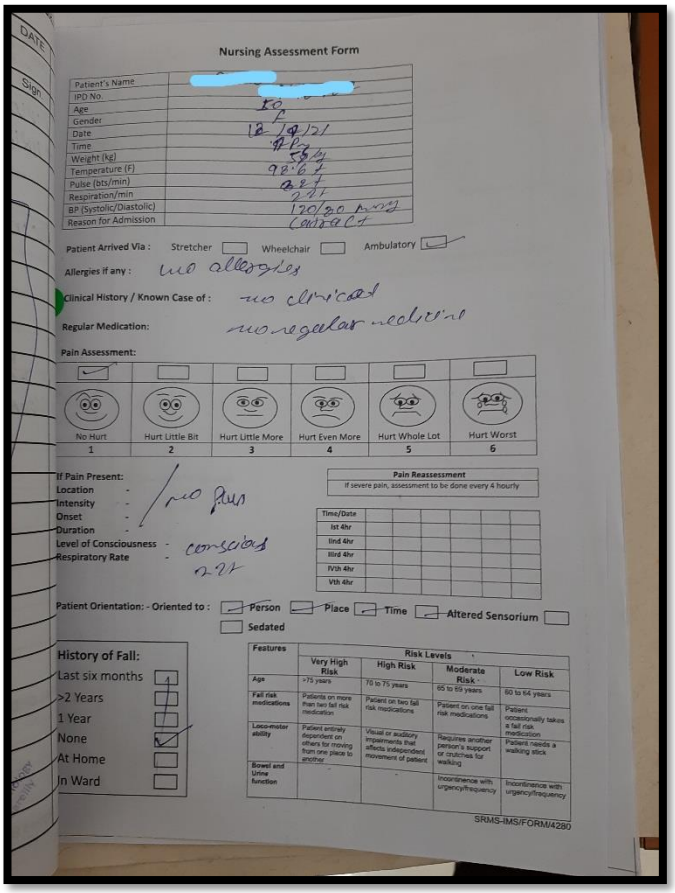
Signature of Ward In-charge

Sign of MRD In-charge

Sign after re-checking

SRMS-IMS/FORM/1757

Image8:MRD IPD document checklist



Nursing Assessment Form

Patient's Name	
IPD No.	
Age	
Gender	
Date	
Time	
Weight (kg)	
Temperature (F)	
Pulse (bts/min)	
Respiration/min	
BP (Systolic/Diastolic)	
Reason for Admission	

Patient Arrived Via : Stretcher ☐ Wheelchair ☐ Ambulatory ☐

Allergies if any :

Clinical History / Known Case of :

Regular Medication:

Pain Assessment:

No Hurt	Hurt Little Bit	Hurt Little More	Hurt Even More	Hurt Whole Lot	Hurt Worst
1	2	3	4	5	6

If Pain Present:
Location -
Intensity -
Onset -
Duration -
Level of Consciousness -
Respiratory Rate -

Pain Reassessment
If severe pain, assessment to be done every 4 hourly

Time/Date						
Ist 4hr						
IInd 4hr						
IIIrd 4hr						
IVth 4hr						
Vth 4hr						

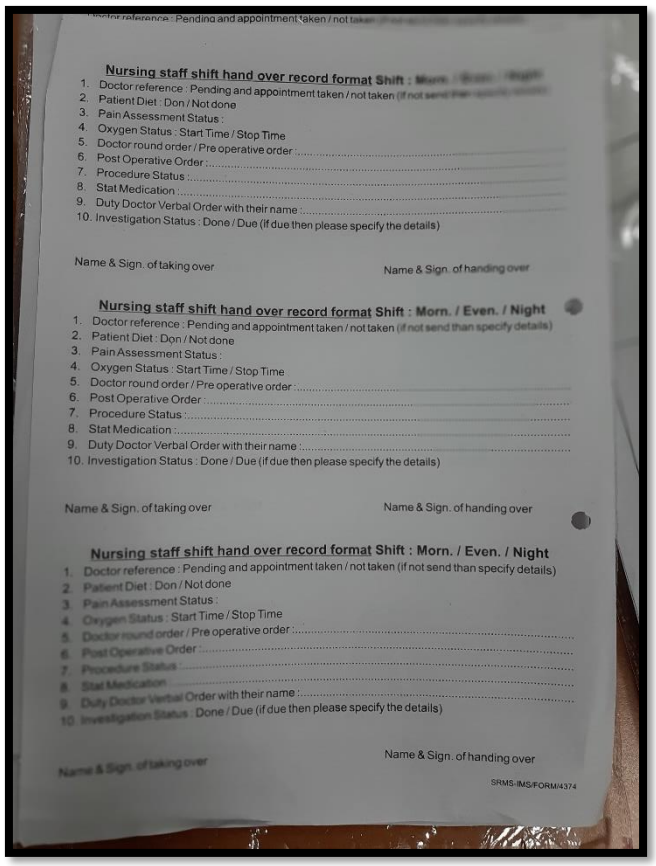
Patient Orientation: - Oriented to : Person ☐ Place ☐ Time ☐ Altered Sensorium ☐
Sedated ☐

History of Fall:
Last six months ☐
>2 Years ☐
1 Year ☐
None ☐
At Home ☐
In Ward ☐

Features	Risk Levels			
	Very High Risk	High Risk	Moderate Risk	Low Risk
Age	>75 years	70 to 75 years	65 to 69 years	60 to 64 years
Fall risk medications	Patients on more than two fall risk medication	Patient on two fall risk medications	Patient on one fall risk medications	Patient occasionally takes a fall risk medication
Loco-motor ability	Patient entirely dependent on others for moving from one place to another	Visual or auditory impairments that affects independent movement of patient	Requires another person's support or crutches for walking	Patient needs a walking stick
Bowel and Urine function			Incontinence with urgency/frequency	Incontinence with urgency/frequency

SRMS-IMS/FORM/4280

Image9:Nursing Assessment form over record



Nursing staff shift hand over record format Shift : Morn. / Even. / Night

1. Doctor reference : Pending and appointment taken / not taken (if not send than specify details)
2. Patient Diet : Don / Not done
3. Pain Assessment Status :
4. Oxygen Status : Start Time / Stop Time
5. Doctor round order / Pre operative order :
6. Post Operative Order :
7. Procedure Status :
8. Stat Medication :
9. Duty Doctor Verbal Order with their name :
10. Investigation Status : Done / Due (if due then please specify the details)

Name & Sign. of taking over — Name & Sign. of handing over

Nursing staff shift hand over record format Shift : Morn. / Even. / Night

1. Doctor reference : Pending and appointment taken / not taken (if not send than specify details)
2. Patient Diet : Don / Not done
3. Pain Assessment Status :
4. Oxygen Status : Start Time / Stop Time
5. Doctor round order / Pre operative order :
6. Post Operative Order :
7. Procedure Status :
8. Stat Medication :
9. Duty Doctor Verbal Order with their name :
10. Investigation Status : Done / Due (if due then please specify the details)

Name & Sign. of taking over — Name & Sign. of handing over

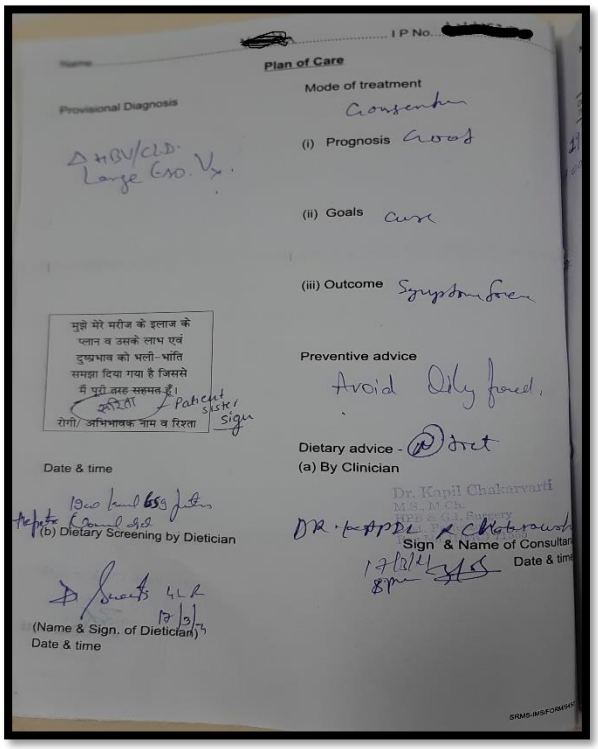
Nursing staff shift hand over record format Shift : Morn. / Even. / Night

1. Doctor reference : Pending and appointment taken / not taken (if not send than specify details)
2. Patient Diet : Don / Not done
3. Pain Assessment Status :
4. Oxygen Status : Start Time / Stop Time
5. Doctor round order / Pre operative order :
6. Post Operative Order :
7. Procedure Status :
8. Stat Medication :
9. Duty Doctor Verbal Order with their name :
10. Investigation Status : Done / Due (if due then please specify the details)

Name & Sign. of taking over — Name & Sign. of handing over

SRMS-IMS/FORM/4374

image10:Nursing Staff Hand



IP No.

Name

Plan of Care

Provisional Diagnosis

Mode of treatment

(i) Prognosis

(ii) Goals

(iii) Outcome

मुझे मेरे मरीज के इलाज के प्लान व उसके लाभ एवं दुष्प्रभाव को भली-भांति समझा दिया गया है जिससे मैं पूरी तरह सहमत हूँ।

रोगी/ अभिभावक नाम व रिश्ता — Patient / sister / Sign

Preventive advice

Dietary advice -
(a) By Clinician

Sign & Name of Consultant

Date & time

(b) Dietary Screening by Dietician

(Name & Sign. of Dietician)

Date & time

SRMS-IMS/FORM/4345

Image11:Plan of care

3.4 Findings

Results:

Total of 400 MRD case files were taken for the audit.

Department Name	Number of Case files
Intensive Care Unit (ICU)	50
Pediatric	50
Dermatology	50
Psychiatry	50
Obstetrics and Gynaecology	50
General Medicine	50
Ophthalmology	50
General Surgery	50
Total	400

Table2: Number of Case files taken from MRD for audit.

					MRD FILES FOR AUDIT AT SRMS IMS										
Files	Department	Face sheet(Complete or incomplete)	Admission advice form(Complete or incomplete)	OPD Prescription Computerized/ Manuscript	OPD Prescription vitals information (Complete or incomplete)	OPD Prescription Drug allergy (Complete or incomplete)	OPD Prescription Medication in Capital letter (Complete or incomplete)	IPD Prescription medication chart of nurse In Capital letter (prescription)	IPD Prescription Treatment/progress Record (Location of Prescription,Date and time,Sign&Seal of Consultant)	Plan of care properly written (Prognosis, goal,outcome,sign of consultant, patient/attandant acceptance of plan of care)	Nursing assesemnt form(complete or incomplete)	Overall Prescription in Capital(complete or incomplete)	Nursing Staff shift Hand over record format(complete or incomplete)	MRD IPD file Document Checklist (complete or incomplete)	Score(max=12)
1	Ophthalmology	0	1	Manuscript	0	0	1	0	1	1	0	0	1	1	6
2	Ophthalmology	0	0	Manuscript	1	0	0	1	1	1	1	0	1	0	6
3	Ophthalmology	0	1	Manuscript	0	0	1	0	1	1	1	0	1	1	7
4	Ophthalmology	0	1	Manuscript	1	0	0	0	1	1	1	0	0	1	6
5	Ophthalmology	0	1	Manuscript	0	1	1	0	1	1	1	0	1	1	8
6	Ophthalmology	0	1	Computerized	1	1	1	0	0	1	1	1	0	1	8
7	Ophthalmology	0	1	Manuscript	1	0	1	0	1	1	1	0	0	1	7
8	Ophthalmology	0	1	Manuscript	0	0	0	1	1	1	1	0	0	1	6
9	Ophthalmology	0	1	Manuscript	1	0	1	1	1	1	1	1	0	0	8
10	Ophthalmology	0	1	Manuscript	0	1	0	1	1	1	1	0	1	1	8
11	Ophthalmology	0	1	Manuscript	0	1	1	1	1	1	1	1	1	1	10
12	Ophthalmology	0	0	Computerized	1	1	1	1	1	1	1	1	1	1	10
13	Ophthalmology	0	1	Computerized	1	1	1	1	1	1	1	0	1	1	10
14	Ophthalmology	0	1	Computerized	1	1	1	1	1	1	0	1	1	1	10
15	Ophthalmology	0	1	Computerized	1	1	1	1	1	1	1	1	1	1	11
16	Ophthalmology	0	1	Manuscript	0	1	0	1	1	1	1	0	0	1	7
17	Ophthalmology	0	0	Computerized	1	1	1	1	1	1	1	1	0	1	9
18	Ophthalmology	0	1	Manuscript	1	0	0	1	1	1	1	0	1	0	7
19	Ophthalmology	0	1	Manuscript	1	0	1	1	1	1	1	1	0	1	9
20	Ophthalmology	0	1	Computerized	1	1	1	1	1	1	0	1	0	1	9
21	Ophthalmology	0	1	Manuscript	1	1	0	1	1	1	1	0	0	1	8
22	Ophthalmology	0	1	Manuscript	0	0	1	0	1	1	1	0	0	1	6
23	Ophthalmology	0	1	Manuscript	1	1	1	0	1	1	0	0	0	1	7
24	Ophthalmology	0	1	Computerized	1	1	1	1	1	1	1	0	1	1	10
25	Ophthalmology	0	1	Manuscript	1	1	0	1	1	1	1	0	0	1	8
26	Ophthalmology	0	1	Computerized	1	1	1	0	1	1	0	1	1	1	9
27	Ophthalmology	0	1	Computerized	1	1	1	0	1	1	0	1	1	1	9
28	Ophthalmology	0	1	Manuscript	0	0	1	0	1	1	1	0	1	1	7
29	Ophthalmology	0	1	Manuscript	1	0	0	0	1	1	1	0	1	1	7
30	Ophthalmology	0	1	Manuscript	0	0	0	0	1	1	1	0	1	1	6

Table3: Master checklist after the audit of 400 case files

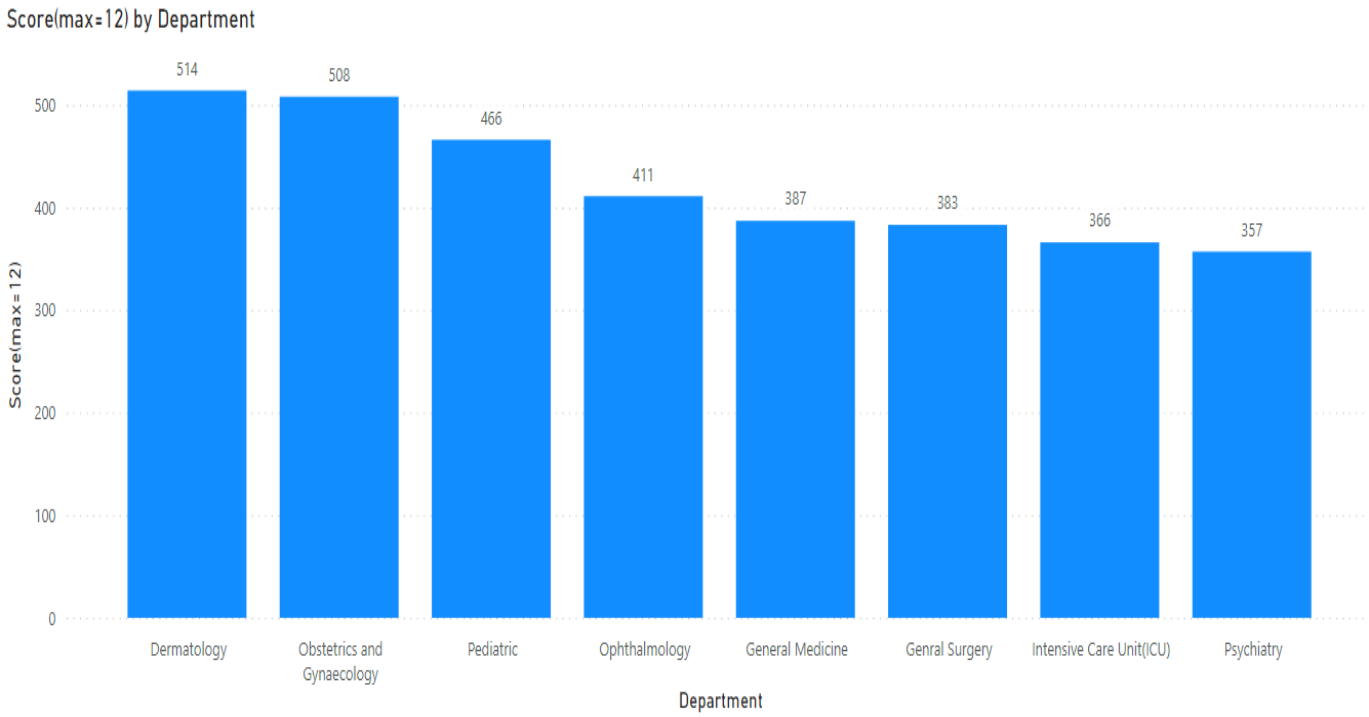
• The figures above show how the results were calculated after the audit, twelve parameters have been calculated from the audit sheet; for each parameter a score is shown which is one for complete and zero for incomplete; the maximum value of a single file can be calculated as 12, the last column in the figure above written as score which shows the final mark of a single file.

• Results are compared and drawn with the aid of Power BI.

Department	Face sheet	Admission advice form	OPD Prescription vitals information	OPD Prescription Drug allergy	OPD Prescription Medication in Capital letter	IPD Prescription medication chart of nurse In Capital letter	IPD Prescription Treatment/ progress Record	Plan of care properly written	Overall Prescription in Capital	Nursing assesemnt form	Nursing Staff shift Hand over record	MRD IPD file	Score(max=12)
Intensive Care Unit(ICU)	0	27	30	34	34	40	31	33	21	40	45	31	366
Pediatric	14	32	44	46	42	43	41	44	34	41	43	42	466
Dermatology	23	40	45	46	48	50	44	46	48	39	41	44	514
Psychiatry	8	50	5	6	10	50	50	46	10	38	40	44	357
Obstetrics and Gynaecology	30	38	48	47	47	50	34	45	44	48	36	41	508
General Medicine	5	25	33	34	29	49	50	45	24	33	34	26	387
Opthalmology	0	45	36	29	34	29	49	50	22	40	34	43	411
Genral Surgery	1	28	28	36	34	50	38	42	30	34	30	32	383
Total	**81**	**285**	**269**	**278**	**278**	**361**	**337**	**351**	**233**	**313**	**303**	**303**	**3392**

Table4: Final Results from the checklist

- The final results of the research study showed above that a total of 400 files were collected and audited by different departments to see how they keep the medical registered files of patients, the table was drawn using the Power BI tool to analyse raw information collected during this audit.

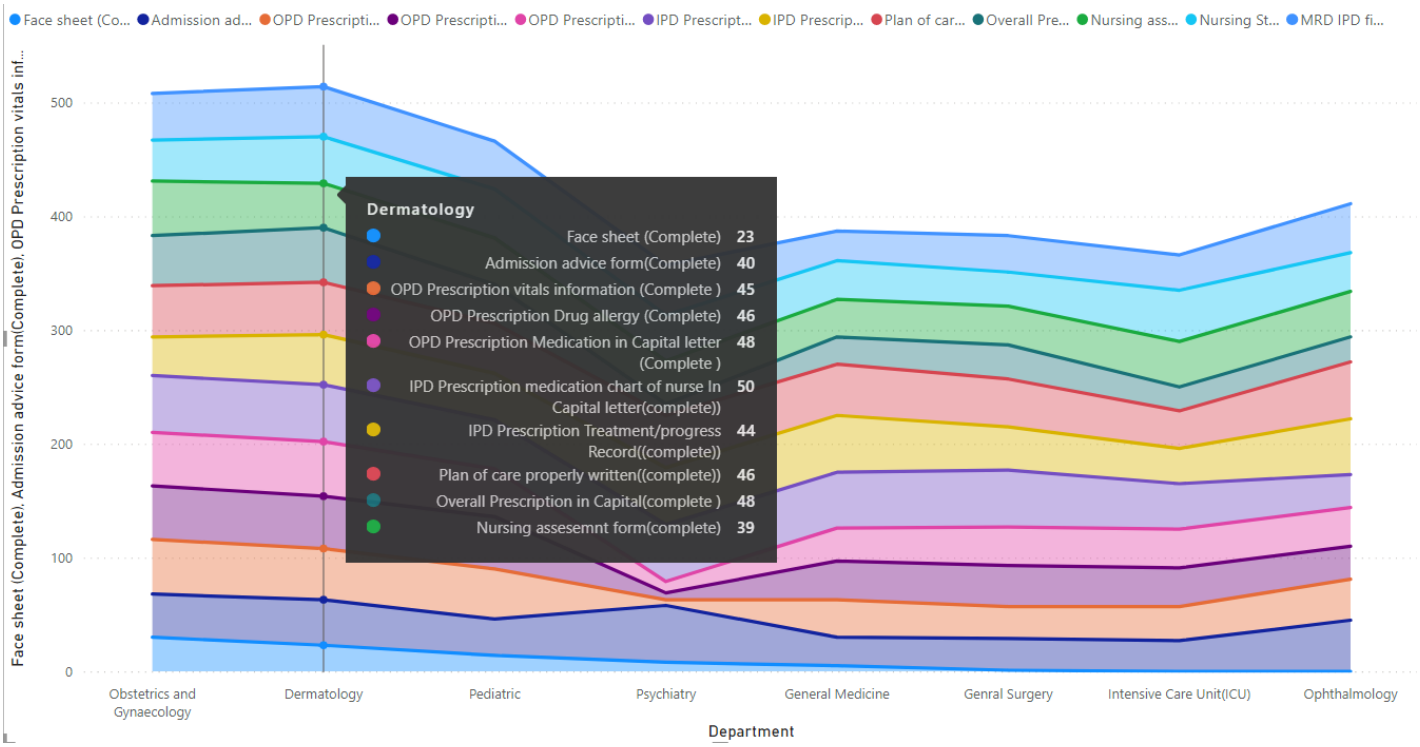


Graph 1: Maximum score scored by different department during the documentation audit.

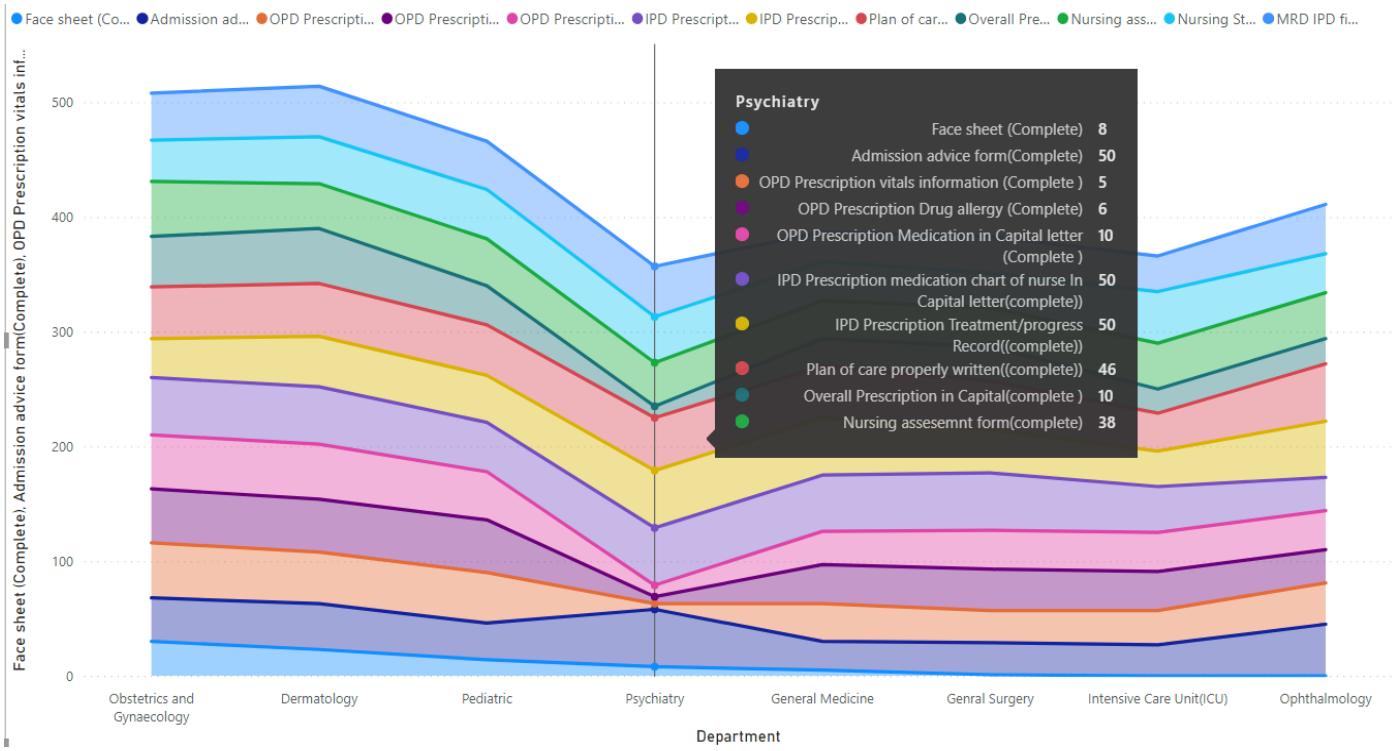
• According to the audit, the Dermatology Department received the highest score of 514 points out of 600, indicating that 85.66 percent of files were completed.

• The Obstetrics and Gynecology department came in second place with a score of 508 out of 600, or 84.66 percent completion of files.
• The third place finisher was Pediatric, with 466 points out of 600, or 77.66 percent completion of files.
• In addition, the Ophthalmology Department received 411 points out of 600, indicating that 68.5 percent of the files were completed.
• General Medicine came in second with 387 points out of 600, or 64.5 percent completion of files.
• General Surgery came in second with 383 points out of a possible 600. That equates to 63.83 percent of the files being completed.
• The Intensive Care Unit (ICU), which received 366 points out of a possible 600, is in second place. That equates to 61 percent of the files being completed.
• The psychiatry department received the lowest score, 357 points out of 600. That is 59.5 percent of the files completed.

Note: The overall total percentage for the entire department is over 50 percent, which is positive in the above results. Also, it has been seen that certain departments have performed well in several parameters, but have not performed well altogether, such as the Psychiatry department.

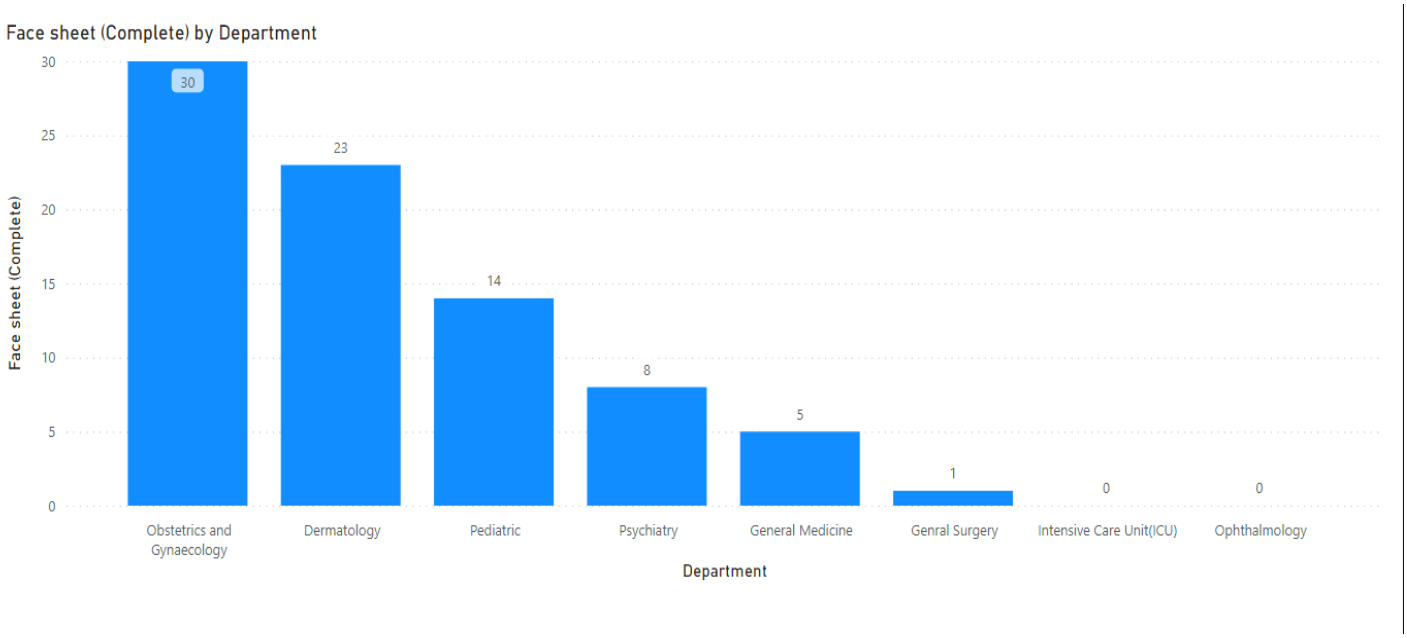


Graph2: Shows Dermatology Department performance during the Audit



Graph3: Show the performance of Psychiatry department during the Audit

- Results for departments to the selected parameters, in this it is observed that how selected departments performed.

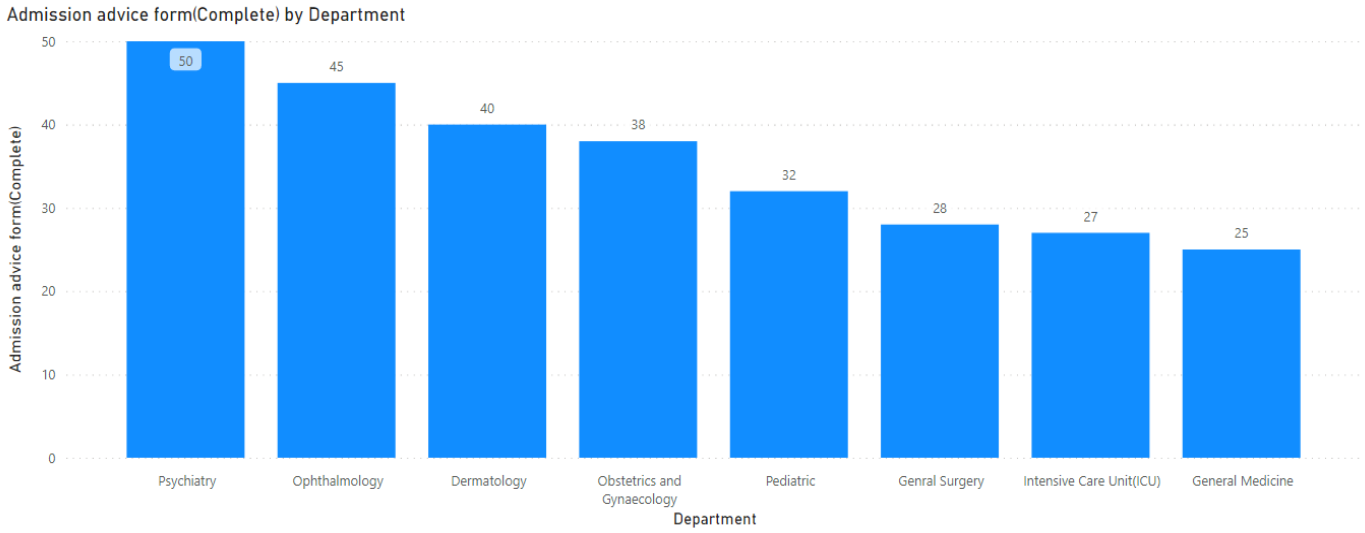


Graph4: The bar graph shows the number of face sheet parameter completed by selected department

• It has been discovered that the Obstetrics and Gynecology department has the largest number of completions, with 30 out of 50 overall, indicating a 60% completion rate.

• Ophthalmology (0), Intensive Care Unit (ICU)(0), General Surgery(1), and General Medicine had the fewest completions (5)

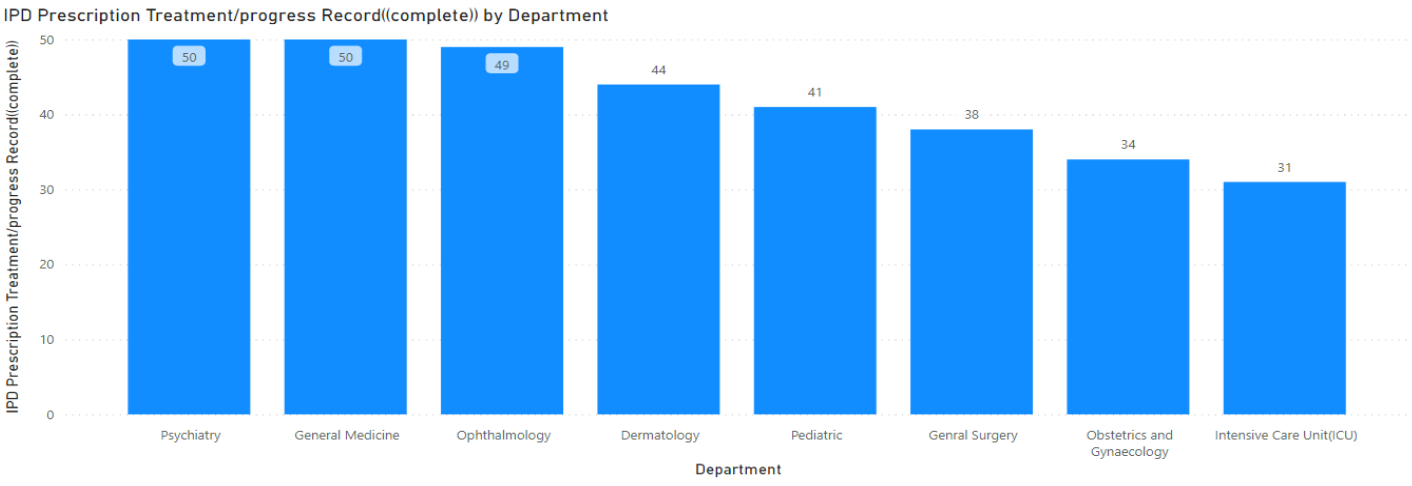
• Other departments didn't fare much better, but the average was still high.



Graph5: Bar graph shows the number of Admission advice form parameter completed by selected department

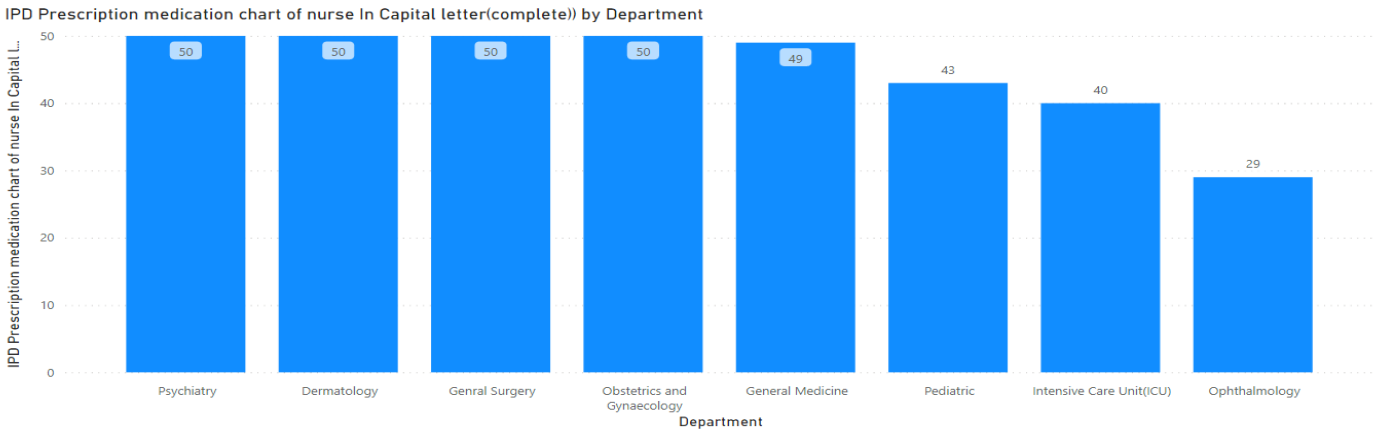
• It was discovered that the Psychiatry Department received a perfect score in this category, i.e., 50 out of 50, or a 100% completion rate.

• General Medicine received the lowest score of 25 out of 50, which equates to a 50% completion rate, which is not terrible. When compared to the other criteria that were chosen,



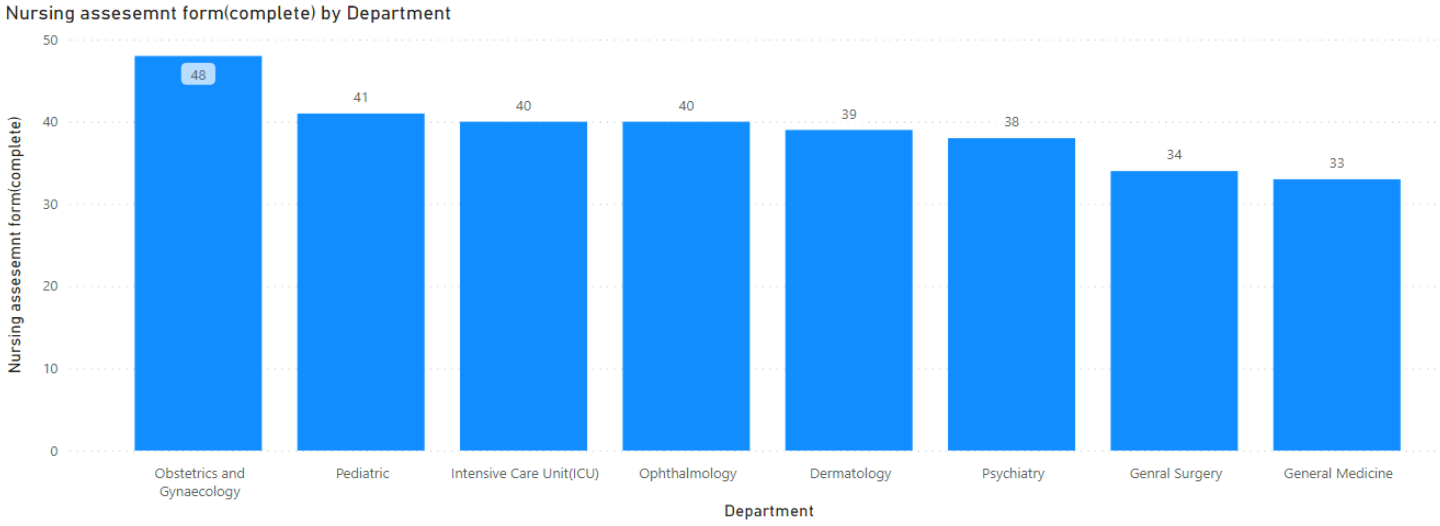
Graph6: The bar graph shows the number of IPD Prescription Treatment/progress Record parameter completed by selected department

- It was discovered that three departments did exceptionally well: Psychiatry, which received a score of 50 (100 percent), General Medicine, which received a score of 50 (100 percent), and Ophthalmology, which received a score of 49 (98 percent).
- Bottom scored by Intensive Care Unit (ICU) by 31 out of 50 and completion percentage is 62% which is above good.



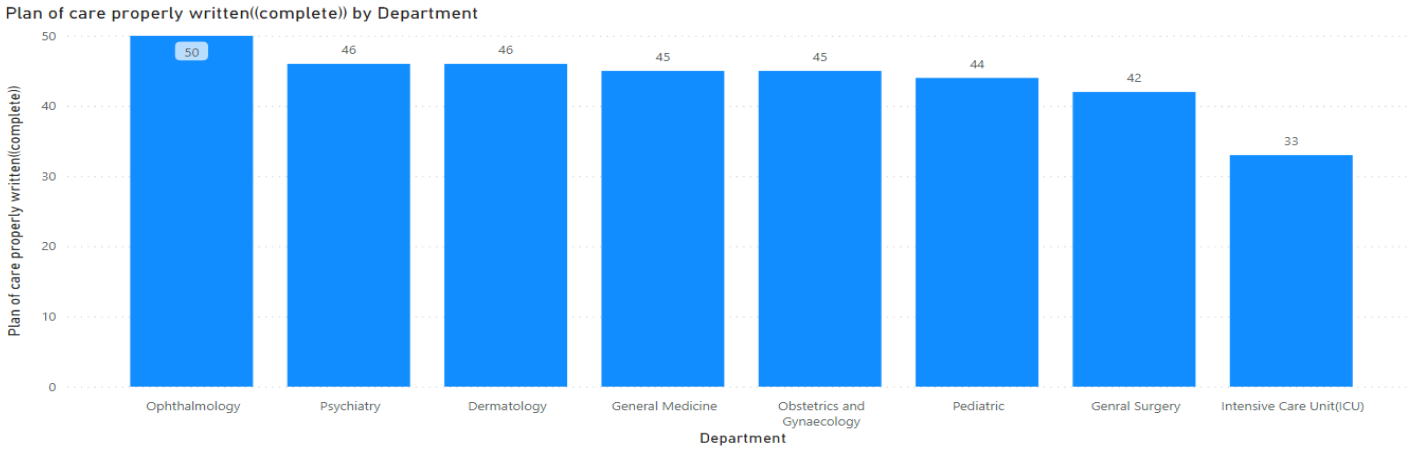
Graph7: Bar graph shows the number of IPD Prescription medication chart of nurse In Capital letter parameter completed by selected department.

- Found that all departments did well in this criteria, with four departments scoring full marks (Psychiatry (100%), Dermatology (100%), General Surgery (100%), and Obstetrics and Gynecology (100%)), and three departments scoring in the 40s.
- Ophthalmology received the lowest score of 29 out of 50, indicating a 58 percent completion rate.



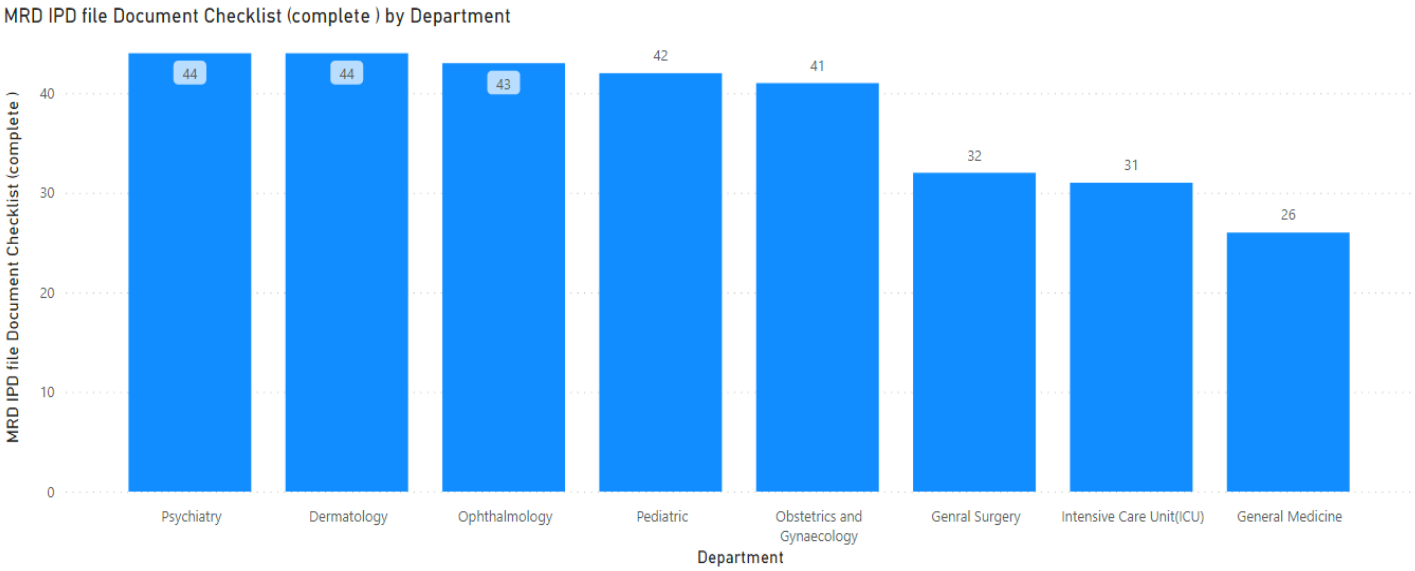
Graph8: Bar graph shows the number of IPD Prescription medication chart of nurse In Capital letter parameter completed by selected department.

- It was discovered that Obstetrics and Gynecology received the highest score of 48 out of 50, with a completion rate of 96 percent, while General Medicine received the lowest score of 33 out of 50,
- with a completion rate of 66 percent, which is significant. Overall, all departments performed well in this parameter.



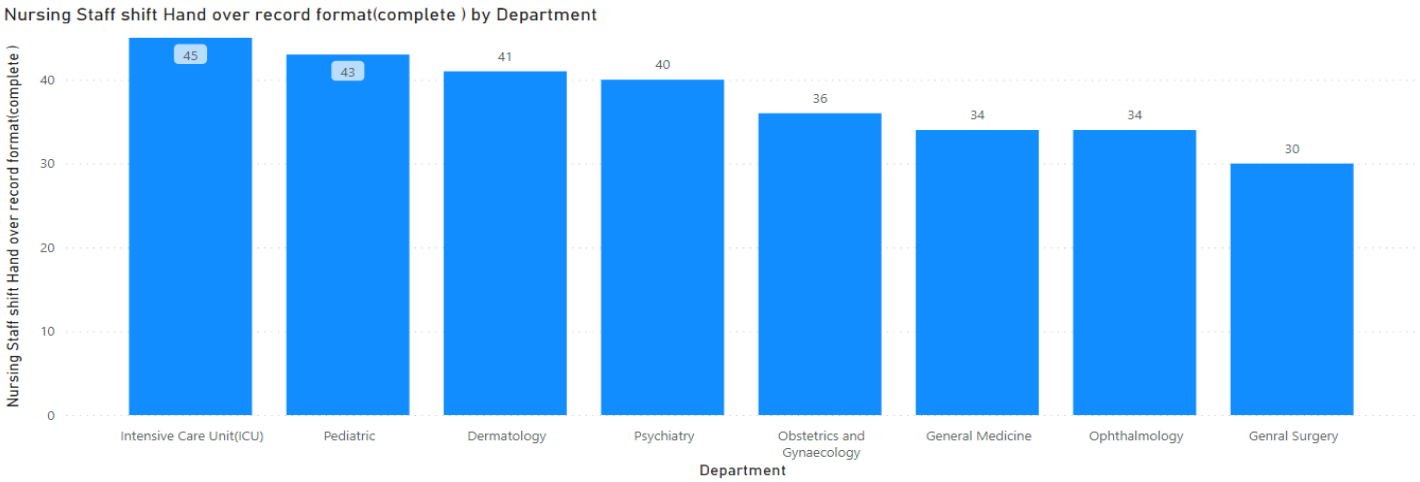
Graph9: Bar graph shows the number of Plan of care properly written parameter completed by selected department.

- It was noted that the ophthalmology department received a perfect score of 50 out of 50, with a 100% completion rate, and that other departments also did well, with scores in the 40s.
- The Intensive Care Unit (ICU) had the lowest score, 33 out of 50, with a 66 percent completion rate.



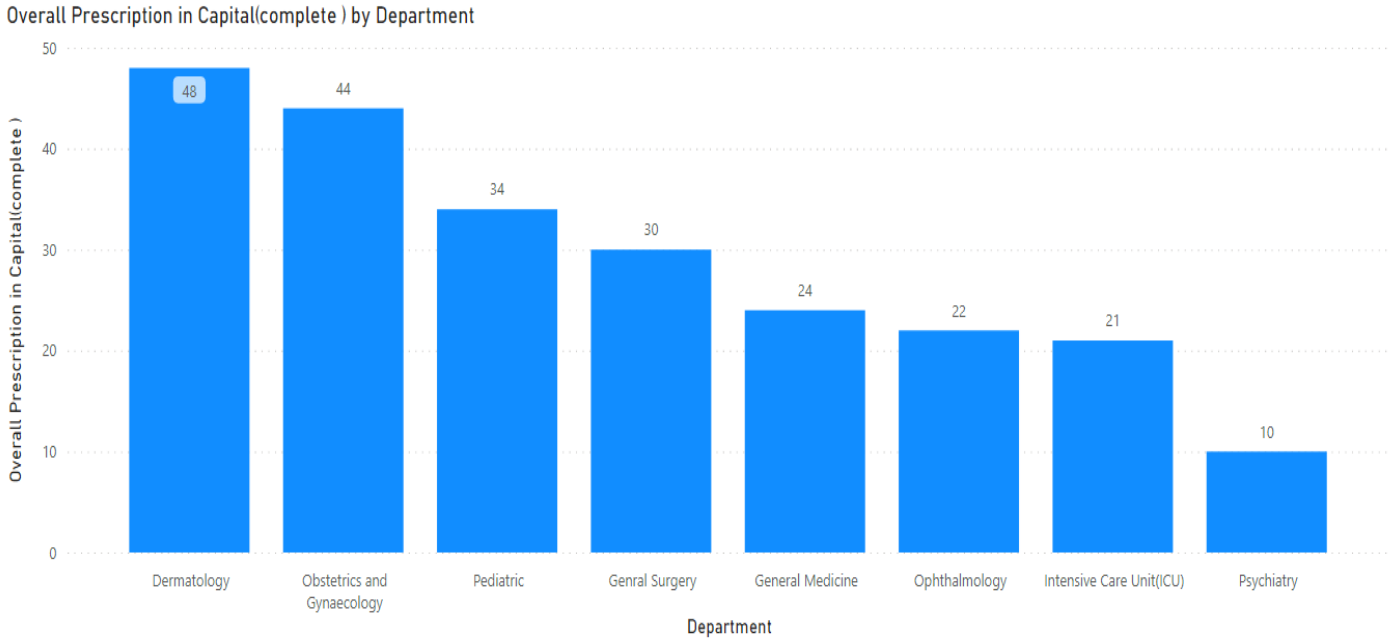
Graph10: Bar graph shows the number of MRD IPD file Document checklist parameter completed by selected department

• It was discovered that the Psychiatry and Dermatology Department received the highest score of 44 out of 50, with an 88 percent completion rate, followed by the Ophthalmology Department with a score of 43 (86 percent) and General Medicine with a score of 26. (52 percent).



Graph11: Bar graph shows the number of Plan of care properly written parameter completed by selected department

- Discovered that the Intensive Care Unit (ICU) outperformed the other departments, scoring 45 out of 50, or a 90% completion rate. General surgery had the lowest score of 30 out of 50, or 60 percent.



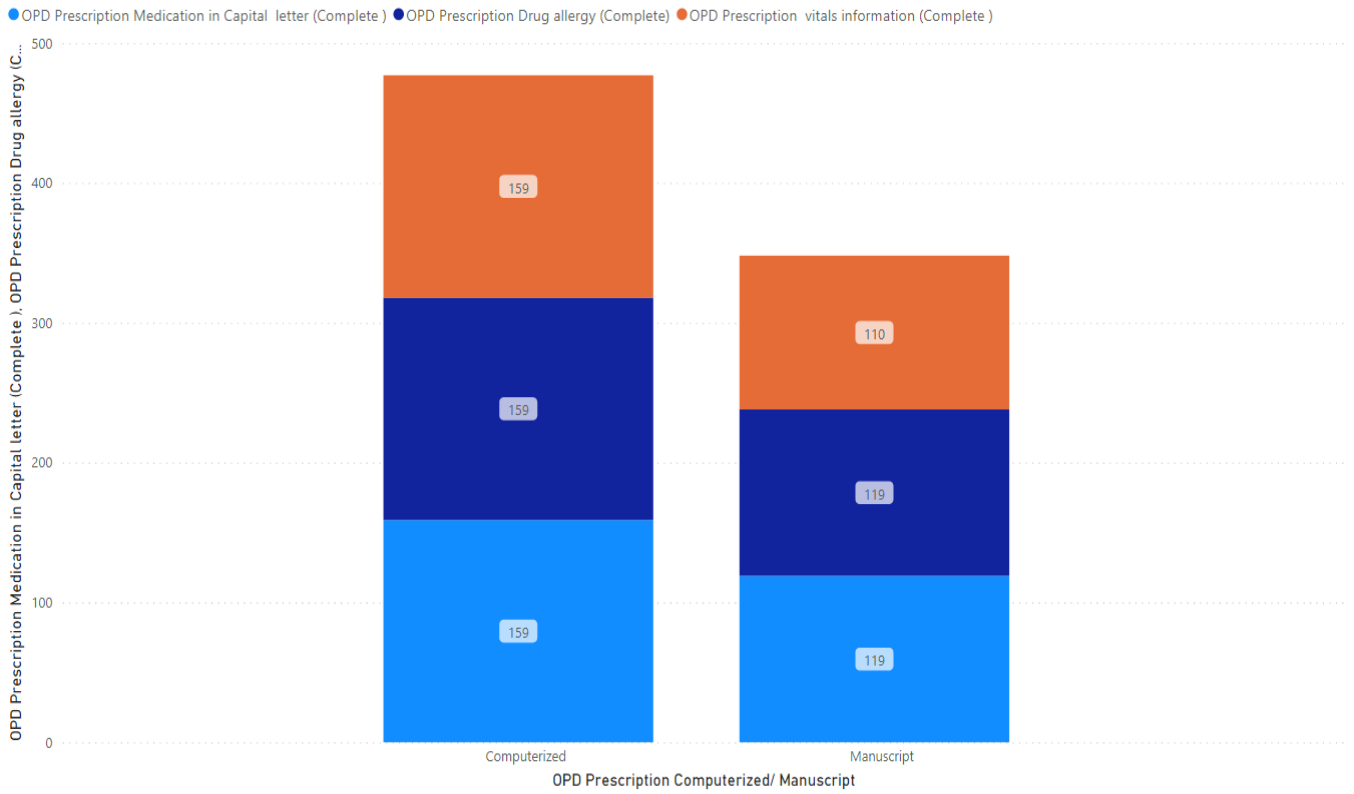
Graph12: Bar graph shows the number of Plan of care properly written parameter completed by selected department.

- It was discovered that Dermatology performed the best in this, scoring 48 out of 50, or 96 percent
- It was also discovered that overall prescription in Capital is related to OPD prescription in Capital and IPD prescription medication chart in Capital; if both are complete, only the overall prescription scoring is given a complete point; if one of those parameters is not complete, only the overall prescription scoring is given a complete point; if one of those parameters is not complete, only the overall prescription scoring is given a complete point; As a result, the Dermatology department comes out on top in this criteria, with Psychiatry earning at least 10 out of 50.

Department	OPD Prescription vitals information	OPD Prescription Drug allergy	OPD Prescription Medication in Capital letter
Psychiatry	**5**	**6**	**10**
Manuscript	5	6	10
Dermatology	**45**	**46**	**48**
Computerized	45	45	45
Manuscript	0	1	3
General Medicine	**33**	**34**	**29**
Manuscript	33	34	29
Genral Surgery	**28**	**36**	**34**
Computerized	1	1	1
Manuscript	27	35	33
Intensive Care Unit(ICU)	**30**	**34**	**34**
Computerized	9	9	9
Manuscript	21	25	25
Obstetrics and Gynaecology	**48**	**47**	**47**
Computerized	44	44	44
Manuscript	4	3	3
Opthalmology	**36**	**29**	**34**
Computerized	19	19	19
Manuscript	17	10	15
Pediatric	**44**	**46**	**42**
Computerized	41	41	41
Manuscript	3	5	1
Total	**269**	**278**	**278**

Table5: OPD prescription Manuscript vs Computerized with three parameters selected from the audit.

• The table depicts the distribution of computerised and manuscript data; it can be seen from the chart that computerised prescriptions have more complete parameters than manuscript prescriptions.

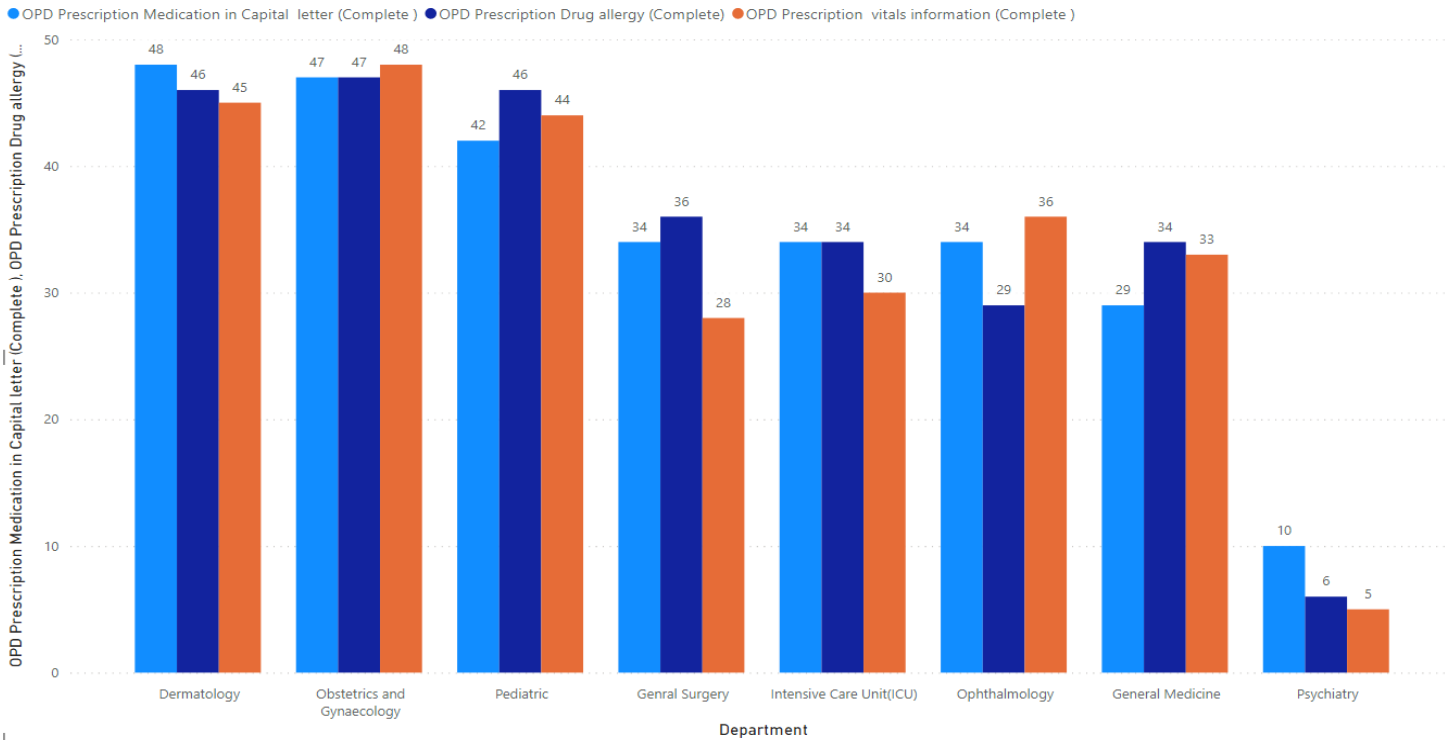


Graph13: Shows the difference in number of completions score for manuscript vs computerized OPD prescription.

Department	OPD Prescription Medication in Capital letter (Incomplete)	OPD Prescription vitals information (Incomplete)	OPD Prescription Drug allergy (Incomplete)
Psychiatry	40	45	44
Dermatology	2	5	4
General Medicine	21	17	16
Genral Surgery	16	22	14
Intensive Care Unit(ICU)	16	20	16
Obstetrics and Gynaecology	3	2	3
Opthalmology	16	14	21
Pediatric	8	6	4
Total	**122**	**131**	**122**

Table6: Shows the Number of incompletions for OPD Manuscript Prescription for three parameters taken during audit.

• It has been discovered that all OPD prescriptions written with a computer are found to be 100 percent complete when compared to those written with a manuscript; it has also been discovered that most of the time, the prescription is not written in capital letters in the manuscript, and that vital information and drug allergies are also missing in the manuscript prescription.



Graph14: Shows departments performance for manuscript and computerized OPD prescriptions

• It was discovered that Obstetrics and Gynecology, Dermatology, and Pediatrics performed better than the other departments, and that these departments have more computerised prescriptions than the other departments.

• It was also discovered that the Psychiatry department has all of the manuscript transcription, resulting in more incomplete data than the other departments.

Serial No	Parameter	Total	Maximum score	Completion percentage
1	Face sheet	81	400	20.25%
2	Admission advice form	285	400	71.25%
3	OPD prescription vitals information	269	400	67.25%
4	OPD prescription Drug allergy	278	400	69.5%
5	OPD Prescription medication in capital letter	278	400	69.5%
6	IPD prescription Medication chart of nurse in Capital letter	361	400	90.25%
7	IPD prescription Treatment/progress record	337	400	84.25%
8	Plan of care properly written	351	400	87.75%
9	Overall prescription in capital	233	400	58.25%
10	Nursing assessment form	313	400	78.25%
11	Staff hand over record	303	400	75.25%
12	MRD IPD file	303	400	75.25%
13	Max score	3392	4800	70.66%

Table7: overall performance of hospital

• The above table depicts the overall performance of the SRMS IMS hospital; it was noted how well the hospital performed during the documentation audit and on other factors. Only the face sheet parameter was determined to be less than 20%, whilst the other parameters had a record of over 50%, which is better.

3.5 Recommendations

1. Using digital OPD Prescription instead of Manuscript Prescription can assist to reduce errors that occur while noting down the medications, allergy, obtaining vitals, and writing out the prescription in Capital.

2. Complete the face sheet more, among the criteria chosen, it was discovered that the face sheet of the files was missing, and the face sheet parameter was the least completed, 81 out of 400, that is 20.25 percent only.

3.Intensive Care Unit (ICU) should focus on finishing the face sheet and utilize computerized prescription over the manuscript.

4. All other parameters had a better record than the face sheet, hence the paediatric department should focus on completing the face sheet.

5. In psychiatry, computerised prescriptions are strongly recommended over traditional manuscript prescriptions because most of the parameters associated with computerised prescriptions, such as OPD prescription vitals information, drug allergies, and medication in capital letters, all have low completion rates because they have manuscript prescriptions. Other metrics showed that psychiatry did well, but it received a lower grade owing to all manuscript prescription.

6. Face sheets should be maintained more in ophthalmology and general surgery departments.

3.6 Conclusion

The study concluded that an audit of the medical files conducted by SRMS IMS evaluates the operations of various departments and the way in which they were conducted in keeping cases files of specific patients, the audit checklists, and the various parameters used in research help to know what department has better record keeping practice study found that it is preferable for hospitals to have OPD prescriptions written by computer rather than by hand. This research will aid hospitals in focusing on departments that score lower in various parameters and can improve in those specific sections to improve quality care in the hospital, as well as from the NABH perspective.

Limitation of the study

1.Time constraint was the major factor

2. Due to covid unable to properly conduct the audit.

3.7 References

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