DR. BABA SAHEB AMBEDKAR HOSPITAL
(GOVT. OF NCT OF DELHI)
SECTOR VI, ROHINI, DELHI—85

F. No.16 (20)/2019/Misc correspondence/BSAH/Part file 1 7347 Dated: 11/4/2020

CIRCULAR

Medical Record Audit is an integral part of National Quality Assurance Standards, aimed at improving the quality of health care services. As medical records serve as documentary evidence in the medico-legal cases it is imperative that we maintain complete and legible patient case files to avoid hassles of litigation process.

A Medical Audit was conducted (as per NQAS format) in the month of March, 2020. It shows the overall percentage score at 45% which needs significant improvement with respect to all three parameters i.e. Adequacy of Documentation, Record Keeping and Adequacy of Clinical Care.

MEDICAL AUDIT REPORT (March,2020)

Ref ID	17181	14666	17531	17592	17725	16271	16297	15304	15049	17698
Name of Department	Medicine	Medicine	Obs & Gynae	Obs & Gynae	Obs & Gynae	ENT	ENT	Surgery	Ortho	Ortho
Score Percentage (Parameter wise)										
Adequacy of Documentation (Weightage-15%)	1.2%	1.8%	1.8%	1.2%	2.4%	1.2%	1.2%	1.2%	1.8%	1.8%
Record Keeping (Weightage-20%)	12%	12.8%	16%	16%	16%	14.5%	15.5%	12.5%	14.5%	15.2%
Clinical Care (Weightage-65%)	34%	28.2%	28.6%	28.2%	30.3%	28.2%	28.2%	28.2%	28.2%	28.2%
Overall Score Percentage	47.2%	42.8%	46.4%	45.4%	48.7%	43.9%	44.9%	41.9%	44.5%	45.2%

Following shortcomings were observed in most of the case files:

1. Adequacy of Documentation:
   - Input/Output chart and TPR chart not maintained in the case sheets.
   - General Consent on the admission summary does not have signatures of witness and date.
   - Informed Consent for Surgery/Procedure not taken on the standard format.

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2. Record Keeping:
   - CR No. must be written on all the patient file forms.
   - Admission notes need to be mentioned on Initial Assessment form.
   - Daily Round notes by Doctors should have date and time clearly mentioned over it.
   - Follow up instructions need to be written on each Discharge summary.

3. Adequacy of Clinical Care:
   - Initial assessment needs to be signed by Resident Doctor and further by Consultant with date & time.
   - Time of ordering Investigations should be mentioned on the case file so that turnaround time for lab reports can be monitored.
   - Presumptive diagnosis must be mentioned on the initial assessment form.
   - Drugs must be prescribed by generic names in place of brand names.

In view of above report, all Clinical HODs and Senior Nursing Incharges are requested to ensure proper documentation, usage of standard formats in the patient case files and to sensitize the Resident Doctors of their units.

Jaiswal 8/04/20

Dr Ashok Jaiswal
Add. Medical Superintendent(I)

F. No.16 (20)/2019/Misc correspondence/BSAH/Part file 1

Dated:

Copy to:-

1. PS to MD for information
2. MS (A&E), MS (Surg & Allied) & All Clinical HODs
3. Nodal Officer-NQAS
4. MRD Incharge
5. DNS/ANS & All Senior Nursing Officers through DNS
6. Suptd. Hospital Manager-Indoor
7. Asstt. programmer to upload on hospital website
8. Guard File

Dr Ashok Jaiswal
Add. Medical Superintendent(I)