All cases of Enteric fever do not require hospitalization!

By Dr Satish Kanojia – VP Clinical Services

32 years female was admitted for 2 days with c/o fever with chills, body ache, nausea +, decreased oral intake, yellow urine and burning while passing urine, for 3-4 days. On admission her vital parameters were Temperature 101.8^{0}F, Pulse 106/min, BP 112/80 mm Hg, and SpO2 96% at RA.

Her lab investigations were done and Typhi dot IgM was positive, and the patient was diagnosed with Enteric fever.

Our clinical team scrutinized the documents and noted the following discrepancies/ inconsistencies in the documents appended:

- On the day of admission RBS was 64 mg/dl (normal range 70-120 mg/dl) which implies that the patient had hypoglycemia and WBC was 16,000/cmm (normal range 4,000-11,000/cmm), implying bacterial infection but the cognizance of these findings was not taken as these tests were not repeated prior to the discharge, as neither the reports nor the bills are available, implying that these deranged lab findings were not the reason for hospitalization.
- One of the presenting complaints is decreased oral intake and it has not been resolved till the discharge and the patient was discharged with decreased oral intake, implying that this was not the reason for hospitalization.
- As per the TPR chart, the patient's vital parameters were monitored more than 10 times a day, but the insured mentions her temperature, BP and pulse were checked only 3-4 times a day, this shed doubt on the veracity of the findings and hence the veracity of the documents too is doubtful.
- As per the hospital tariff, rent of the Suite room, the room in which the patient was admitted, is Rs 3,000/- per day but the hospital bill has levied Rs 3,500/- per day; this implies inflation in charges levied by the hospital.
- The hospital has billed Rs 14,800/- and inpatient receipt is available which mentions that the payment of Rs 14,800/- was made in cash; but as per the insured payment to the hospital is pending; this raises doubt on the veracity of the Inpatient receipt.
- As per the insured during the hospitalization she went home for taking a bath but the treating doctor's clarification letter mentions that the patient never went outside the

hospital during admission except for sonography, but the signature of the treating doctor on the clarification letter differs when compared to his signature on the discharge summary.

- The medication sheet and the TPR chart do not bear the signatures of the nursing staff.
- The patient has been suffering for 3-4 days but there is no evidence of OPD treatment attempted prior to the hospitalization.

Patient could have been treated on OPD basis and hospitalization was not required. Further, the discrepancies noted above shed doubt on the veracity of the documents and the veracity of the rationality in the management of the patient.

For details, drop in a mail to info@inchesgroup.com