ASSESSMENT OF MEDICAL RECORDS (OPEN & CLOSE FILES AND PRESCRIPTION) FOR QUALITY IMPROVEMENT THROUGH INTERNAL AUDIT

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By

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Under the Supervision and Guidance of

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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Mr. Akshat Tomar** S/o Mr. Ramraghuveer Singh has successfully completed his internship program from **10 April 2024 to 10 June 2024** at Apex Hospitals Pvt. Ltd. Malviya Nagar, Jaipur.

He has completed his internship in the area of **Medical Operations.**

We wish him all the best for his future endeavor.

For Apex Hospitals Pvt. Ltd.

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Authorized Signatory

DECLARATION BY STUDENT

I hereby declare that this dissertation titled **assessment of medical records (open & close files and prescription) for quality improvement through internal audit** is the Bonafede record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Dr Akshat Tomar

(Signature)

Date :- 5th july 2024

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that dissertation titled ASSESSMENT OF MEDICAL RECORDS (OPEN&CLOSE FILES AND PRESCRIPTION) FOR QUALITY IMPROVEMENT THROUGH INTERNAL AUDIT is a record of the research work undertaken by Dr Akshat Tomar in partial fulfilment of the requirements for the award of the degree of MBA (Hospital Management) from the IIHMR University, Jaipur under my guidance and supervision and his approach to the research study has been sincere, scientific, and analytical.

8/7/24

Faculty Guide

IIHMR University, Jaipur

Date 5th/July/2024

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Best Regards

Dr Akshat Tomer

01/07/2024

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ABSTRACT

KEY WORDS:

Medical record, open files, close files, prescription and internal audits.

BACKGROUND

Through internal audit processes are beneficial to healthcare institutions because through such processes, they are able to determine areas that require attention with regard to improvement. monitor key performance pointers; and in the long run boost the general quality of services provided to patients. The present paper shall focus on the significance of intake of evaluating medical documents, especially in connection with the existence of open and closed files, and prescription. interventions, to ensure improvement of practice in healthcare facilities

OBJECTIVE

Identifying discrepancies, errors, and omissions in medical records and prescriptions, Ensuring the accuracy, completeness, and timeliness of documentation. And lastly Improving the legibility and organization of medical records and prescriptions.

METHODOLOGY

A comparative study involving 200 patients data (open file, close file and prescription), from apex hospital suitated in jaipur was conducted. Random sampling was used for selection of 200 patients data (open file, close file and prescription). Data was gathered from the admitted patients of all floors of Apex hospital situated in jaipur using the interanal audit and evaluate all the medical record.

RESULTS:

The main focus of the study was improving medical records' credibility and enhance the quality of patient care to a greater extent of Apex Hospital in jaipur. During the study conducted in Apex hospital jaipur, every morning during the rounds in different floors, it was clear that there were several issues in the hospital which needed attention. The data collected gave an insight to the specific gaps in deficiency in service which were to be analyzed and given solutions upon

CONCLUSION:

The assessment of medical records, open and closed files, and prescriptions plays a vital role in quality improvement within healthcare institutions. The aim and
That being said, the objectives of internal audits on medical records and prescriptions initiated are as follows: to improve the quality, safety, and satisfaction of patients. Therefore, healthcare institutions should strive to fix all sorts of problems concerning documentation and prescriptions in order to proactively avail quality care to the client.

CHAPTER-1 Introduction -

From this perspective, the credo pertaining to medical records in the ever-shifting context of healthcare is the following

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documents, especially in connection with the existence of open and closed files, and prescription.

interventions, to ensure improvement of practice in healthcare facilities.

They lay the foundation of patient care since documented medical records are essential tools in the doctor patient's relationship.

the detailed records of patient's diagnosis, key findings and management plans.

medications. These kinds of records have to be, and should be up-to-date, and must be retrievable with ease.

available to the providers to enable provision of quality services to the patients.

It is evident that the elements of analysis of both open and closed medical records are used in the discharge of this task.

To find faults and omissions that can interfere with the delivery of patient care, I used.

registered medical records are defined as actual open accounts that are documented as currently being active.

constantly replenished by the health care professionals from affiliated health facilities. These records must reflect the respect for the children's rights in accordance with the provisions of section 55 of the Children Act of 2001.

most current data concerning the patient's health status, therapy regimen, and more.

any modifications of the medicines or treatments. Through internal audit processes,

Institutions of health can privately take a look at the open records that concern them to be certain that

one is sure that information is correctly recorded, that all the necessary data is incorporated, and

it is appropriate because any changes in a particular patient's health status are handled effectively.

Furthermore, a review of selective charts; these refer to records of patients that are no longer active in the facility.

Files that are closed or discharged, also has equally important roles of pushing the act forward.

quality improvement. A closed record gives the worker a broader picture of a

patient's entire treatment process facilitating subsequent healthcare providers to assess the previous

measures, results, and any possibilities for improvement of the implemented interventions. By

In managing a patient's record, closed records particularly are closed to the public hence, through needed audits, various health care institutions can

determine the characteristics, tendencies and good practices that can be followed to improve

future patient care.

Prescription practices are another major focus area of the medical record review, which

can be considered to have a major influence in quality improvement in healthcare. Medication

MEDICAL RECORDS

Medical records refer to the source of data which is in recorded form detailing health status of a patient and his/her treatment. Such records are useful to health care facilities for to have a complete history of a patient's health, diseases, operations, prescribed drugs, and diseases to which the patient is allergic or diseases that run in his/her family. Documentation entailing past and current medical history, results of the laboratory and diagnostic tests, imaging studies, as well as the treatment regimen of the patient. The importance of maintaining comprehensive, accurate, and current medical records is vital in the delivery of healthcare that patients need and are entitled to, as it aids in the coordination of the patient's care by all the health care givers or entities involved and help to avoid medical errors that may occurred due to lack of updating medical records. More so, medical records are essential in research, quality improvement, and matters to do with the legal processes of healthcare. This means that standard polices and measures must be adhered to in the healthcare facilities in order to ensure that; data and information in the medical records are secured and protected from the public domain. Thus, electronic health records that are common these days, assist and help in the ways of communication and sharing of medical info with different healthcare providers. Finally, it can be stressed that the medical records remain among the significant elements of the healthcare system and it cannot be overestimated the role that it plays in providing the population with safe and quality medical assistance.

OPEN FILE MEDICAL RECORD

Open file medical records are extremely useful in the healthcare setting as a method of organizing and maintaining patient records concerning the treatment strategies. These records include information about a patient's previous illnesses and diseases, their treatment history, surgical operations, prescribed medications and known allergies, and test outcomes. These records play an important role in the manipulations of the healthcare provider about a specific patient's condition and possible course of action to take. Thirdly, under the open file medical records system, the caregivers and all the physicians and other providers treating the patient get updated and significantly informed. In addition, records offer a full detailed passive health history of a patient which is

important when considering tendencies or cycles that the patient may go through in the future. In general, open file medical records are crucial in the provision of efficient and quality services.

CLOSE FILE MEDICAL RECORDS

As members of healthcare profession, and as part of DC's policies and procedures, client records must be properly closed and kept as per the applicable laws and regulations. The act of closing a record in medical field means that the patient has been treated, and thus forms the basis for the correct filing of important health information. The paper work must be properly done and available up to date and appropriately stored and secured to ensure patients' privacy and confidentiality is observed. Closing medical records also enable the provision of care by summarization of patient's medical history, treatment and conclusions that might be essential for future management of the patient. There are factors that must be observed when closing a medical record or dictating how they are to be closed since such records must be well-organized for purposes of being retrieved when needed in the future. Also, the involvement of well-organized and accurate medical records can facilitate the communication and improve care coordination among the medical professionals; this is done while adhering to legal and regulatory standards. Hence, in order to achieve the best result, it is advisable to follow required protocols and regulations regarding the proper closing of the medical records and their further storage.

PRESCRIPTIONS

Prescription is a vital tool in present day health delivery system whose primary usefulness is to help patient get the right drug regime and management of their diseases. The prescription of the drugs entails the assessment of the medical history of the patient, current complaints, and other aspects before the prescription of the medications to ensure that the patient is fit for the drugs that are going to be given to him or her. The guidelines and protocols that have been put in place in the provision of health care are very imperative to ensure that errors in writing prescriptions or provision of medication are also restricted to the highest level. Besides, prescriptions act as a written order, course of

treatment, details, and dosages of drugs and directions on the use of the drugs accompanied by instructions and any warning that the patient should heed. Individuals are urged to stick strictly to the recipes given to them by the physi Crimean health care practitioners and report any uneasiness or complication immediately. Finally, prescriptions are a key driver of patient health and facility of numerous conditions' management.

Electronic Prescriptions

Electronic Prescriptions also known as EMRs has gone a long way in managing patients information than the conventional paper base prescriptions. It enables the Health care practitioners to get the exact and up to date clinical data from the patients within the comfort of a click hence enhancing the quality of service delivery to the clients. Moreover, electronic medical records improve the sharing of information among practitioners, decrease administrative work, and increase productivity in healthcare facilities. Adopting electronic medical records is a necessity for the health care intuitions of the modern society to provide quality services to the patients.

Hand-Writing Prescriptions

Further, legibility and accuracy when prescribing the medications is crucialary for the healthcare professionals especially while hand-writing the prescriptions. The doctors' messy writing causes confusion to the pharmacists and possible mistakes for the patients. Special care should be taken by the medical providers to write a clean and legible prescription where no regarding odd abbreviations rather than the generally recognized ones are used on the prescription and no other unwanted items are written on the prescription that might divert the attention of the pharmacist who is deciphering the prescription. Moreover, it is vital for the prescribers to verify several things before forwarding the prescription to the pharmacy to prevent misunderstanding or

miscommunication of the intended medication and dosage instructions. Regarding the consideration in hand-writing prescriber's instructions, healthcare professionals prizing legibility and avoiding mistakes are important for enhancing patient safety as well as the proper efficacy of prescribed treatments.

AIMS & OBJECTIVES

The study aims and objectives according to the research questions are as follows:

Information found in open and closed medical records, and prescriptions are vital in the evaluation of quality in health facilities. Thus, the primary and secondary goals of such kinds of evaluation through internal audit are diverse and are of paramount importance in providing the best possible care to the patients. This essay will discuss the justification for the assessment of medical records, the purpose of the activity and part that internal audit plays in it.

First of all, the evaluation of clients' records is crucial to keeping it updated, comprehensive and compliant with the law. It is a record of a patient's history including diagnoses, treatments, and other health information kept in the interest of the individual patient. Hence, it becomes significant that the patient records are frequently audited so that they accurately reflect the current and correct information that meet legal requirements. Through completion of comprehensive evaluations on such files as the open and closed file, it becomes possible to note any disparities, deficits or questions arising that may affect standards in the healthcare organizations.

However, the evaluation of prescriptions also plays an important role in stabilizing the situation and maintaining patient protection and high quality of work. Prescriptions are the notes that dispense directions on what the patient has to do concerning a particular drug, how often to take it, among others. Some of the eliminations or misrepresentation in prescriptions may lead to dangerous outcomes such as drug reactions, medication mistakes, and failure of the treatment. When the prescriptions are audited internally, it can help in the identification of possible problems such as wrong dosages, drug combinations/contraception's, or expired drugs. This enables the facilitation of the early detection and rectification of any mistakes that may have been committed with the intention of protecting the patients from any harm.

The intended purpose of auditing of medical records and prescriptions for quality is directed towards the improvement of the results that are being delivered to the patient, their satisfaction, and needed safety. Through proper analysis of the problems that arise in documenting the patient data and the prescriptions, healthcare institutions can complement the quality of healthcare given to the patients. Such studies may seem to enhance health benefits, curb medical mistakes, and boost patron satisfaction. Also, it contains the accuracy and completeness of the medical records and prescription since it is legal to observe as per some country laws and regulations. It means that institutions that pay much attention to the proper assessment of documentation routines are in a better position to address the demands of the regulations and avoid legal dangers.

Thus, creating objectives is essential in order to succeed in the set aim of enhancing quality through medical record and prescription review. The

objectives of conducting internal audits on medical records and prescriptions may include:

The objectives of conducting internal audits on medical records and prescriptions may include:

1. Identifying discrepancies, errors, and omissions in medical records and prescriptions.

2. Ensuring the accuracy, completeness, and timeliness of documentation.

3. Improving the legibility and organization of medical records and prescriptions.

4. Enhancing communication and coordination among healthcare providers.

5. Monitoring compliance with legal and regulatory requirements.

6. Implementing corrective actions and continuous quality improvement processes.

By setting clear objectives for the assessment of medical records and prescriptions, healthcare institutions can focus their efforts on specific areas for improvement and measure the effectiveness of their internal audit processes. Additionally, establishing objectives helps to prioritize resources, allocate responsibilities, and track progress towards quality improvement goals.

In conclusion, the assessment of medical records, open and closed files, and prescriptions plays a vital role in quality improvement within healthcare institutions. The aim and
That being said, the objectives of internal audits on medical records and prescriptions initiated are as follows: to improve the quality, safety, and satisfaction of patients. Therefore, healthcare institutions should strive to fix all sorts of problems concerning documentation and prescriptions in order to proactively avail quality care to the clients. Internal audit provides an efficient

method of overseeing and enhancing the efficiency, comprehensiveness, and compliance of the medical reports and prescriptions. When health care organizations define the purpose of these assessments, they can track their performance in accomplishing improvement objectives hence provide improved care.

1. Locating any missing information, mistakes and anomalies in documents concerning patient's medical history and prescriptions.

The need to embrace accurate and advanced records and prescriptions of illnesses is an essential factor in the attainment of quality patient care. It is vital to detect failures, mistakes, and oversights in these documents for the patient's safety and to minimize the risk of adverse outcomes. Physicians and other medical personnel need to ensure that they scrutinize all medical documents as well as prescriptions looking for elements such as disparity, inaccuracy, or omission since such discrepancies might help in the development of unfavourable effects. It is a common occurrence to have wrong input of the patient information or may be wrong prescriptions as far as dosage and frequencies or completely missed out significant facts such as an allergic reaction or some other medical history of the patient. This paper will explain how risks can be contained, and patients provide with ideal and efficient care through review and verification mechanisms. Moreover, the use of eHS and CDSS in one's clinical practice enables easier identification of such differences and can also easily improve the corrections made. The outcome of this discussion is that with strong emphasis on the specifics of medical documentation, health care systems would train and improve the quality of the interventions towards patients.

2. The following are the main objectives of record management:

In the sphere of professional activities, the relevance, the comprehensiveness, and the actuality of documentation are among the most important

responsibilities. To provide record of information in a business and organizational setting, documentation is a process that is carried out when compiling documents such as reports and records among others, and it is a very crucial aspect of a business or an organization's operations as it is the foundation of its functionality and credibility. Documentation, is not so much about detail and getting facts correct to the decimal point but so much about the pursuit of standards and the desire to maintain them. Accuracy of information is crucial and that is why even an individual figure, letter or word should not be taken lightly to avoid compromising the information being provided. Whereas, the completeness requires the approach that does not leave any single opening or void in the entire process. A complete document shortens the risk of omitting some area of the subject matter and makes sure that all the vital details are included. However, the timeliness in completing documentation is essential in the ever-adynamic environment of today's business and scholarly world. On this note, flexibility and efficiency in providing and delivering the output encapsulates a good organizational response. Since documentation affects decision-making processes, delayed production of the report hinders the proper functioning of the organization. For this reason, implementing strong procedures and processes of document handling is very critical. They should include all aspects starting from the generation and/or collection of documents to the revision and approval processes as well as the dissemination systems. Besides, it is equally evident that the adoption of technology to manage the documentation processes cannot be overemphasized. Starting from the special software for writing, ending with Cloud space for editing, technology has a lot of solutions that helps to make documentation accurate, complete, and timely. However, as many an organization gets swept off their feet with technological innovations it is vital not to lose the human factor in documentation. Technical writers with ample experience and the vision to look out for minutiae, are indispensable when it comes to reviewing and standardizing all documentation procedures. Hiring and bonus incentives should be introduced to encourage the organization to follow high standards of documentation. Thus, the strict following of protocols, guidelines and formats in documenting does not only

pertain to punctuality and correctness but actually represents the authors' scrupulousness in departing the profession and everyday work with honesty and dedication.

Ensuring better presentation and arrangement of the documents and prescriptions in the domain of healthcare.

In particular, medical records and prescriptions format and structure are indispensable components that reflect how the healthcare delivery system is managed and, therefore, influence patients' welfare. Enhancing the readability of electronic medical records helps physicians to understand the information about the patient's medical history, medical conditions, drugs prescribed, and/or the nursing care plan for the patient. Inability to identify the written contents can affect prescription writing, diagnosis, and analysis of a patient's condition which puts the life of patients in danger. Likewise, proper management of records of patients'' especially health records and prescriptions is vital for the efficient provision of medical services. It eliminates confusion on who to work on what, decreases the likelihood of losing documents and/or files, and provides easy access to important documents when the need arises. Hence, emphasizing on measures that improve legibility and arrangement of information in the clinical records will be very vital in this field, to guarantee a standard form of administration in the patient industry. This could include the following, organising documents into the correct forms, adoption of the electronic health record systems, course on how to document properly, and prescription management system. Incorporation of the methods of appropriate text formatting, standardization of labeling of patient documents and prescriptions can greatly enhance the safety of the operations in healthcare departments as well as overal quality of treatment.

4. Improving the interaction and cooperation of various healthcare workers

The foundation of healthcare and patient care lies in proper communication and professional collaboration of the staff. The enhanced coordination wherein multiple

healthcare professionals are needed each coming with his or her special skills and approach implies the need for an effective communication system that should allow

organisations should remain committed to compliance, ensuring that they monitor it to the necessary extent and avoiding becoming legally liable and remain equipped with the tools needed for creating organisational change, which in turn will lead the organisations to stability and successful sustainability. With focus on computerisation of the primary care workplace, including effective EHRs, remote consulting, team messaging and periodical interprofessional team conferences, the health care professionals can overcome silos and collaborate effectively and purposefully from the patient's perspective. Also, relating to the communication, protocols, guidelines, and perhaps, standard operating procedures may be developed to enhance the very processes and guarantee that information, which, indeed, plays a crucial role in providing care continually, is transferred without errors. Higher-level management must establish a structure for handling communication- and coordination-related issues, for that is the key to making patients better, avoiding failures and mistakes, increasing the efficiency of entities and institutions in the system, and creating a learning environment that promotes knowledge sharing and adaptation.

5. Being updated on the legal and regulatory policies.

The compliance with legal and regulatory is a very important activity that has to be carried out to ascertain how organizations are conducting themselves in an ethical and legal way. It entails periodic survey and analysis to determine the extent to which the organisation is compliant to the legal requirements of industries it operates in. By doing this, a firm is able to come across with any violation or non-compliance with the set laws which can later lead to legal suits to be taken to court. Thus, the regular assessment of compliance helps organizations prove their willingness to adhere to the norms of ethical activity. Also, customers, investors and regulators take comfort in knowing that the organization is committed to ushering to the rules and regulations that herald the sector. Compliance monitoring is a critical legal tactic in any organization since failure to adhere to the rules of the business world can lead to the compromise of the organization's reputation and

credibility in the marketplace. As today's regulatory framework becomes more and more demanding, compliance monitoring has to become an essential function for every organization as a part of governance and risk management systems.

6. Initiating appropriate corrective actions and the ongoing concept of quality improvement.

Applying corrective action and cqi's are critical factors in any organization because they are regarded as main organizational end technology strategies. Thus, it would be possible not only to identify the primary threats that emerged from the analysis of the SWOT but also reveal the tendencies that require additional attention and corrective measures by the company. And this in turn also means that the organization is functioning at its optimum level which certainly has positive effects on performance and productivity. The Acceptance of the concept of continuous quality entails the routinised assessments and improvements of the current processes with a view of optimising them. It laid emphasis on the fact that in order to overcome the business rivals and to meet the newer challenges in the market, one must always try to find new ways through which the working of an organization can be made more efficient. In regards to these initiatives, in the long run, they cause the customers, employees and the organization to be happy hence gaining high results. Hence, effective and timely corrective actions and established continuous improvement programs remain strategic for companies to sustain their competitive advantage in today's dynamic business environment

CHAPTER-2 Review of literature

1. Madhav M Singh, Saroj Patnaik, Bhandaru Sridhar in 2017 December states that Medical records are technically valid health records which must provide an overall correct description of each patient's details of care or contact with hospital personnel. And it form a very important and critical document in hospital. These records are vital for legal purposes and for future planning of the hospital medical care. All possible steps should be taken to ensure that all hospital medical records are maintained in systemic and orderly manner. The importance of the medical records should also be communicated to all staff. Periodic audits of the medical records will help to determine the possible deficiency in keeping records, which can be improved and worked upon by the hospital. And he also recommend Root cause analysis should be conducted to determine the rationale for departmental lapses.
   The interns should be made aware of the significance of accurate record keeping for both patient care and research by the clinical and administrative personnel.
   Standardisation of medical record keeping, including admission and discharge summaries, across the whole hospital.

   In hospitals, emphasis should be placed on rewarding the top-performing departments/units and teaching and training the accountable personnel to keep a thorough record of every patient.
   A quarterly medical audit of the documentation process ought to be conducted.
   It is important to provide proper training to the interns and residents who are in charge of filling up the inpatient records in a methodical way.
   Every week, a consultant reviews the medical data to ensure than

2. Maleka Serour and Abeer K. Al-Baho came to the conclusion in 2002 that auditing is the process of critically and methodically evaluating our own professional actions with the goal of enhancing individual performance and, ultimately, the quality. An audit is a cycle made up of certain tasks that must be carried out in order to provide the intended

results. The subjects chosen ought to be pertinent and ought to touch on areas that want improvement. Any comprehensive approach to auditing must start with the identification of clear audit criteria. The standards that are set should be reasonable and doable. The amount of data collected should be limited to what is required to achieve the specific audit's objectives. Everyone involved should be ready to make the necessary adjustments. Putting changes into practice is the most difficult step in the audit cycle. The team must determine whether to proceed with any necessary efforts to reach higher standards or whether it is content with the performance, particularly with respect to those results that are close to the set standards, after the results are presented to it. This is especially appropriate in cases when the initial requirements were set lower than 100%. Resetting the agreed-upon requirements to reasonable percentages can occasionally be justified in the case of poor performance. The group needs to talk about how they need to work together, adjust, and meet the predetermined goals. It must weigh the benefits and drawbacks of each option before selecting the best fit. It must take into account the most realistic approaches, and everyone participating in that phase must be familiar with the aims of doing that and their roles. The team must determine whether to acquire additional data and when to repeat the audit in the future. It is imperative for the audit leader to oversee the process and encourage others to contribute their thoughts in order to bring about change and maintain excitement.

3. A study conducted in 2021 by Suman Agarwal, Ranjit Singh, and Chandra Kant Upadhyay concludes that an organisation must continuously examine the quality of its services if it is to endure longer. Additionally, the expectations of the patient and the management must be well synchronised. Singh and others. (2020) have developed a fuzzy analytical hierarchical approach to address six additional aspects, and they have named it "Heal Qual" in order to address the current situation. Therefore, in order to comprehend the most recent developments in customer preferences, managers need to keep scanning the environment. Patient satisfaction is a function of health service quality perceptions, and patient satisfaction determines whether or not patients are loyal to their healthcare providers (Naidu, 2009; Suhail & Srinivasulu, 2021). To increase market share and gain patient loyalty, healthcare facilities must enhance their service quality (Arab et al., 2012). This will also increase profits and draw in new

patients (Ravishankar et al., 2018). To ensure that patients receive the appropriate calibre of medical care, service quality must be raised (Wu, 2011). Nonetheless, there is a need to enhance service quality in all the areas the study found, as there is a general discrepancy between patients' views and expectations (Ranjith, 2018; Lim & Tang, 2000; Aghamolaei et al., 2014). This can necessitate adding a new dimension (Carman, 1990) or changing or eliminating the prior dimensions of service excellence (Khambhati, 2017). As a result, one of the most crucial success elements for the healthcare sector is service quality, which must be improved in accordance with the needs of patients and the changing environment, with a focus on enhancing customer experiences. Figure provides a kaleidoscopic overview of the studies conducted on service quality with regard to hospital units.

4. By using this framework, healthcare providers can comprehend how patients and those who accompany them assess the overall quality of the treatments they receive. Healthcare administrators can measure themselves against rivals by using the suggested instruments to get feedback on how they are performing on service quality characteristics. The citation analysis indicates that, in order to improve productivity and efficiency, particular attention should be paid to effective operations, independent of employee-related procedures. Future research will focus on examining additional service quality models that have been published in the literature. The secret to the success is choosing the right model that balances client loyalty and service excellence. The effective application of quality management in medical facilities. With the following implications for the study topic, the analysis and analytical evaluation can assist in identifying the mechanisms and causal links with the components described in implementation processes.

5. A 2021 study by Nicole Rose and Daniel S.J. Pang emphasises that the main objective of clinical audit is quality improvement, which comes from looking at and assessing procedures and results in comparison to clear standards. As a result, the standard of care ought to rise in the end. A framework for ethical review is provided by an understanding of the audit cycle process. Assuming that clinical audit is exempt from ethical scrutiny is oversimplified. Despite the fact that clinical audit frequently varies from prospective clinical research in that it does not randomly assign animals to undergo distinct treatments

6. 6. Mokholelana M. Ramukumba Souher El Amouri came to the conclusion in 2018 that while there are many ways used to keep an eye on the quality of documentation in nursing practice, documentation auditing is one of the key tactics in processes aimed at improving quality. The nurses talked about how they took part in the audit of the documents. Data demonstrated that the audit procedure used adhered to the general audit framework, which offered the necessary organisation and substance for the gathering, analysing, and presenting of data. It was discovered that the audit's planning and preparation were strong points. This study identified a number of enablers for this team's documentation audit implementation. Regardless of the degree of assurance or proficiency they expressed, there was sound preparation, and the audit's purpose and process were clearly stated. The team's decisions to improve the audit process and tool's validity and reliability were strongly backed by the literature. The basis for the audit criteria was provided by the hospital's and SEHA's standards and rules. These served as reference points for evaluating the level of documentation. As a result, the audit had sufficient organisational backing. Despite having many jobs and time constraints, the study participants showed commitment. According to this survey, nurses were largely satisfied with the policies and the auditing procedure they used. They acknowledged some progress in the form of improved documentation in the audits that followed. On the other hand, there were issues like ongoing revisions to the documentation processes, which call for changing the audit tool. It is accepted that electronic documentation is more sophisticated than paper-based audits. This study demonstrated the importance of documentation audits in guaranteeing the accuracy of patient records, the involvement of nurses in audits, and the chance that audits offer to compare the standard of documentation in nursing practice with the recommendations.

7. Kabiru Danladi Garba and Yahya I.'s 2018 study shows that information is clearly crucial for every patient to receive the right care. In this specific instance, the value of the information generated to support hospitals cannot be quantified, nor can the exact cost of doing so. One cannot overstate the benefits of having medical records. The purpose of a medical record, which is a crucial tool in both hospital and medical practice, is to improve patient care by meticulously documenting all pertinent information related to the patient's condition. Medical records are therefore necessary to guarantee that patient data is kept up to date and used in a methodical manner. He

goes on to say that before utilising electronic medical records, system designers must take into account how personally identifiable patient information will be maintained and also adhere to legal regulations. Among the precautions taken to protect electronic medical records are technological compliance solutions. Data encryption, which limits access to records by managing Internet Transfer Protocols, is one such technology compliance option. To determine who obtained the leaked data in this instance, the activities pertaining to electronic medical records are monitored. Using biometrics (such as fingerprint ID recognition) to secure access to computers on networks and information storage devices is another method of protecting electronic medical data.

8. S.A. MIRAJ in 2022 clarified that by comparing patient care procedures to self-defined standard norms, clinical audits facilitate a more accountable and patient-centric healthcare paradigm. They also give legislators, hospital managers, and medical professionals vital information. It is imperative to provide clinical staff with education regarding the importance of precise form recording and hospital-wide uniformity in the medical record that summarises admission and discharge. The systematic and scientific maintenance of hospital medical records should be ensured with the utmost care; the use of technology techniques and software can greatly aid in the removal of errors. Senior consultants must frequently exercise and explain to all concerned staff the need of maintaining accurate medical records in order to prevent gaps. By doing so, it will be feasible to identify potential record-keeping deficiencies and address them before they accumulate and become noticeable during clinical audits.An previous study by Singh et al8 discovered that the paediatric and gynaecology wards of a multispecialty hospital were not deemed appropriate or up to date among the many wards, including the medical, obstetrics, surgical, paediatric, and psychiatry wards. There was evidently a significant disparity in the quality of record-keeping across the board, primarily as a result of preventable mistakes done with a casual and thoughtless attitude. Robertson et al.9 and Walker et al.10 have also observed that interns and residents are frequently tasked with filling out in-patient records in hospitals that were studied. However, these individuals are not serious in their work, which leads to mistakes and inadequacies. They should be instructed on how to accurately and scientifically fill out the records, and consultants should verify the medical records on a weekly basis to ensure that they are being completed. The results of the current investigation also point to a comparable

circumstance in which the majority of the staff's negligence causes these kinds of errors in audits and medical records. These led to callous audit lapses that violated the NABH requirements because no meaningful monitoring was being carried out, which eventually affected the effectiveness of the healthcare system. Health care system stakeholders can improve health care delivery by using audit information wisely and honestly with the right training. This will assist patients and the government by utilising data provided by the health information system in a way that maximises its benefits Medical records are an essential component of any hospital and are crucial for both legal planning and future development of the hospital's medical care system. Using some of the readily accessible state-of-the-art technology, great care should have been made to guarantee that all hospital medical records are maintained in a systematic and scientific manner. In the current random sampling of the audit files, this was completely lacking. All of the affected staff members should have been informed of the significance of the medical records. Senior staff did not conduct any frequent audits of the medical records, which could have assisted in identifying any potential record-keeping deficiencies. It was suggested by some authors3 that expenditures can be significantly lowered by employing proper health informatics software whereby statistical techniques could be judiciously used for the management of big data suggesting appropriate predictive models and training which could benefit everyone including patients, hospitals, system making it a sustainable.

9. A third-level teaching hospital's internal audit programme significantly improved the quality of medical records before and after it was implemented, according to a 2019 study by E. AZZOLINI et al. Due to significant differences within departments and Care Units, 40% of the required level of acceptability was not fully achieved in the 2013 baseline quality evaluation, which revealed multiple problems. Furthermore, these results align with the descriptions found in earlier research. In 2010, Attena et al. found that the compilation quality was significantly below the reference standard value of 100%. The data that showed the worst quality was related to the physical examination's completeness (56.2%), the patient chart's low presence (12.9%), and the discharge summary (18.0%). Significant variations were observed among the diseases for different items, and teaching hospitals and certain private hospitals demonstrated superior accuracy. Only 0.5% of medical records fully satisfy the 26 quality standards,

according to a 2002 study conducted in many Italian regions by the Agency for Regional Health Services. Even in the hospital with the best performance, the indicator of acceptance stopped at 6.7%. The traceability of signatures in the medical journal was the primary shortcoming. Significant variations were observed among the diseases for different items, and teaching hospitals and certain private hospitals demonstrated superior accuracy. Only 0.5% of medical records fully satisfy the 26 quality standards, according to a 2002 study conducted in many Italian regions by the Agency for Regional Health Services. Even in the hospital with the best performance, the indicator of acceptance stopped at 6.7%. The traceability of signatures in the medical journal was the primary shortcoming. The quality of the pain evaluation in the current study (29.3%) is still an problem and the Drug Therapy Chart's completeness (40.3%), which stand out as the main concerns prior to the intervention.They came to the conclusion that each clinician could utilise the 48-item evaluation grid as a helpful tool to evaluate the quality of a sample of their own medical records, and that internal quality assessment may be used as one of the departmental performance indicators. Our findings highlight the significance of actively involving health professionals in audit and assigning them formal responsibilities for enhancing the quality of clinical documentation while we wait for the complete development and implementation of the electronic medical record, which should improve the quality of clinical documentation.

10. In 2017, Pavan Kumar Kandula and colleagues According to his research, the prescription audit criteria' compliance rate was 64.53 percent. This number needs to be raised by holding monthly staff training sessions as well as large and small team meetings with the organization's physicians. A month-by-month analysis revealed that the number of prescription audit non-compliance cases decreased from 67 in July 2015 to 31 in December 2015. This is mostly because the hospital's management adopted the clinical chemist's recommendation. During the course of his six-month investigation, 1093 prescriptions were examined; Figure 1 displays the patient demographicsMale patients made up the majority (56.4%) of the 1093 patients who finished the research. The age group of 40–59 years old accounted for the majority of study participants (32.4%). Twelve factors in all were accessed for the audit of prescriptions. Based on the chart, we can estimate that out of the 1093 prescription audit samples, only 2.2%

(280) had non-compliance, 64.5% (8464) had compliance, and 33.3% (4372) did not meet the criteria.

11. Tulika Singh pointed out in her 2018 study that in order to increase hospital quality, we must teach our prescribing physicians to write logical prescriptions and follow WHO guidelines.Any hospital that wants to continuously enhance its quality of care and rationalise drug prescriptions should conduct periodic prescription audits. A doctor's prescription is one of their most essential interventions, and it is their ethical and legal responsibility to create clear, concise prescriptions. In our investigation, we discovered that every prescription had the full patient information (name, age, sex, and address) as well as the prescription date. This was a result of the fact that these particulars were printed at the time of registration. Research that audited handwritten prescriptions discovered that nearly all of them lacked patient information.[9] In addition to making sure the patient receives the appropriate care for their illness, it is crucial to provide accurate patient information for medicolegal purposes. Upon analysis, it was discovered that the prescriptions lacked information regarding the patient's history, physical examination, diagnosis, and investigations. The reasons may include a high volume of cases in the outpatient department, vague concerns, or doctors communicating verbally rather than in writing. Regarding follow-up guidance, the rationale for referrals, dos and don'ts, medicine composition, and administration instructions, the prescriptions were lacking. Errors in dosage calculations and treatment duration omissions were also frequent prescribing 27.5% in each case. The majority of medications come in a variety of dose forms and strengths, which makes distributing them difficult. It may also result in side effects related to under- or overdose, including treatment failure, antibiotic resistance, and adverse medication reactions. The most frequent types of prescribing errors identified in numerous research conducted worldwide were incorrect duration, dose omission, and incorrect dose. The doctors' notoriously illegible handwriting is a known cause of medication errors, incorrect drug delivery, and dangerous drug responses. 15% of physicians who wrote prescriptions had handwriting that was difficult to read. Only 3.3% of the prescriptions in our survey included the prescribing doctor's registration number, and 65.8% of the prescriptions had the doctor's signature or initials clearly visible. In order to verify the legitimacy of prescriptions and identify the prescribing physician, certain details are crucial. The use

of capital letters while prescribing medications should be promoted, and if at all practicable, an electronic prescribing system should be used to prevent such errors.

CHAPTER-3 Methodology

Study Area- APEX Hospital, Jaipur

Study Population – APEX Hospital Patients

Inclusion- All the patients who completed and submitted the feedback form.

Exclusion- Day Care Files and Lab Reports

Duration Of the Study- 3 months

Sample Size- 200

Sampling Techniques- Random sampling

Type of Study – Quantitative

Research Questions

- how to improve quality of medical record through internal audit
- find out the difference of medical record quality before and after internal audit in apex hospitals, jaipur
- What are the key challenges of open file, close file and prescription audit in apex hospital Jaipur
- Find out the efficacy of internal audit as tool to improve quality of medical record

CHAPTER-4 Result

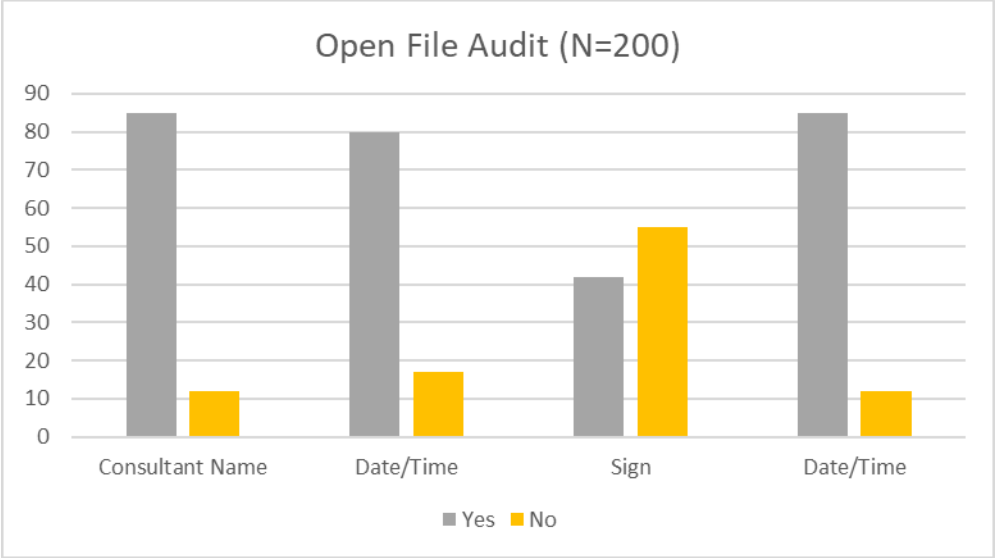

Fig 1

The audit revealed, from a total of 200 files that were audited, it was seen that the consultant's name was recorded in 42.5 percent of them—85—to be exact. This implies that the recording of a consultant's name stood at a medium scale of compliance. Interestingly, in 12 files—6 percent of the total—the consultant's name was not recorded. This may lead to a lack of clarity on the responsible consultant in certain medical decisions, hence affecting the continuity and accountability of the patient's care.

Date/Time Documentation

Proper documentation of dates and times makes accurate medical record-keeping. For the first case of date/time recording in the checklist, 80 cases out of the 200 cases had fully and accurately documented dates and times—a response rate of 40%, while 17 cases, 8.5%, did not. If there are no date/time stamps in the medical history, proper timeline patient care cannot be traced or tracked. The quality of an audit and subsequent medical reviews is affected.

The second date/time recording instance reflected precisely the same findings as reported in the column of consultant name, where 85 had the date and time recorded and 12 were not. This may indicate potential duplication in audit data or a constant pattern in documentation practices, needing further investigation for understanding this correlation.

Sign Presence

The audit revealed a large deficit in sign documentation. Only 42 of the 200 audited files had a sign documented, whereas 55—27.5 percent—had no sign documented. This also represents the highest noncompliance rate of categories reviewed. This huge risk is posed by the lack of documentation on signs because it may lead to ambiguities when checking for authenticity and approval of the same medical records. That will be imperative in maintaining the integrity of the patient's record and also in ensuring that signs are consistently recorded for any legal cases.

Key observations and recommendations

Consultant Name documentation: moderate compliance

The findings indicate that there was a fair level of compliance, with 42.5% of the files indicating the consultant's name. There should be an increase in this percentage by insisting that the importance of such practices be instilled into all medical personnel attending to patients.

Date/Time Recording Practices:

The audit showed a date/time discrepancy in documentation, first at 40% compliance, then mirrored it with 42.5% on the second instance. The current procedures of documentation should be reviewed to improve accuracy by finding and resolving these systemic issues causing such gaps.

Critical Gap in Signature Documentation:

Only 21% were compliant with regard to recording of signs. This is something that needs immediate improvement. Regular training sessions and putting compulsory checks in place would fortify the fact that the signs would be recorded, hence leading toward increasing the reliability and validity of medical records.

CHAPTER-5 Discussion

Consultant Name Documentation

The findings of the audit about consultant name documentation record a mixed case of compliance in the hospital. While 42.5% of cases had correctly documented the name of the consultant, absence in 6% of cases is a worrying trend. There is likely to be an oversight or even failure in adhering to standard documentation protocols. Identification of the consultant for attribution of a medical decision to the appropriate health care provider, allowing accountability and easier follow-up. This was present in only 60% of the notes, suggesting that some staff are more diligent than others and may require further education or reminders regarding this practice.

Date/Time Recording

An accurate recording of date and time is important for maintaining a sequential timeline of patient care. The audit results show that only 40% of the records indicated the first instance of date and time appropriately. A slight increase to 42.5% in the second instance, mirroring the consultant name results, may indicate a flaw in the documentation process or some type

of misunderstanding about the audit criteria. An initial non-compliance rate of 8.5% and a second instance rate of 6% indicate that there is an urgent need for having a standard method for recording dates and times. Such discrepancies at the events related to a patient's care can significantly affect the traceability; therefore, it may affect the clinical audit and patient management.

Sign Documentation

The most alarming finding of the audit, however, was in relation to sign documentation compliance: very low at 21 percent. The high percentage of records missing signatures, 27.5 percent, seriously places under doubt the authenticity and validation of medical records. Signatures are an important endorsement to the information documented, basically signing to confirm that details have been reviewed and approved by the responsible health-care provider. The high rate of non-compliance is an indication that stringent checks are either not in place or that there has been a complete oversight in day-to-day practices. This loophole should be urgently plugged, ensuring that all medical records are signed with full legal and clinical validity.

Implications and Recommendations

The results of these audits reflect miscellaneous important key areas that mainly require serious attention in order to enhance the quality of record-keeping. The moderate compliance for consultant name and date/time documentation, together with a significant gap in sign documentation, may point to systemic problems within the facility's documentation processes.

Training and Education:

The regular holding of training sessions can impress on them the rationale behind complete and accurate documentation. Healthcare providers must understand the critical role that comprehensive records play in patient care, legal compliance, and clinical audits.

Standard Work Procedures:

Thus, standardized procedures with regards to documentation can be designed and implemented for killing variations. Guidelines and checklists shall be given to all staff so that uniformity and completeness in recording certain important details are maintained.

Regular Audit and Feedback:

Apart from this, regular audits and feedback to the staff would help in the detection of areas that are non-compliant and facilitate continuous improvement. Such audits should strive towards understanding the root cause than pitching on gaps alone and address them effectively.

Technology Solutions:

This could be further enhanced through the requirement of fields for consultant names, date/time stamps, and signatures within EHR systems. Automated reminders and validation checks in EHR systems further ensure that all information is recorded accurately.

CHAPTER-6 CONCLUSION

An analysis of nurses' notes on clients' folders within the healthcare facility has provided considerable understanding of the existing status of documenting. The observational audit looked at consultant name insertion, date/time stamping, communication documentation, among other areas, and notably revealed both the admirable practices and deficiencies in the process.

Consultant Name Presence:

Based on the audit of the record, it was revealed that the consultant's name appeared in 42. 5% of the cases. This means that the respondents complied moderately well with the provision of this information; however, the fact that 6% of the respondents did not provide this information at all implies that there is room for improvement in this area. Accurate documentation of the consultant's name helps in holding him/her accountable and also useful when the patient will need the consultant in later visits.

Date/Time Recording:

An important procedure that cannot be overemphasized is the documentation of date and time as this helps in establishing the timeline of the treatment process, and the study identified that this was done poorly. Again, in the first instance of the date/time recording, there was an indication in 40% of cases, whereas; the second instance recorded a slightly higher figure of 42 percent. 5%. The inclusion of these numbers speaks to the importance of 'best Practices' that would help in the proper definition and specification of date and time while recording medical records to improve on the possibility of creating connected and coherent medical records.

Sign Documentation:

The worst result was observed in the sign documentation compliance where only 21% of the records were signed appropriately. This the case as there is absence of signatures in 27. Frequently, the illegitimate production takes place 5% of cases which is potentially dangerous to the reliability and accuracy of medical records. Use of signatory whichever documentation is being created is very important in order to uphold legal and clinical accountability.

Key Recommendations:

Enhanced Training and Education: Staff should be put through training where documentation is stressed as an important process and where they are introduced to prescribed documentation protocols.

Standardized Documentation Procedures: It is for this reason that problems of recording important information should be addressed by developing strict procedures and formats or checklists.

Regular Audits and Feedback: Audits that are periodically conducted along with other constructive criticisms will help to expose areas of non-compliance and constant improvement.

Often the illegitimate production happens 5 percent of the time which is very risky to the credibility and precision of the clinical records. Therefore, wherever any documentation is being prepared, the use of signatory is highly important in order to bear legal and clinical responsibilities.

Enhanced Training and Education: Staff should be put through training where documentation is stressed as an important process and where they are introduced to prescribed documentation protocols.

Standardized Documentation Procedures: It is for this reason that problems of recording important information should be addressed by developing strict procedures and formats or checklists.

Regular Audits and Feedback: Audits that are periodically conducted along with other constructive criticisms will help to expose areas of non-compliance and constant improvement.

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ANNEXURE

Open File Audit

S.No	DATE	MNIP/UHID	Department where file audited	History	Plan of care(Ticked)	Consultant Name	Nutrional Assessment	Countersigned by doctor details						Medication Chart					Consents					Initial Assessment			Tra
								Consultant Name	Date/Time	Sign	Resident Name	Date/Time	Sign	Total medicine	Total Medication in Capital	Dose	Frequency	Route	Informed	HIV	High Risk	Ventilator High Risk	Surgery	pt. in time	pt. Initial Assessment time	TAT (MINS)	Transfusion Consent
1	07-04-2024	359628	SICU	Y	Y	BM GOYAL	Y	Y	Y	Y	Y	Y	Y	15	15	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	WRONG	N/A
2	10-04-2024	2400534	HDU	Y	Y	VIJAYANT	Y	N	N	N	Y	Y	Y	7	6	Y	Y	Y	Y	Y	Y	N	N	N	Y	not	N/A
3	15-04-2024	2400741	PVT-123	Y	Y	SACHIN	Y	N	Y	Y	Y	Y	Y	3	3	Y	Y	Y	N	N	N	N	N	Y	Y	10	N/A
4	14-04-2024	2400707	DEL WARD	Y	N	PRITHVI	Y	Y	Y	N	Y	Y	Y	10	10	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	WRONG	N/A
5	08-04-2024	2400396	PVT-123	y	y	KAPIL DEV	Y	Y	Y	Y	Y	Y	Y	9	9	Y	Y	Y	N	N	N	N	N	Y	Y	30	N/A
6	22-04-2024	2401066	SPVT-134A	Y	Y	SACHIN	Y	N	N	N	Y	Y	Y	8	6	Y	Y	Y	N	N	N	N	N	Y	Y	WRONG	N/A
7	11-04-2024	2400590	CTVS	Y	Y	BM GOYAL	Y	Y	Y	Y	Y	Y	Y	20	10	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	30	N/A
8	17-04-2024	2400895	HDU	Y	Y	VIPUL	Y	Y	Y	N	Y	Y	Y	7	7	Y	Y	Y	N	N	N	N	N	Y(5PM)	Y(4:30)	WRONG	N/A
9	07-04-2024	2400348	GW	Y	Y	KULDEEP	Y	Y	Y	N	Y	Y	Y	9	6	Y	Y	Y	Y	N	P	N	P	Y	N	not mentioned	N/A
10	08-04-2024	2400392	DEL WARD	Y	Y	VIPIN	Y	Y	Y	N	Y	Y	Y	5	5	Y	Y	Y	N	N	N	N	N	Y	Y	0	N/A
11	23-04-2024	2401132	SPVT-533	Y	Y	SACHIN	Y	Y	Y	Y	Y	Y	Y	13	3	Y	Y	Y	Y	N	Y	N	Y	Y	Y	16	N/A
12	03-04-2024	2400149	DEL WARD	Y	Y	SACHIN	Y	Y	Y	Y	Y	Y	Y	10	6	Y	Y	Y	Y	N	N	N	Y	Y	Y	320	N/A
13	04-04-2024	2400207	DEL WARD	Y	Y	SANDEEP	Y	Y	Y	N	Y	Y	Y	8	8	Y	Y	Y	Y	Y	Y	N	Y	Y(1:20PM)	Y(1:08PM)	WRONG	N/A
14	08-04-2024	2400416	GW	Y	Y	KULDEEP	Y	Y	Y	N	Y	Y	Y	10	9	Y	Y	Y	N	N	N	N	N	Y	Y	60	N/A
15	06-04-2024	2400327	ICU-3	Y	N	LALIT	Y	Y	Y	Y	Y	Y	Y	4	4	Y	Y	Y	Y	Y	Y	N	Y	Y(6:30PM)	Y(5:00PM)	WRONG	N/A
16	12-04-2024	2400641	DEL WARD	Y	Y	ANAND MOHAN	Y	Y	Y	N	Y	Y	Y	2	2	Y	Y	Y	N	N	N	N	N	Y	Y	120	N/A
17	26-03-2024	2318536	HDU	Y	Y	LALIT	Y	Y	Y	Y	Y	Y	Y	19	15	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	30	N/A
18	03-04-2024	2400147	SPVT-513	Y	Y	ASHISH	Y	Y	N	Y	Y	Y	Y	10	10	Y	Y	Y	Y	N	N	N	Y	Y	Y	110	N/A
19	04-04-2024	2400185	SPVT-537	Y	N	SHAILENDRA	Y	N	N	N	Y	Y	Y	10	9	Y	Y	Y	Y	Y	N	N	Y	Y	Y	20	Y
20	10-04-2024	2400542	CTVS	Y	Y	AMIT	Y	Y	Y	N	Y	Y	Y	10	10	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	30	Y
21	11-04-2024	2400591	DEL WARD	Y	Y	AJAY PAL	Y	Y	Y	N	Y	Y	Y	18	15	Y	Y	Y	Y	N	N	N	N	Y	Y	15	N/A
22	17-04-2024	2400878	DEL WARD	Y	Y	SUNIL	Y	Y	Y	N	Y	Y	Y	2	2	Y	Y	Y	Y	N	N	N	Y	Y	Y	7	N/A
23	08-04-2024	2400386	SPVT-513	Y	Y	KULDEEP	Y	Y	Y	N	Y	Y	Y	6	6	Y	Y	Y	Y	N	N	N	Y	Y	Y	0	N/A
24	02-04-2024	2400081	DEL WARD	Y	Y	SACHIN	Y	N	N	Y	Y	Y	Y	9	9	Y	Y	Y	Y	N	Y	N	Y	Y	Y	10	N/A
25	03-04-2024	2400123	SPVT-538	Y	Y	VIPUL	Y	Y	Y	Y	Y	Y	Y	26	23	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	75	N/A
26	19-04-2024	2400952	CTVS	Y	N	BM GOYAL	Y	Y	Y	Y	Y	Y	Y	8	8	Y	Y	Y	N	Y	Y	Y	Y	Y(9:30)	Y(9:00)	WRONG	N/A
27	29-03-2024	2318723	DEL WARD	Y	Y	VIJAYANT	Y	Y	Y	N	Y	Y	Y	7	7	Y	Y	Y	Y	N	N	N	N	Y(4:00PM)	Y(2:30PM)	WRONG	N/A
28	05-04-2024	2400250	SPVT-529	Y	Y	PRADEEP	Y	Y	Y	Y	Y	Y	Y	8	7	Y	Y	Y	Y	N	Y	N	Y	Y	Y	180	N/A
29	17-04-2024	2400873	DEL WARD	Y	Y	ASHISH	Y	Y	Y	N	Y	Y	Y	5	4	Y	Y	Y	Y	N	N	N	N	Y	Y	30	N/A
30	12-04-2024	240661	SPVT-511	Y	Y	VIPIN	Y	Y	Y	N	Y	N	Y	7	7	Y	Y	Y	Y	Y	Y	Y	N	Y	N	not mentioned	N/A
31	12-04-2024	2400638	PVT-131	Y	Y	ASHISH	Y	Y	Y	N	Y	Y	Y	17	13	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	230	Y
32	12-04-2024	2400637	PVT-125	Y	Y	SAURABH	Y	Y	Y	N	Y	Y	Y	12	5	Y	Y	Y	Y	N	Y	N	Y	Y	Y	20	N/A
33	18-04-2024	2400923	PVT-135-A	Y	Y	VIJAYANT	Y	Y	Y	N	Y	Y	Y	2	2	Y	Y	Y	Y	N	N	N	N	Y	Y	140	N/A
34	13-04-2024	2400689	PVT-132	Y	Y	PRITHVI	Y	Y	Y	Y	Y	Y	Y	16	16	Y	Y	Y	Y	N	N	N	N	Y(3:00PM)	Y(2:30PM)	WRONG	N/A
35	11-04-2024	2400587	SPVT-514	Y	Y	ASHISH VERMA	Y	Y	Y	Y	Y	Y	Y	17	13	Y	Y	Y	Y	N	N	N	N	Y	Y	150	N/A
36	14-04-2024	2400728	CTVS	Y	N	BM GOYAL	Y	Y	Y	N	Y	Y	Y	17	11	Y	Y	Y	Y	N	Y	Y	Y	Y(5:40PM)	Y(5:00PM)	WRONG	Y
37	23-04-2024	2401183	DEL WARD	Y	Y	KULDEEP	Y	Y	N	N	Y	Y	Y	10	10	Y	Y	Y	Y	Y	Y	N	N	Y	Y	55	N/A
38	04-04-2024	2400221	DEL WARD	Y	Y	ASHISH	Y	Y	N	N	Y	N	Y	7	7	Y	Y	Y	Y	N	N	N	Y	Y	N	not mentioned	N/A
39	03-04-2024	2400135	DEL WARD	Y	Y	SACHIN	Y	Y	Y	Y	Y	Y	Y	10	10	Y	Y	Y	Y	N	Y	N	Y	Y	Y	40	N/A
40	12-04-2024	2400650	SPVT-536	Y	Y	VIPUL	Y	Y	Y	Y	Y	Y	Y	9	9	Y	Y	Y	Y	Y	Y	N	N	Y	Y	120	N/A
41	09-04-2024	2400200	SPVT-516	Y	Y	NEERAJ	Y	Y	Y	Y	Y	N	Y	14	9	Y	Y	Y	Y	N	Y	Y	Y	Y	N	not mentioned	Y

THANK YOU