ASSESSING INPATIENT DOCUMENTATION COMPLIANCE THROUGH A MULTI-PARAMETER AUDIT: A CROSS-SECTIONAL STUDY TO ENHANCE CARE CONTINUITY AND CLINICAL STANDARDS

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in

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by

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Under the Supervision and Guidance of

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TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Ms.Shaineela Siddiqui** has worked as a trainee under **Dr. Ranjana Rathore** in the department of **Quality** from **10-March-2025 to 31-May-2025**.

Her performance during the period was found good.

We wish her all the best in her future endeavours.

For Fortis Escorts Hospital, Jaipur

Authorised Signatory

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that dissertation titled **'Assessing Inpatient Documentation Compliance Through a Multi - Parameter Audit: A Cross - Sectional Study to Enhance Care Continuity and Clinical Standards'** is a record of the research work undertaken by Shaineela Siddiqui in partial fulfillment of the requirements for the award of the degree of MBA Hospital and Health Management from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

Dr. Swapnil Gadhave
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Date

Dr. Sanjay Gupta
School Dean
IIHMR University, Jaipur
Date

DECLARATION BY STUDENT

I hereby declare that this dissertation titled Assessing Inpatient Documentation Compliance Through a Multi-Parameter Audit: A Cross-Sectional Study to Enhance Care Continuity and Clinical Standards is the Bonafide 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 Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature) Shaineela

Miss. Shaineela Siddiqui

Date: 19/6/25

ABSTRACT:

Background: Accurate and comprehensive inpatient documentation is vital for ensuring patient safety, facilitating effective communication among healthcare providers, and meeting medico-legal requirements. Despite established protocols, inconsistencies in documentation practices persist, potentially compromising the quality of care.

Aim: This dissertation aims to assess the level of compliance in inpatient documentation practices using a structured audit approach, and to identify areas needing improvement to strengthen documentation standards within the hospital.

Objective: The primary objective is to evaluate the quality and completeness of inpatient records across departments, highlight patterns of non-compliance, and offer actionable insights to support better documentation and clinical governance.

Methods: A cross-sectional audit was conducted on 120 inpatient records across Medical Intensive Care Units (MICUs), Surgical Intensive Care Units (SICUs), and general wards. A structured checklist, encompassing various documentation parameters, was utilized to assess the completeness and accuracy of records.

Results: The audit revealed high compliance in structured documentation areas such as treatment sheet and admission form. However, significant gaps were identified in some sections, including progress notes and interdisciplinary communication entries. Common deficiencies encompassed missing signatures, incomplete assessments, and delayed documentation updates.

Conclusion: While certain aspects of inpatient documentation meet established standards, notable deficiencies highlight the need for targeted interventions. Enhancing documentation practices requires a multifaceted approach, including staff training, streamlined processes, and regular audits to foster a culture of accountability and continuous improvement.

Keywords: Inpatient Documentation, Audit, Compliance, Patient Safety, Clinical Governance, Care Continuity, ICU Records

AKNOWLEDGEMENT

I take this opportunity to express my sincere gratitude for the support and guidance I received throughout the course of my clinical audit project, titled Assessing Inpatient Documentation Compliance Through a Multi-Parameter Audit: A Cross-Sectional Study to Enhance Care Continuity and Clinical Standards, at Fortis Escorts Hospital as a part of my M.B.A. (Hospital and Health Management) program at IIHMR University.

This project would not have been possible without the encouragement and cooperation of several individuals. I am deeply thankful to Dr. Ranjana Rathore, who provided valuable guidance and oversight during each phase of this audit. Her mentorship, constructive suggestions, and unwavering support played a pivotal role in shaping this project.

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I sincerely acknowledge the efforts of all those who assisted me during the various stages of this audit, especially during manual reviews and the re-audit phase. Their contributions played a key role in the successful completion of this project.

Lastly, I would like to thank my peers and everyone who encouraged and supported me directly or indirectly throughout this journey.

Sincerely,

Shaineela Siddiqui

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Chapter 1: Introduction

Medical records are a vital part of hospital care, serving as both a legal document and a communication tool that ensures all healthcare providers are aligned in managing a patient's care. High-quality documentation within inpatient files reflects the accuracy, completeness, and timeliness of clinical information. When done correctly, it supports continuity of care, patient safety, and accountability among care teams. Medical records are the backbone of patient care in any hospital. It provides a comprehensive record of a patient's health journey, enabling healthcare professionals to make informed decisions and ensure continuity of care.

Proper documentation facilitates clear communication among doctors, nurses, and other caregivers, reducing the risk of errors and enhancing patient safety. More than just a legal requirement, documentation is a practical tool that allows healthcare professionals to communicate clearly, make informed decisions, and ensure continuity of care. Whether it's a doctor writing progress notes, a nurse recording vital signs, or a therapist updating a treatment plan, each entry plays a role in painting the full picture of the patient's condition.

High-quality documentation serves multiple purposes: it supports accurate diagnosis and treatment, ensures legal compliance, and aids in billing and reimbursement processes. Inadequate or incomplete records can lead to miscommunication, delayed treatments, and potential legal issue.

Good documentation is not just about writing everything down—it's about writing the right things, at the right time, in the right way. When documentation is consistent and complete, it helps reduce medical errors, supports evidence-based care, and improves patient outcomes. Compliance with documentation standards ensures that critical information isn't missed and that care is delivered according to protocol. Medical documentation is essential for both hospitals and patients as it serves multiple critical functions. For hospitals, accurate records support clinical decision-making, ensure compliance with legal and accreditation standards. It also helps monitor quality indicators and streamline communication across departments. For patients, proper documentation ensures continuity of care, minimizes the risk of medical errors, and allows for informed, timely interventions. It gives patients a clear history of their treatment and promotes

transparency in the care process, ultimately contributing to safer and more effective healthcare delivery.

An audit is a systematic review process that evaluates whether the expected standards of documentation are being followed. In hospitals, documentation audits help identify patterns of non-compliance, highlight areas needing improvement, and promote clinical governance. They are particularly useful in high-dependency areas like ICUs and wards, where proper documentation can directly impact patient safety.

A complete inpatient file typically includes a wide range of documents, starting from the admission form, initial doctor and nursing assessments, and prescriptions, consent forms followed by daily records like treatment sheets, progress notes, and nursing assessments. For surgical cases, it also includes pre-operative orders, anaesthesia records, and the surgical safety checklist. To ensure that all these documents are properly filled, hospitals conduct regular documentation audits. To maintain high standards, hospitals implement documentation compliance protocols. Compliance ensures that all necessary information is accurately recorded. Regular audits play a crucial role in this process. An audit is a structured review of patient files using a checklist to verify whether the necessary forms are present, complete, and accurate. An open file audit is done while the patient is still admitted, which allows real-time correction of missing or incomplete entries. Open file audits, conducted while the patient is still admitted, allow for real-time identification and correction of documentation gaps, thereby improving ongoing patient care. Such audits have been shown to enhance the quality of medical records and support better healthcare outcomes. These audits not only help maintain compliance with quality standards but also strengthen communication among healthcare teams and support safer, more coordinated care. The aim of this dissertation is to systematically review inpatient documentation using a multi-parameter audit approach, quantify compliance and non-compliance patterns, and offer insights that can help enhance care continuity and reinforce clinical standards. By identifying documentation trends across departments and understanding where lapses are most frequent, the findings of this dissertation intend to support informed interventions, quality improvement efforts, and a more consistent documentation culture across the organization

RESEARCH QUESTION

• How compliant are inpatient files with hospital documentation standards after two days of admission?

• What are the common deficiencies or missing elements found in documentation across different wards?

• How can audit findings support improved continuity of care and adherence to clinical standards?

AIM:

To assess documentation compliance in inpatient records across MICU, SICU, and general wards of the hospital, with the goal of identifying gaps in clinical documentation and providing actionable recommendations to improve compliance, patient safety, and care continuity.

OBJECTIVES:

1. To evaluate how well inpatient documentation is being completed using a structured, multi-parameter checklist:

It focuses on assessing the overall quality and completeness of documentation across a variety of forms used in inpatient care. By using a checklist developed around the hospital's own documentation standards, the audit helps determine whether key details—such as patient history, treatment plans, and daily progress—are being recorded in a clear, consistent, and complete manner.

2. To identify patterns of non-compliance and documentation gaps across different departments:

Beyond individual file assessment, this objective seeks to identify recurring trends in non-compliance—whether systemic or department-specific. Analysing documentation practices across MICUs, SICUs, and general wards allows for comparative insights into where deviations from standard practices are most frequent, thereby enabling a more targeted and department-sensitive approach to quality improvement.

3. To generate actionable recommendations aimed at strengthening documentation practices and supporting patient safety initiatives:

It focuses on translating identified gaps into practical, evidence-informed interventions. These may include structural changes to documentation formats, reinforcement of staff training, or process-level adjustments to improve compliance

Chapter 2: Review of Literature

Accurate and comprehensive documentation in inpatient settings is pivotal for ensuring patient safety, continuity of care, and legal protection. Various studies have highlighted the challenges and strategies associated with improving documentation practices.

A retrospective audit conducted in surgical inpatient records revealed significant deficiencies in documentation quality. The study implemented a two-cycle audit process, which led to a notable improvement in compliance rates, emphasizing the effectiveness of regular audits in enhancing documentation standards [1].

In a teaching hospital in Pune, India, an explorative and retrospective quantitative survey assessed the compliance levels of inpatient healthcare records. The study utilized a three-point Likert scale to evaluate documentation and found considerable gaps, particularly in progress notes and consent forms. The findings underscored the necessity for standardized protocols and continuous training to improve documentation practices [2].

The legal implications of inadequate medical record-keeping have also been extensively discussed. Thomas emphasized that well-maintained medical records are crucial in defending against negligence claims. The absence or poor quality of documentation can significantly weaken a healthcare provider's legal position, highlighting the need for meticulous record-keeping [3].

A clinical audit conducted by Awad et al. focused on assessing the quality of inpatient medical records. The study identified several areas needing improvement, including the documentation of patient history and treatment plans. The authors recommended regular training sessions and the implementation of standardized documentation templates to enhance the quality of medical records [4].

These studies collectively underscore the importance of regular audits, standardized documentation protocols, and continuous staff training to enhance the quality of inpatient medical records. Implementing these strategies can lead to improved patient outcomes, better legal protection for healthcare providers, and overall enhancement of clinical standards.

Chapter 3: Methodology

STUDY TYPE - A retrospective descriptive cross-sectional study.

STUDY AREA – MICU, SICU and Ward

STUDY POPULATION

The audit encompassed a total of 120 Inpatient Files drawn from three clinical settings over a two-month period (March–April 2025) at Fortis Escort Hospital, Jaipur:

- Medical Intensive Care Units (MICUs): 69 Files
- Surgical Intensive Care Units (SICUs): 30 Files
- General Wards: 21 Files

INCLUSION CRITERIA

- Inpatient files from MICU, SICU, and general wards.
- Patients who have completed at least 48 hours of admission.
- Patients who were admitted and present in the hospital during the data collection period.

EXCLUSION CRITERIA

- Emergency and OPD case files.
- Chemotherapy Daycare and Pulmonary care files
- Files of patients discharged within 48 hours.

DURATION OF STUDY

2 months.

SAMPLE SIZE

A total of 120 patient records that met criteria of inclusion and exclusion were reviewed for this audit.

SAMPLING TECHNIQUE

Stratified purposive sampling ensured representation from three strata:

- Medical ICUs (MICU-1,2,3,5)
- Surgical ICUs (SICU-1,2,3,4)

- General wards

Only patient files of those admitted for at least 48 hours were included, ensuring sufficient documentation for meaningful assessment. Within each stratum, files were selected randomly from the eligible pool.

DATA COLLECTION

Data was collected from patient case files from inpatient departments in the hospital such as medical ICUs (MICUs), surgical ICUs (SICUs), and general wards. A structured, department-approved audit checklist was utilized, comprising 24 key documentation forms—each with its own set of critical parameters. The scoring criteria were standardized: a score of 10 was assigned for full compliance, 5 for partial compliance, and 0 for non-compliance. Fields not applicable to the patient's context were marked as "NA" and excluded from the analysis.

The selection of files was based on inpatients who had completed a minimum of 48 hours of admission, ensuring that documentation reviewed reflected active clinical involvement and ongoing care. Each patient file was thoroughly assessed across all applicable forms, and scores were directly recorded into a pre-structured checklist for consistency and accuracy. The checklist scores were then recorded on a separate spreadsheet, will be used for analysis later.

AUDIT CHECKLIST

The audit checklist encompasses 24 distinct forms, each representing a critical stage of inpatient care—from initial prescription and admission through surgery, anaesthesia. Within each form, specific sub-headings are included to ensure that all essential data elements are captured.

Every parameter listed in the checklist was systematically reviewed in each patient file, with scores assigned as follows:

- **10 = Full Compliance:** all required fields present, legible, and correctly completed
- **5 = Partial Compliance:** some elements incomplete or only partially legible
- **0 = Non-Compliance:** entry missing or illegible
- **NA = Not Applicable:** field irrelevant for that patient encounter

This structured approach guarantees a uniform, objective assessment of documentation quality across MICUs, SICUs, and wards, pinpointing strengths as well as areas needing improvement.

DATA ANALYSIS

METHOD USED: MS Excel

3.1 FORM-WISE DOCUMENTATION COMPLIANCE

FORM 1: PRESCRIPTION

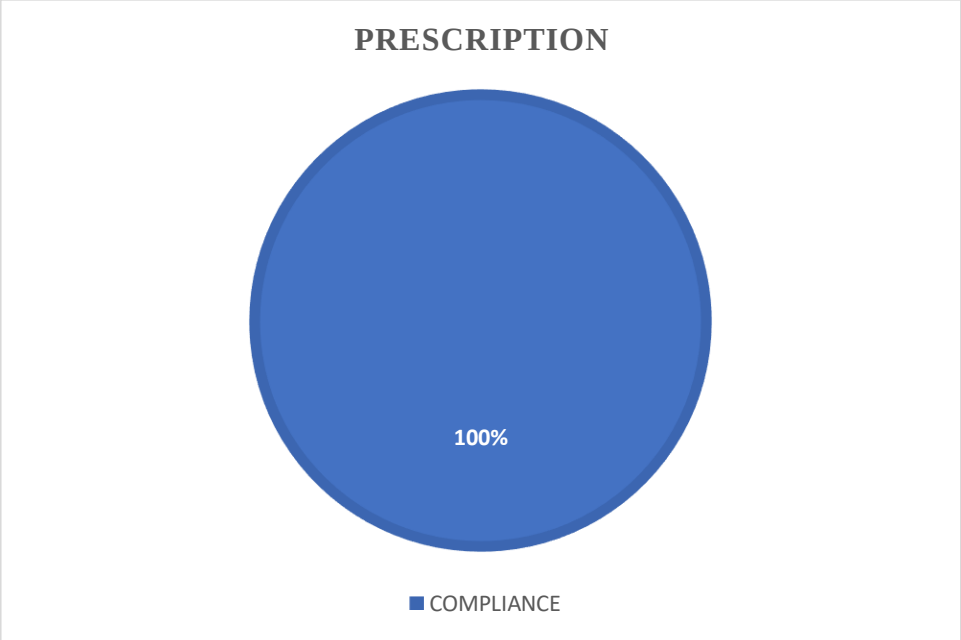

Fig3.1.1

INTERPRETATION

Prescription form showed 100 % compliance.

FORM 2: ADMISSION FORM

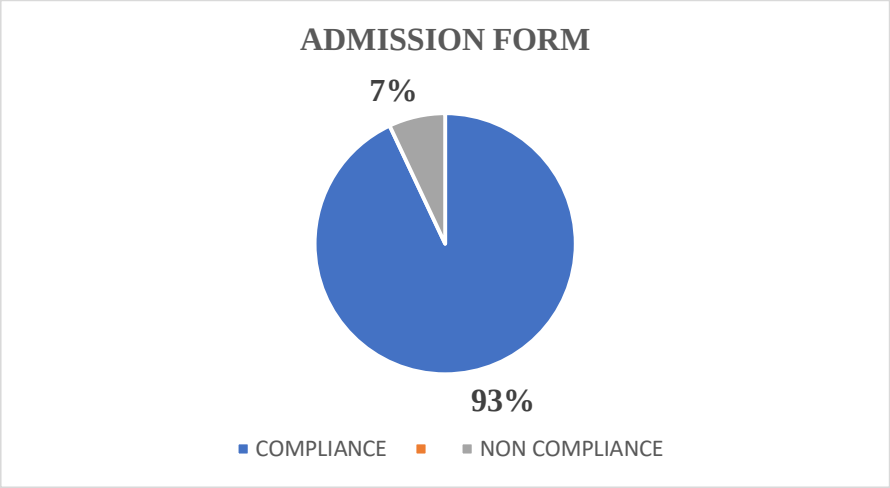

Fig3.1.2

INTERPRETATION

For the Admission Form, 93 % of the 120 audited files met all required documentation standards, while 7 % (9 files) had one or more missing or incomplete fields. This high level of compliance suggests that the admission process is generally well understood and executed by staff; however, the remaining non-compliant files indicate isolated gaps. It was observed that out of 120 files, only 111 files were compliant and 9 files were non-compliant.

FORM 3: TRIAGE DOCTOR ASSESSMENT

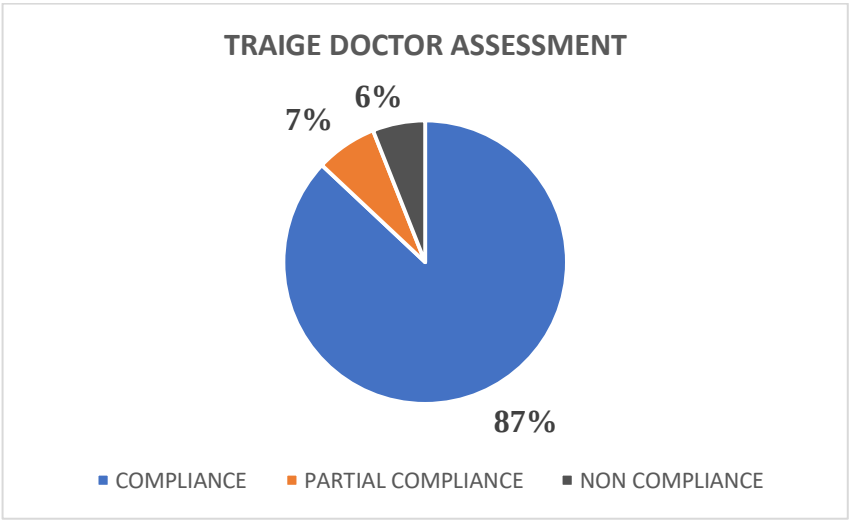

Fig3.1.3

INTERPRETATION

The Triage Doctor Assessment shows 87 % full compliance, with 7 % of entries partially completed and 6 % entirely missing critical information. This indicates that while most triage assessments are documented correctly, a small but meaningful proportion of files exhibit incomplete or absent details. It was observed that out of 120 files, only 76 files were compliant, 6 files were partially compliant and 5 files were non-compliant and 33 were not applicable files.

FORM 4: DOCTOR INITIAL ASSESSMENT

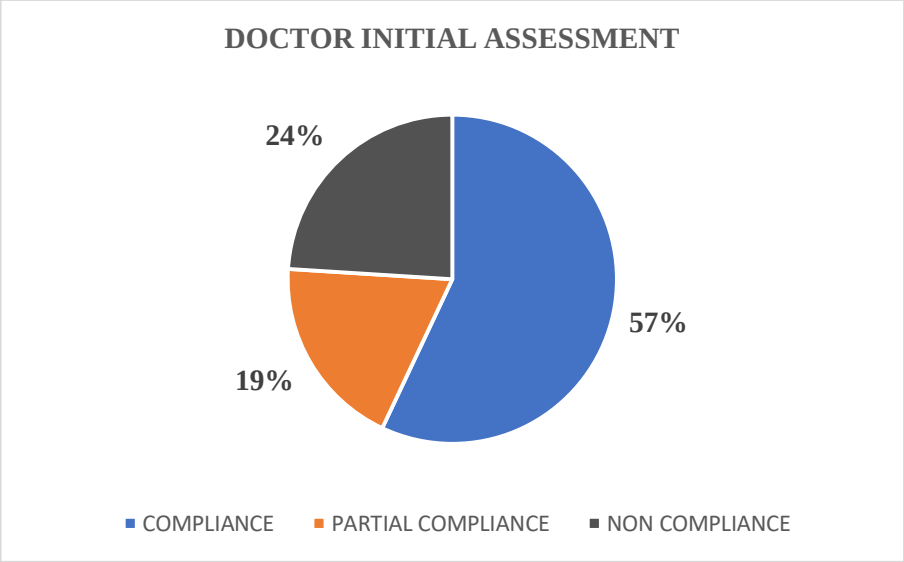

Fig3.1.4

INTERPRETATION

The doctor initial assessment shows 57% full compliance with 19% partial and 24% non-compliance. Out of 120 files, 68 were found to be compliant, 23 were partial compliant and 29 files were non-compliant.

FORM 5: TREATMENT SHEET

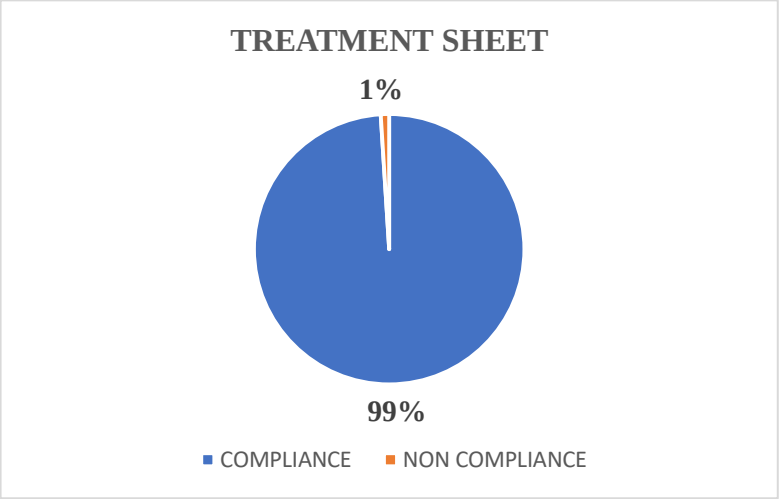

Fig3.1.5

INTERPRETATION

Treatment sheet showed 99% compliance and 1% non-compliance. Out of 120 files 119 showed full compliance and only 1 file showed non-compliance.

FORM 6: PROGRESS NOTE

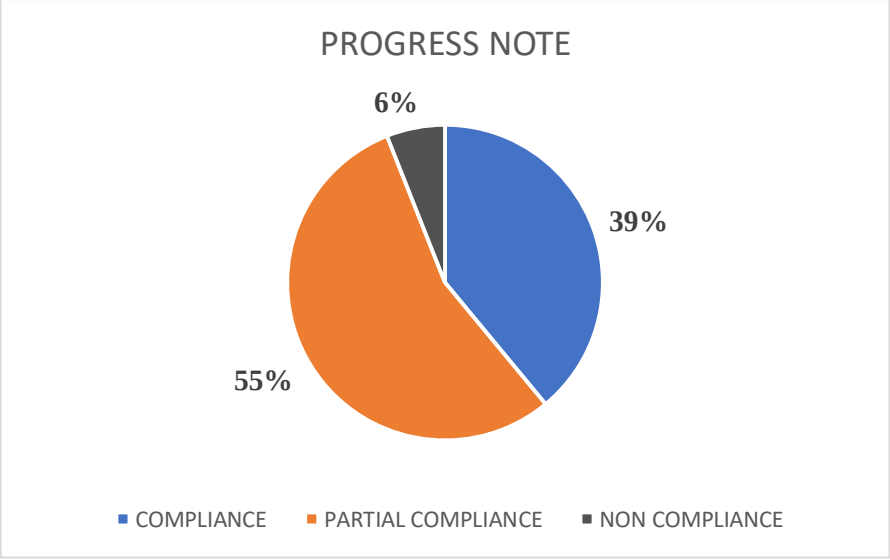

Fig3.1.6

INTERPRETATION

Progress note showed 39% compliance, 55% partial compliance and 6% non-compliance. Out of 120 files 47 compliant showed full compliance, 66 partially compliant and 7 file showed non-compliance.

FORM 7: PRE OPERATIVE ANESTHESIA ASSESSMENT AND ORDERS

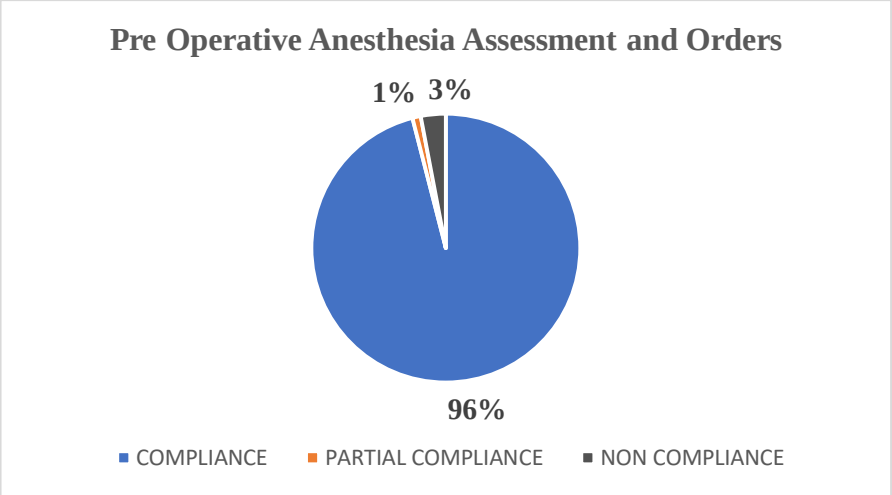

Fig3.1.7

INTERPRETATION

Pre operative anaesthesia assessment and orders showed 96% compliance and 1% partial compliance and 3% non-compliance. Out of 120 files, 67 files were total applicable and out of those 64 files showed full compliance and only 1 file showed partial compliance and 2 files showed non-compliance.

FORM 8: ANAESTHESIA RECORD

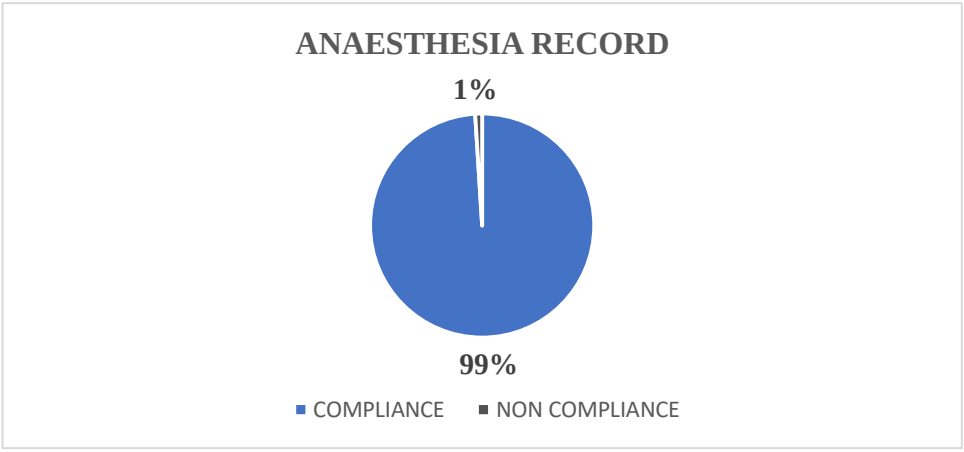

Fig3.1.8

INTERPRETATION

Anaesthesia record showed 99% compliance and 1% non-compliance. Out of 120 files, 67 files were total applicable and out of those 66 files showed full compliance and only 1 file showed non-compliance.

FORM 9: SURGICAL SAFETY CHECKLIST

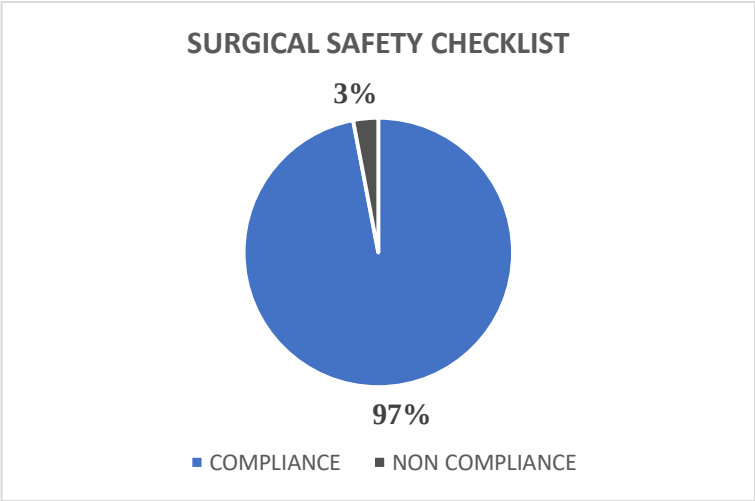

Fig3.1.9

INTERPRETATION

Anaesthesia record showed 97% compliance and 3% non-compliance. Out of 120 files, 67 files were total applicable and out of those 65 files showed full compliance and only 2 file showed non-compliance.

FORM 10: OT NOTES

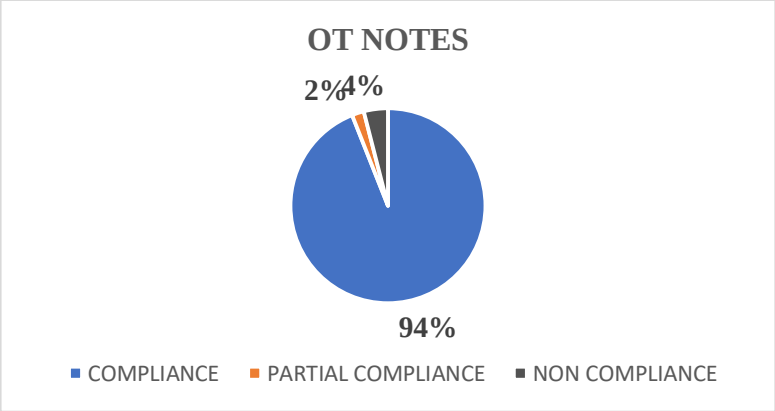

Fig3.1.10

INTERPRETATION

OT notes showed 94% compliance, 2% partial compliance and 4% non-compliance. Out of 120 files, 67 files were total applicable and out of those 63 files showed full compliance, 1 file showed partial compliance and 3 file showed non-compliance.

FORM 11: CONSENT FORMS

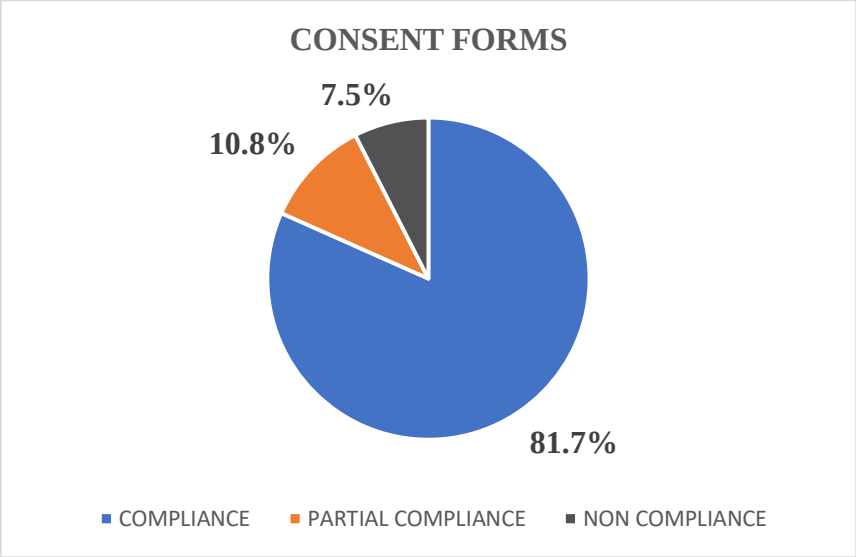

Fig3.1.11

INTERPRETATION

OT notes showed 81.7%% compliance, 10.8% partial compliance and 7.5% non-compliance. Out of 120 files, 98 files showed full compliance, 13 file showed partial compliance and file showed non-compliance.

FORM 12: TRIAGE NURSING ASSESSMENT

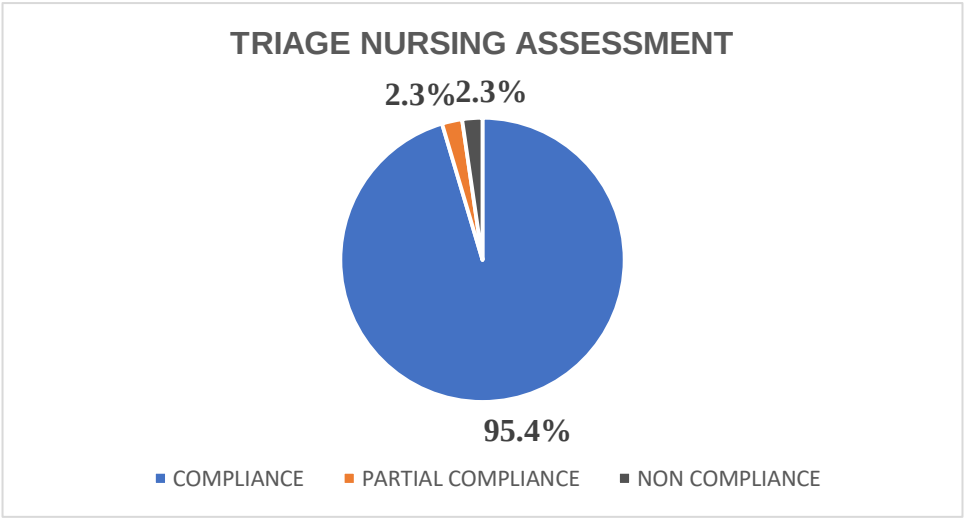

Fig3.1.12

INTERPRETATION

Triage nursing assessment notes showed 95.4% compliance, 2.3% partial compliance and 2.3% non-compliance. Out of 120 files, 87 files were total applicable and out of those 83 files showed full compliance, 2 file showed partial compliance and 2 file showed non-compliance.

FORM 13: NURSING ADMISSION ASSESSMENT

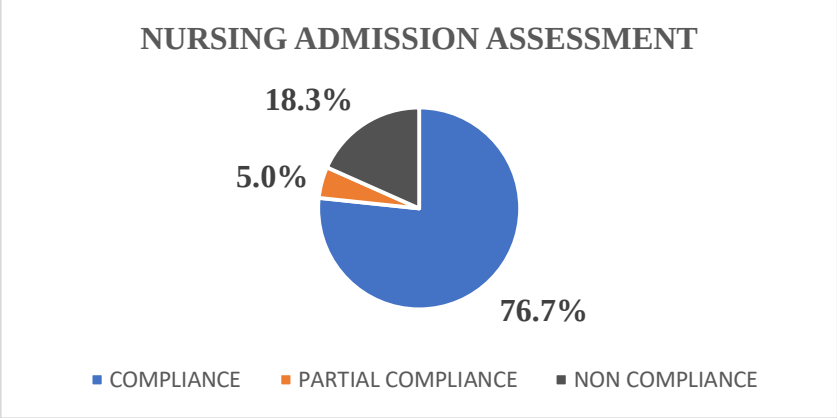

Fig3.1.13

INTERPRETATION

Nursing admission assessment notes showed 76.7% compliance, 5% partial compliance and 18.3% non-compliance. Out of 120 files, 92 files showed full compliance, 6 file showed partial compliance and 22 file showed non-compliance.

FORM 14: DAILY NURSING ASSESSMENT

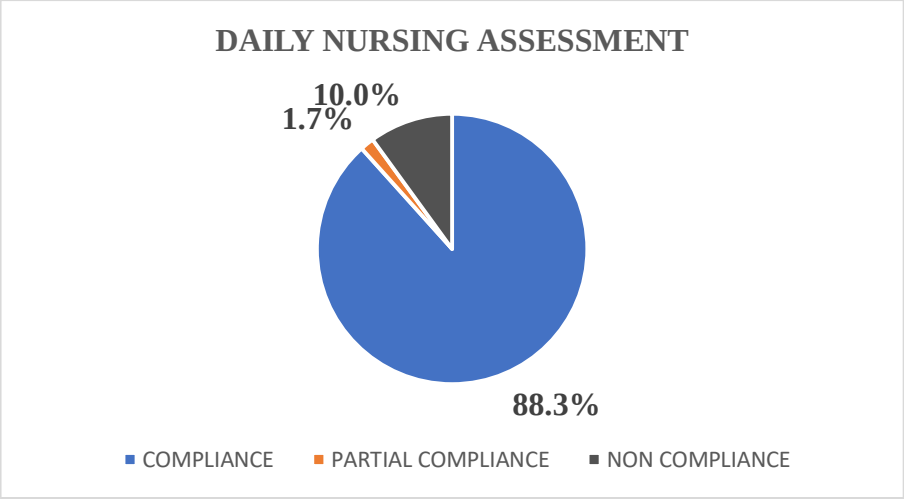

Fig3.1.14

INTERPRETATION

Nursing admission assessment notes showed 88.3% compliance, 1.7% partial compliance and 10% non-compliance. Out of 120 files, 106 files showed full compliance, 2 file showed partial compliance and 12 file showed non-compliance.

FORM 15: IN HOUSE TRANSFER FORM

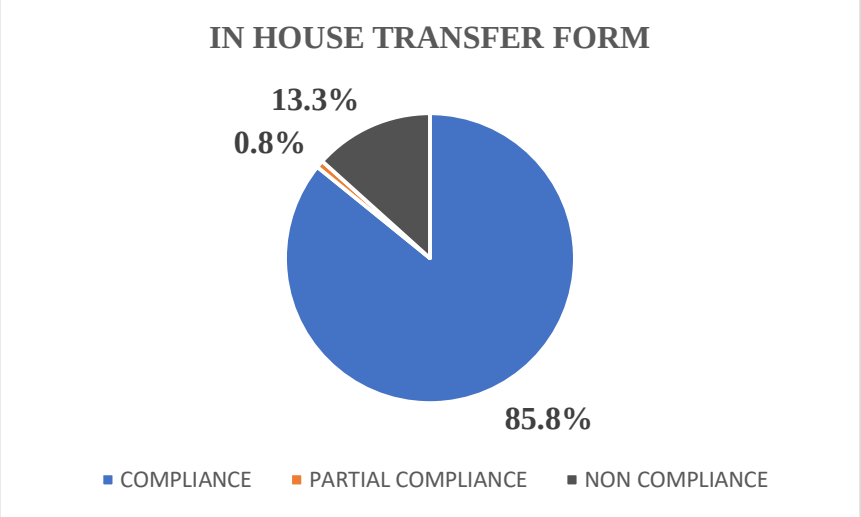

Fig3.1.15

INTERPRETATION

In house transfer form showed 85.8% compliance, 0.8% partial compliance and 13.3% non-compliance. Out of 120 files, 103 files showed full compliance, 1 file showed partial compliance and 16 file showed non-compliance.

FORM 16: PATIENT AND FAMILY EDUCATION RECORD

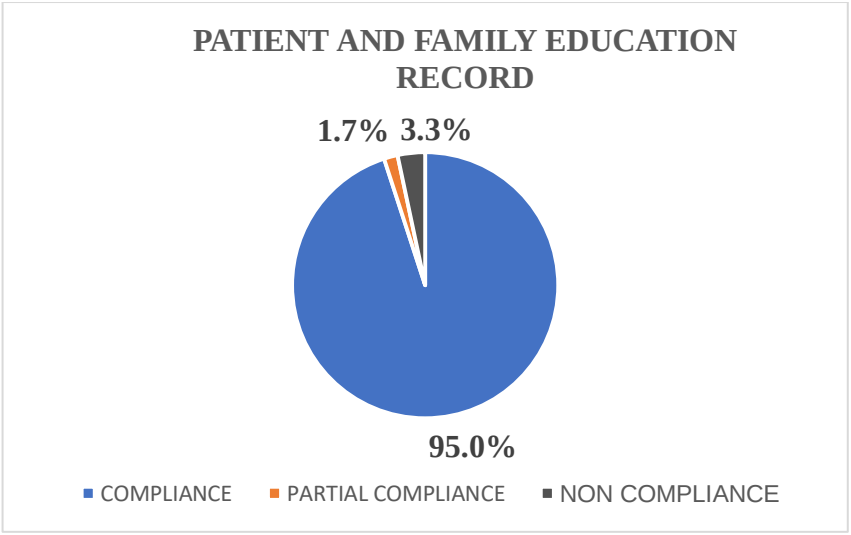

Fig3.1.16

INTERPRETATION

In house transfer form showed 85.8% compliance, 0.8% partial compliance and 13.3% non-compliance. Out of 120 files, 114 files showed full compliance, 2 file showed partial compliance and 4 file showed non-compliance.

FORM 17: RELATIVE COMMUNICATION RECORD

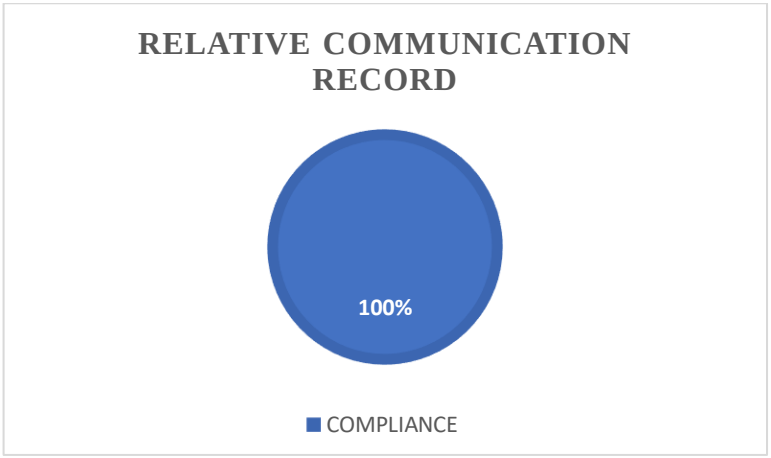

Fig3.1.17

INTERPRETATION

Critical care relative communication record showed 100% compliance. All 120 files showed full compliance.

FORM 18: BLOOD TRANSFUSION MONITORING FORM

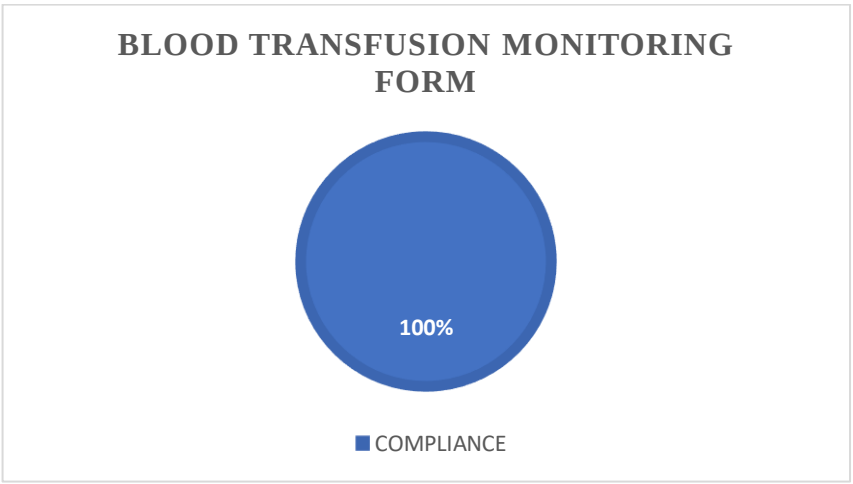

Fig3.1.18

INTERPRETATION

Blood transfusion monitoring form showed 100% compliance. Out of 120 files only 29 files were applicable and each of them showed full compliance.

FORM 19: BLOOD TRANSFUSION CONSENT FORM

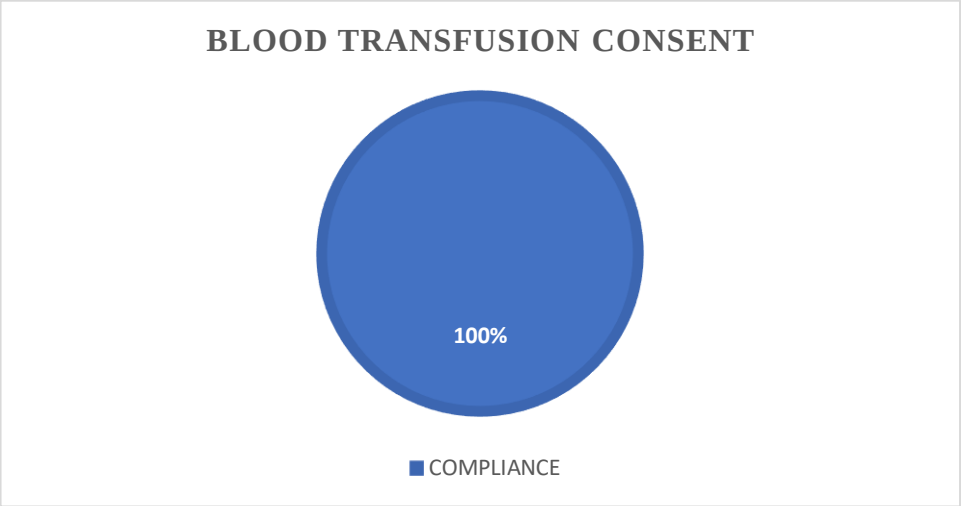

Fig3.1.19

INTERPRETATION

Blood transfusion consent form showed 100% compliance. Out of 120 files only 29 files were applicable and each of them showed full compliance.

FORM 20: RESTRAINT CONSENT

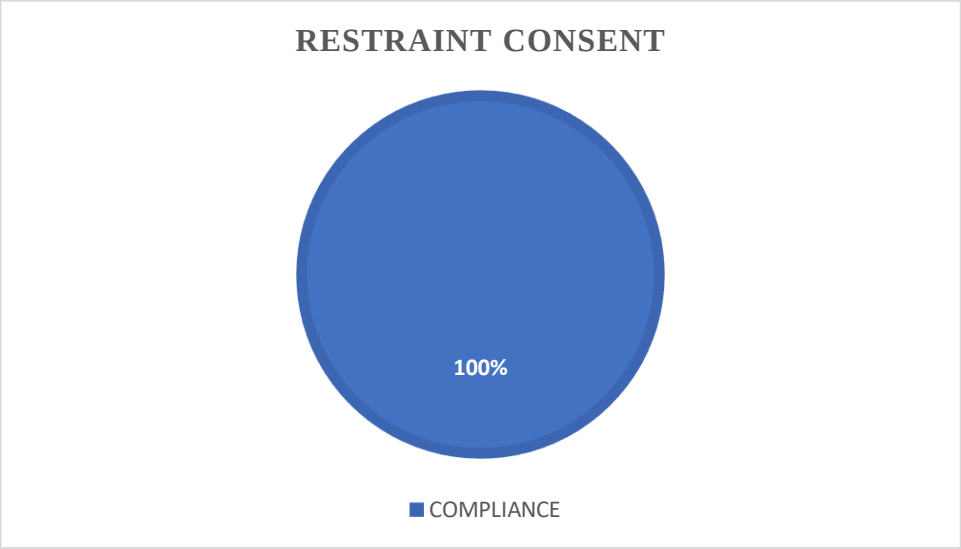

Fig3.1.20

INTERPRETATION

The restraint consent form showed 100% compliance. Out of 120 files only 5 files were applicable and each of them showed full compliance.

FORM 21: CATH LAB PROCEDURE NOTES FORM

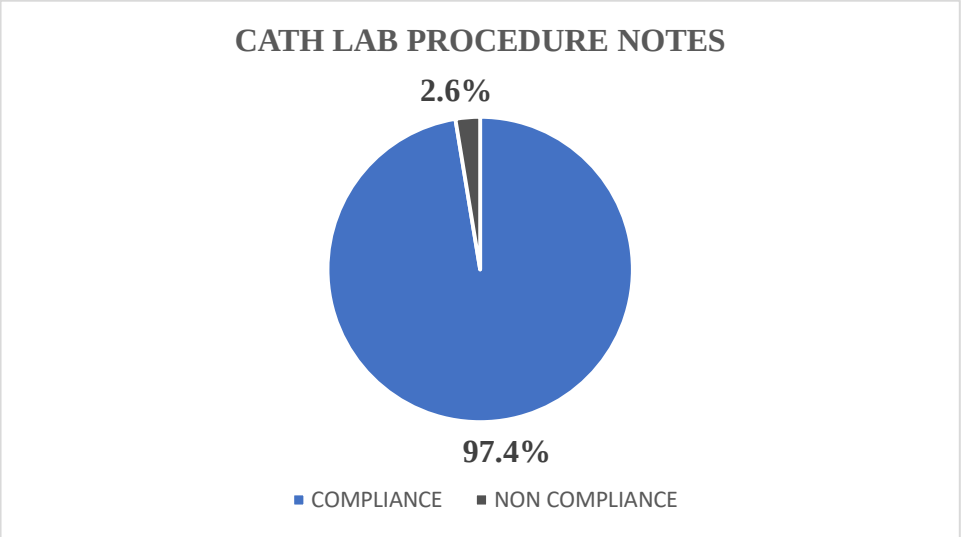

Fig3.1.21

INTERPRETATION

The restraint consent form showed 100% compliance. Out of 120 files only 77 files were applicable and out of those 75 showed full compliance while 2 files showed non-compliance.

FORM 22: BUNDLE OF CARE CHECKLIST

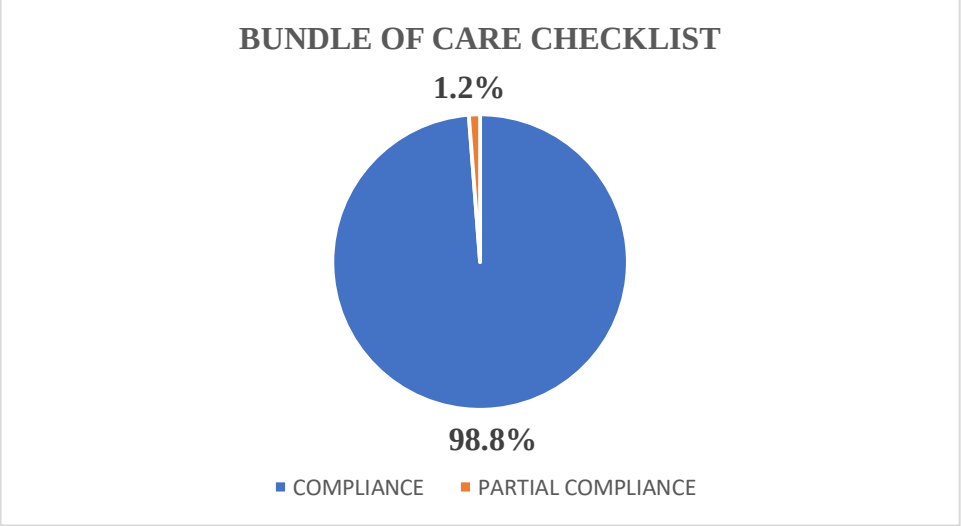

Fig3.1.22

INTERPRETATION

The bundle of care checklist form showed 100% compliance. Out of 120 files only 82 files were applicable and out of those 81 showed full compliance while 1 file showed partial compliance.

FORM 23: NUTRITION ASSESSMENT FORM

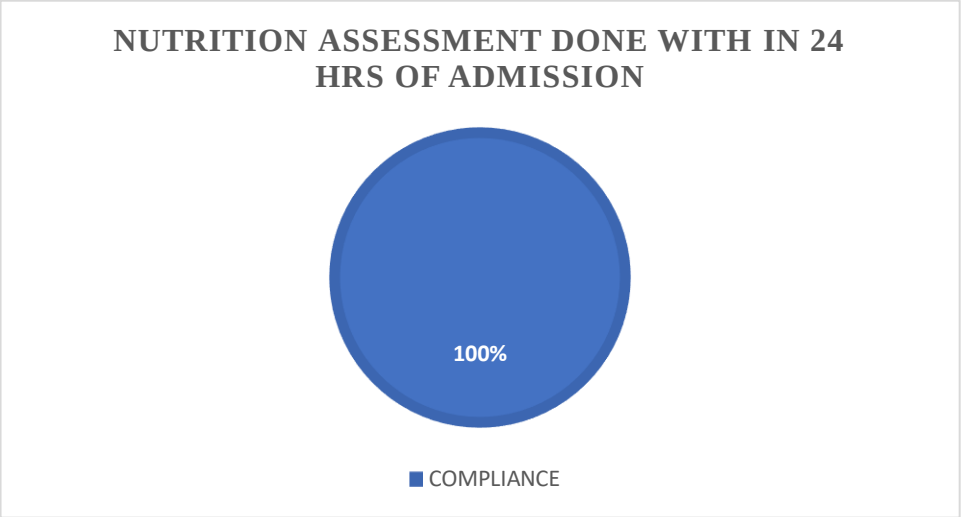

Fig3.1.23

INTERPRETATION

Nutrition assessment form showed 100% compliance.

FORM 24: PHYSIOTHERAPHY ASSESSMENT FORM

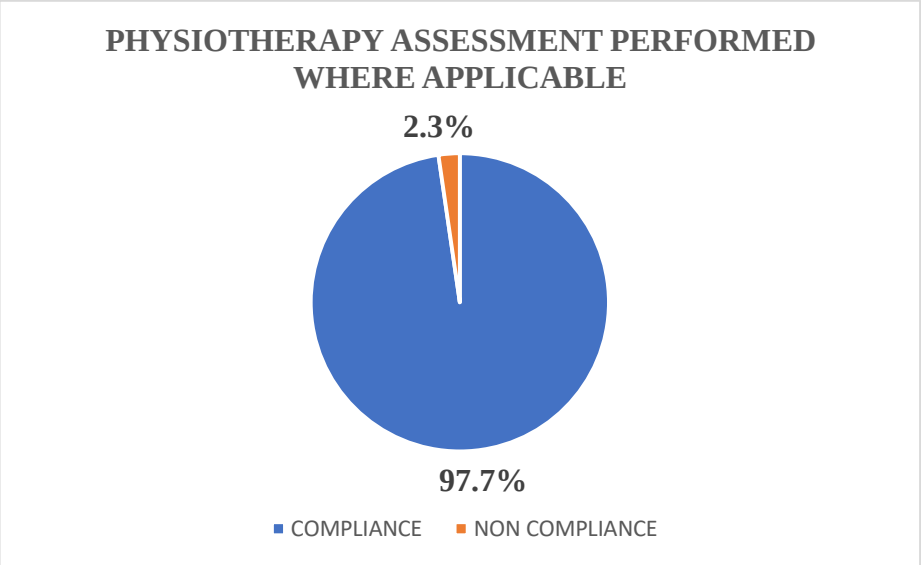

Fig3.1.24

INTERPRETATION

Physiotherapy assessment form showed 97.7% compliance and 2.3% partial compliance. Out of 120 files, only 43 were applicable and out of these 42 files showed compliance and only 1 file showed non-compliance.

3.2 CATEGORY-WISE COMPLIANCE WITHIN FORMS

ADMISSION FORM

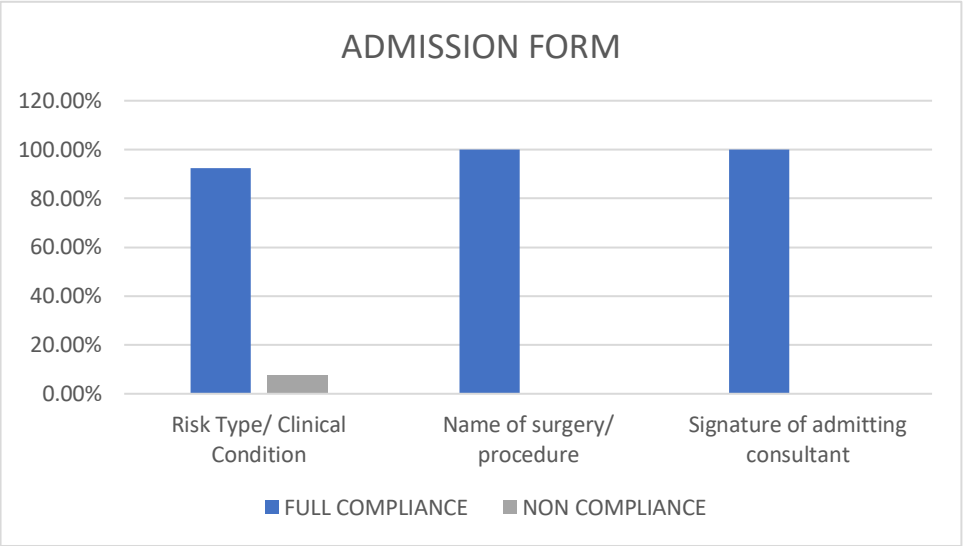

Fig3.2.1

INTERPRETATION

The Admission Form showed strong documentation practices overall. Both "Name of Surgery/Procedure" and "Signature of Admitting Consultant" achieved 100% compliance, reflecting these fields are well-integrated into admission routines.

However, "Risk Type/Clinical Condition" showed a slightly lower compliance rate 92.5% with around 7.5% non-compliance, suggesting that this field might sometimes be overlooked—possibly due to unclear responsibility or clinical urgency at the time of admission.

TRIAGE DOCTOR ASSESSMENT FORM

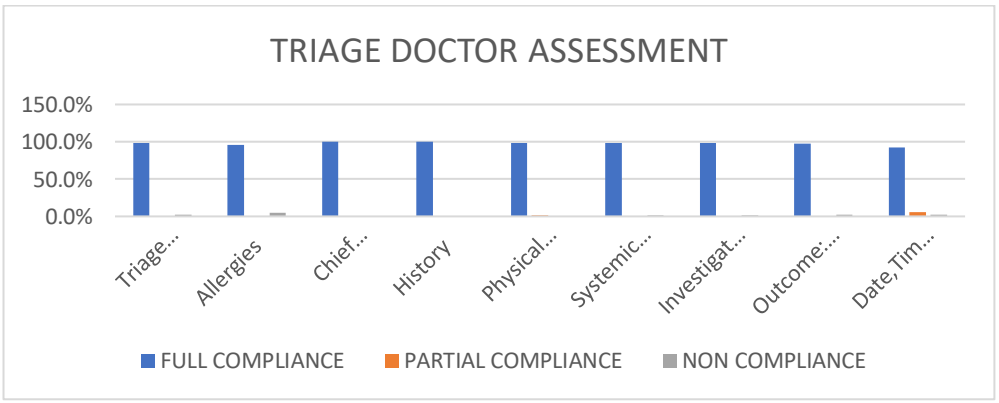

Fig3.2.2

INTERPRETATION

The Triage Doctor Assessment form overall showed good compliance across most fields, yet some specific areas stood out:

Fields like Triage Priority, Chief Complaints, History, Physical Examination, Systemic Examination, and Investigation consistently showed high full compliance (>95%), indicating they are reliably completed during the initial assessment process.

However, the “Allergies” category showed a visible drop in compliance, suggesting it is often missed or under-documented.

The field “Date, Time, Name and Sign of Transferring and Receiving Doctor” showed partial and non-compliance.

DOCTOR INITIAL ASSESSMENT

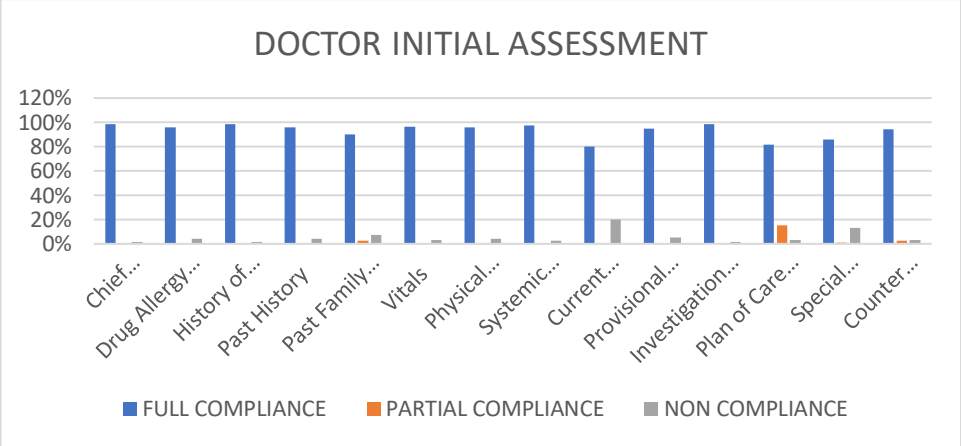

Fig3.2.3

INTERPRETATION

This assessment form showed The Doctor Initial Assessment form showed considerable variation across its documentation categories. Fields like Chief Complaints and History, Vitals, Physical and Systemic Examination, and Investigation showed high compliance, with most entries fully completed. However, some critical areas exhibited notable gaps.

The field "Current Medication" had the lowest compliance, with only 80% fully compliant and a significant 20% showing non-compliance, likely due to oversight or lack of updated medication history at the time of initial assessment. "Special Instructions (Diet Orders)" also demonstrated a concerning 13% non-compliance, pointing to a pattern of this section being overlooked. "Plan of Care with Goals" had 15% partial compliance,

suggesting that while intent was there, the documentation often lacked clarity or was left incomplete. Additionally, “Past Family History” and “Drug Allergy” showed non-compliance rates of 7.5% and 4%, respectively, indicating that background patient history is sometimes underreported or deprioritized.

Notably, Counter-signature by Consultant/Team Member within 24 hours also showed moderate non-compliance, reflecting a delay or missed validation process.

PROGRESS NOTE

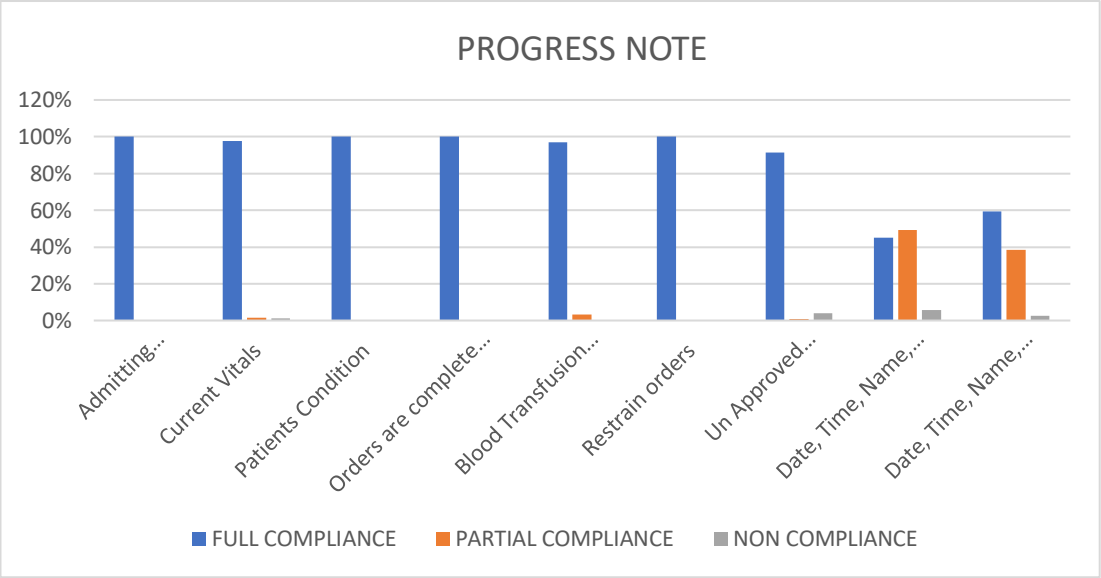

Fig3.2.4

INTERPRETATION

The Progress Note form showed polarized compliance patterns, with some fields well-maintained and others significantly lacking. Sections such as Admitting Consultant's Note, Current Vitals, Patient's Condition, Orders, Blood Transfusion Notes, and Restrain Orders all demonstrated high compliance, indicating that key clinical updates and orders are generally well-documented.

However, "Date, Time, Name, and Signature of Doctor" showed only 45% compliance, with 49% marked as partially compliant and 5.8% completely non-compliant. This suggests documentation may often be incomplete. Similarly, "Date, Time, Name, and Signature of Nurse" showed 59% full compliance, 38% partial, and 2% non-compliance, reflecting similar issues on the nursing side.

The use of unapproved abbreviations was relatively minimal but still present, with a small fraction showing non-compliance, indicating the need for ongoing reinforcement of standardized terminology.

NURSING ADMISSION ASSESSMENT

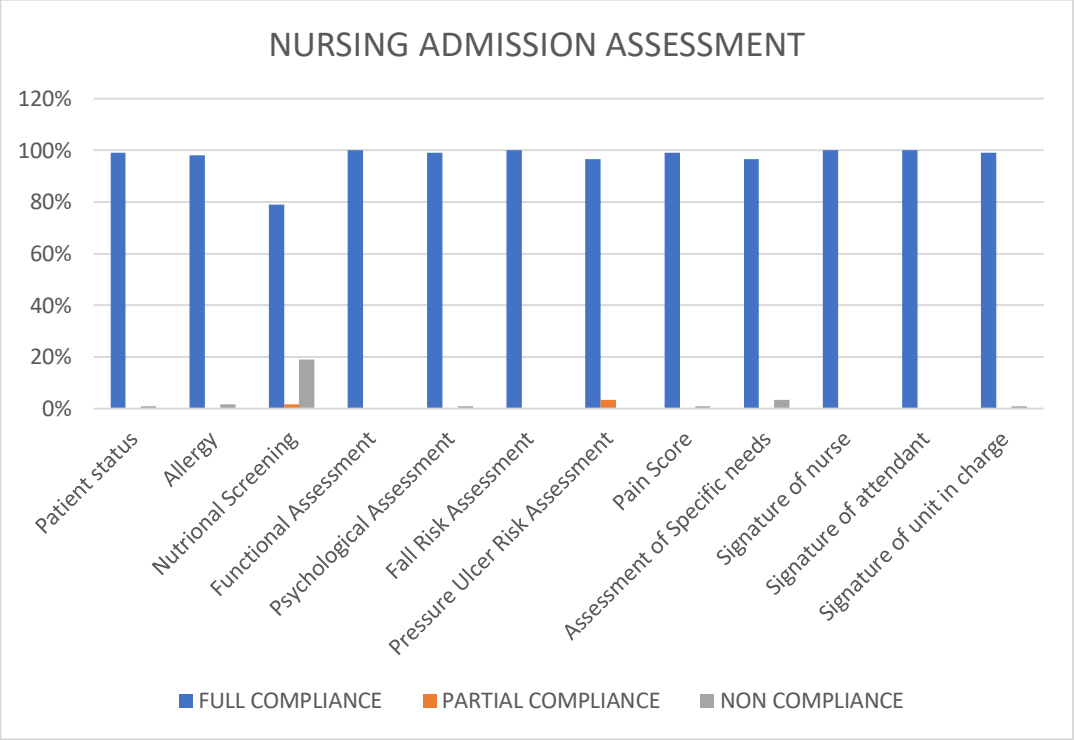

Fig3.2.5

INTERPRETATION

This form showed high compliance across most fields, such as patient status, allergy, psychological assessment, fall risk, pain score, and signature fields—each above 95%. However, two notable areas of concern emerged:

• "Nutritional Screening" showed the lowest compliance (~79%), with significant non-compliance (~19%), indicating this section is often skipped, possibly due to time constraints or lack of clear responsibility.

• "Pressure Ulcer Risk" also showed partial compliance (~3%), suggesting assessments were initiated but not fully completed or scored.

INHOUSE TRANSFER FORM

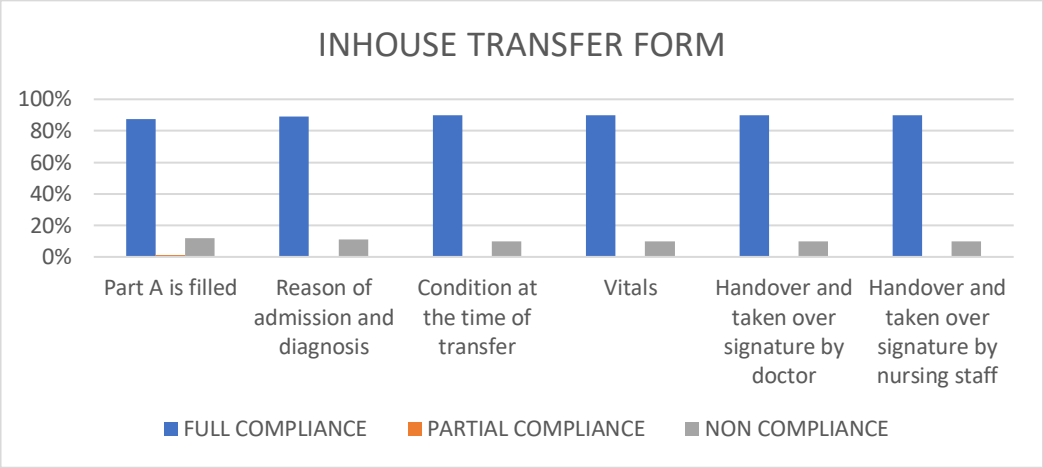

Fig3.2.6

INTERPRETATION

The Inhouse Transfer Form showed consistent compliance (~87–90%) across all subcategories, including Part A completion, reason for admission, vitals, and handover documentation.

Despite overall strong performance, non-compliance (~10–12%) persisted in each category—especially in handover signatures by doctors and nursing staff. This suggests that while transfer documentation is generally respected, formal handover validation is sometimes bypassed in practice.

PATIENT AND FAMILY EDUCATION RECORD

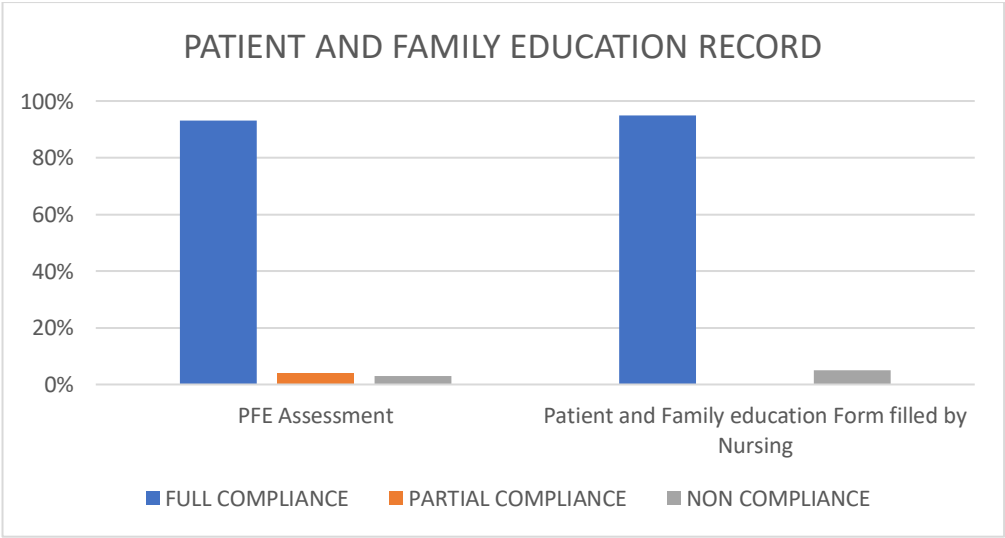

Fig3.2.7

INTERPRETATION

This form reflected good compliance overall, with PFE Assessment and Nursing Education Form both above 90% compliance. However, partial compliance (4%) was noted in PFE assessment, likely indicating cases where education was initiated but not fully documented. Additionally, non-compliance (5%) was observed in the nursing documentation of education.

3.3 DEPARTMENT-WISE DOCUMENTATION COMPLIANCE

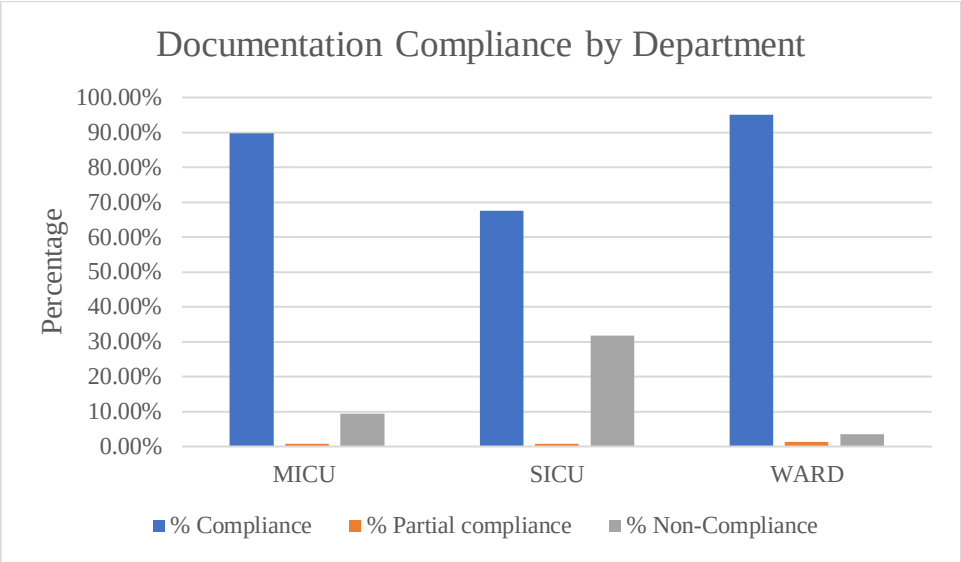

Fig.3.3.1

INTERPRETATION

MICU showed high full compliance (89.8%), with minimal partial compliance and about 9.4% non-compliance. This indicates that, despite being a high-acuity setting, documentation in MICUs is well integrated into the workflow. However, the small proportion of non-compliance could be due to time-sensitive patient care demands that sometimes deprioritize documentation.

SICU displayed the lowest full compliance (67.5%) and the highest non-compliance (31.7%) among all departments. This gap could reflect surgical emergency pressures, handover inconsistencies, or delays in consultant validation during documentation. It highlights a critical area for focused interventions. Wards demonstrated the strongest documentation performance overall, with 95% full compliance, 1% partial, and only 4% non-compliance. These results may be attributed to more predictable patient care routines and clearly assigned responsibilities in the ward setting.

Chapter 4: Results

A total of 120 inpatient files were audited across different clinical settings—69 from Medical Intensive Care Units (MICUs), 30 from Surgical Intensive Care Units (SICUs), and 21 from general wards. Overall compliance patterns varied notably across these departments. Wards demonstrated the highest level of full compliance, with 95% of documentation completed as per protocol, followed by MICUs with 89.80%. SICUs, in contrast, recorded the lowest full compliance rate at 67.50% and the highest non-compliance at 31.70%, pointing toward the operational pressures and documentation challenges that are often more prominent in surgical critical care settings. Partial compliance remained low across all departments, with values between 0.80% and 1%.

Form-wise analysis further revealed the strengths and gaps in documentation quality. The Prescription form demonstrated 100% compliance across all parameters, highlighting strong adherence in medication-related documentation. Similarly, the Treatment Sheet was consistently well-maintained, with 100% compliance in all sections except for a minor 1% non-compliance in the use of unapproved abbreviations.

The Admission Form showed 93% full compliance, with 7% non-compliance, The Triage Doctor Assessment reflected 87% full compliance, 7% partial compliance, and 6% non-compliance, with occasional lapses noted in allergy documentation and outcome recording.

Lower compliance was observed in more narrative or judgment-based forms. The Doctor Initial Assessment demonstrated only 57% full compliance, with 19% partially completed entries and 24% non-compliance. Fields like current medications, special instructions, and care planning were most frequently missed or incomplete. The Progress Note form showed the lowest full compliance, at just 39%, with 55% of entries partially completed and 6% entirely missing—largely due to inconsistent signatures and incomplete updates from clinical staff.

Among nursing documentation, the Daily Nursing Assessment achieved 88% compliance, 1.7% partial, and 10% non-compliance, whereas the Nursing Admission Assessment showed 77% compliance, 5% partial, and a notable 19% non-compliance, particularly in nutritional and risk assessments. The In-House Transfer Form recorded a moderate 86% full compliance, reflecting some variability in documenting reasons for transfer and interdepartmental handover details.

The Admission Form showed high documentation quality, with the "Risk Type/Clinical Condition" field being the only outlier—recording 92.5% full compliance and 7.5% non-compliance. Within the Triage Doctor Assessment form, the "Allergy" section was frequently overlooked, resulting in 4.6% non-compliance, likely due to it being perceived as non-urgent during initial evaluations. In the Doctor Initial Assessment, notable documentation lapses were found in "Current Medications" (20% non-compliance), "Special Instructions – First Diet Order" (13%), and "Plan of Care with Goals," which showed 15% partial compliance. Additional areas like "Past Family History" (7.5% non-compliance), "Provisional Diagnosis" (5%), and "Drug Allergy" and "Physical Examination" (4% each) also reflected inconsistencies.

The Progress Note form showed mixed performance. While categories such as the consultant's 24-hour note, patient's condition, legible orders, and restraint orders achieved full compliance, documentation of "Date, Time, Name, and Signature of Doctor" and "Nurse" remained weak. Only 45% of doctor sign-offs and 59% of nurse sign-offs were fully compliant, with a large portion falling under partial compliance (49% and 38% respectively), and 5.8% non-compliance noted in the doctor's signature section alone.

The Pre-Anaesthesia Assessment (PAC) and Anaesthesia Record forms both performed well, each maintaining 98% compliance across most subcategories, with minor gaps noted in the "Anaesthesia Plan" field—3% partial compliance and 2% non-compliance. The Surgical Safety Checklist recorded 96% compliance, with 4% non-compliance consistently observed across time stamps and signature fields. OT Notes also showed high overall documentation quality, with compliance ranging between 95–98% for most fields. Slight lapses were noted in "Specimen Sent to Lab by Nurse" (96% compliance, 4% non-compliance) and "Brief Note of Surgery" (95% compliance, 5% non-compliance).

Consent Forms were mostly complete, though a few areas required attention. "Benefits Mentioned" showed 87% compliance, with 6% partial and 8% non-compliance, while the "Risk and Alternatives" category showed 89% compliance, 4% partial, and 7% non-compliance. Witness signatures and the General Consent for Admission showed minor documentation lapses at 2% non-compliance.

In the Triage Nursing Assessment form, most fields achieved 100% compliance, with the exception of "Date, Time, Name, and Signature of Transferring and Receiving Nurse," which recorded 98% compliance and minor partial completion. The Nursing Admission

Assessment form revealed more prominent gaps, with “Nutritional Screening” showing the lowest compliance at 79% and 19% non-compliance. “Assessment of Specific Needs” achieved 97% compliance, while the “Pressure Ulcer Risk Assessment” recorded 3% partial compliance.

The Daily Nursing Assessment form showed consistent performance across categories with 96% full compliance and 4% non-compliance overall. However, the “Pain Assessment” subcategory reflected slightly lower documentation, with 94% full and 6% non-compliance. The “Counter-signature of Shift In-Charge on Handover” field also showed a 5% non-compliance rate.

The In-House Transfer Form reflected a general compliance rate of 90%, with two subcategories— “Reason for Admission and Diagnosis” and “Part A Completion”—showing slightly lower compliance at 89% and 87%, respectively, and 12% non-compliance in Part A.

Patient and Family Education (PFE) records showed promising adherence, with 93% compliance in PFE assessment and 95% in form completion by nursing staff. However, a small proportion of records displayed 4% partial and 5% non-compliance in the PFE assessment section. The Relative Communication Record form showed 100% compliance, demonstrating consistent use across the files reviewed.

Several specialized forms, including the Blood Transfusion Monitoring Form, Blood Transfusion Consent, Restraint Consent, and Nutrition Assessment within 24 hours of admission, also recorded 100% compliance, indicating that structured processes in these areas were well followed. The Bundle of Care Checklist achieved 99% compliance, with 1% partial documentation. Similarly, the Physiotherapy Assessment Form showed 98% compliance and 2% non-compliance, while the Cath Lab Procedure Notes form reflected 97% compliance with a minor 3% documentation lapse.

Chapter 5: Discussion

This audit brought to light significant differences in documentation compliance across departments and forms, revealing not just where documentation is being completed, but where and why it is being missed. What stood out most was not simply the percentages, but the underlying patterns that reflect workflow pressures, staff roles, and perhaps even perceptions around the importance of certain forms.

Departments such as the wards demonstrated consistently high compliance. This may be attributed to a more stable environment with manageable patient turnover and routine monitoring, allowing staff to complete documentation with fewer interruptions. In contrast, SICUs—which showed the highest rate of non-compliance—are often high-pressure settings where clinical urgency takes precedence, and documentation, especially in forms like progress notes or initial assessments, can become secondary to immediate care needs.

A recurring concern was the lack of signatures from doctors in progress notes. While the clinical content was often present, the absence of proper sign-off undermines the legal and professional validity of those entries. This issue, though seemingly minor, carries significant implications in medico-legal settings and for accountability during care transitions. It also reflects a behavioural trend where documentation is delegated or rushed, especially in busy units or during shift changes.

Similarly, forms requiring cross-disciplinary input, like the Nursing Admission Assessment, often showed incomplete nutritional screenings and risk assessments. These fields are essential for early care planning, yet they were frequently left blank or inadequately filled. This could stem from gaps in awareness, time constraints during patient admission, or lack of clarity on responsibility—whether it's the primary nurse, dietician, or physician who should initiate these assessments.

The Doctor Initial Assessment also presented challenges. Several fields such as “current medications” and “special instructions for diet” were frequently missed. These omissions suggest not only time constraints but possibly a perception that these fields are either redundant or less critical—especially when verbal communication substitutes for formal record-keeping. However, missing these key entries creates gaps in continuity and may lead to repeated history-taking or missed precautions, particularly when care shifts between teams.

Interestingly, structured forms like the prescription sheet and treatment sheet, where completion is embedded in the prescribing workflow, achieved near-perfect compliance. This suggests that when documentation is part of a clearly defined process, supported by prompts or tied to other essential tasks (like ordering medication), adherence improves. On the other hand, forms that require narrative input or frequent updating, like progress notes, seem more vulnerable to inconsistency.

The audit revealed a layered picture of documentation practices—where well-structured forms such as prescriptions, treatment sheets, and transfusion records consistently demonstrated high compliance, while narrative-driven or multi-provider entries revealed gaps. These results reflect a broader reality within hospital workflows: documentation that is closely tied to routine clinical processes is more likely to be completed, whereas sections that require reflection, updates, or interdisciplinary input often get overlooked.

Similarly, incomplete nutritional screenings and nursing admission assessments suggest that certain fields may be deprioritized, especially during high patient turnover or when roles are poorly delineated between departments.

This audit serves not only to identify compliance percentages but also to uncover behavioural and structural patterns behind those numbers. It reinforces the need for more seamless integration of documentation into daily workflows, clearer assignment of responsibilities for specific forms, and perhaps a shift in institutional culture to recognize documentation as a clinical function—not just an administrative one. The findings underscore how documentation habits directly impact patient safety, care continuity, and institutional accountability

What these trends collectively suggest is that compliance is not only a matter of knowing what to fill—but also how documentation fits into the clinical workflow. Forms that are tightly woven into standard processes get filled. Those that exist in parallel—especially those perceived as clerical—are more likely to be missed.

Addressing these documentation gaps requires more than reminders or reprimands. It calls for making documentation easier to complete, clarifying responsibility for specific fields, and integrating audits as part of a culture of clinical quality—not just administrative oversight. By streamlining form design, reinforcing expectations during onboarding and shift handovers, and embedding regular feedback loops, departments can begin to close these gaps in meaningful ways.

This audit highlights that improving documentation isn't just about checking boxes. It's about ensuring that critical information—whether about a medication, an allergy, a nutritional risk, or a post-operative instruction—is consistently captured and communicated. Only then can documentation truly support what it's meant to: safe, continuous, and accountable care.

Limitations

1. Real-Time, Open File Audit:

The data were collected from open patient files during the period of hospitalization, offering a practical view of documentation as it happens. However, this also meant that certain entries—particularly those completed later in the stay or at discharge—may not have been captured. As a result, some files may have appeared incomplete simply because documentation was still in progress.

2. Focus on Presence, Not Content Quality:

The scoring system focused on whether documentation was present and complete, not on the depth, clarity, or clinical accuracy of what was written. A field marked as “compliant” may still contain vague or superficial information that doesn’t fully support continuity of care. This nuance was outside the scope of the current audit but is important to recognize.

3. No Link to Patient Outcomes:

The audit was designed to assess documentation compliance, not clinical outcomes. While poor documentation is known to impact care quality, this study did not measure direct links to adverse events, readmissions, or patient safety incidents. Exploring those outcomes would add further value in future studies.

Chapter 7: Conclusion

This cross-sectional study set out to assess the quality and completeness of inpatient documentation using a structured, multi-parameter audit checklist. The findings brought to light consistent lapses in both medical and nursing documentation, including incomplete clinical assessments, missing vital details such as medication lists and diagnoses, and unsigned progress notes. Consent forms also showed a concerning trend, with essential fields outlining the risks and benefits of procedures often left blank.

These gaps are not merely administrative oversights—they have a direct impact on patient safety, communication between care teams, and the legal integrity of the hospital's medical records. Incomplete or unclear documentation can lead to miscommunication, medical errors, and challenges in defending the care provided during medico-legal reviews.

The study underlines the urgent need to equip healthcare professionals—both doctors and nurses—with better awareness and training on the importance of accurate, timely, and standardized documentation. Emphasizing why we document, rather than simply how to document, can create a more accountable and care-driven approach. Signatures and verifications should not be treated as formality but as an essential closure to each entry, ensuring that responsibility is clear and traceable.

Inpatient documentation serves as a mirror to the patient's entire clinical journey—from admission to discharge. It reflects the quality of care delivered, and when done well, supports clinical decisions, protects legal interests, and builds trust with patients and their families. Regular audits play a vital role in maintaining and improving this quality. When audits are used not just for inspection but for education and feedback, they can become powerful tools for continuous improvement. This study highlights that improving documentation is a shared responsibility that requires consistent monitoring, supportive interventions, and a hospital culture that values transparency and quality. By taking corrective steps—like regular audits, training sessions, peer reviews, and smarter systems—we not only reduce the risk of errors but also enhance the overall standard of patient care. Ultimately, good documentation is not just about records—it's about respect for the patient and pride in the care we provide.

RECOMMENDATIONS

1. Introduce a monthly documentation audit with departmental feedback:

To keep staff of hospital engaged and aware, a structured monthly audit of documentation should be conducted in which each department receives feedback on common misses, trends and areas of improvement.

2. Leverage technology with smart forms and mandatory fields:

As hospital gradually move towards EMR, incorporating smart forms with non-skippable mandatory fields can reduce unintentional omissions. For instance, the system could prompt the doctors or the nurse to completely fill key details like current medications and plan of care with goal fields.

3. Understand the reason of repeated non-compliance:

Issues like consistent blank entries in the Doctor initial assessment form and in consent forms keep appearing then it's essential to go beyond numbers and try to understand the reason behind this issue. Discussion with the staff can uncover reason such as time constraints or unclear form structures or workflow challenges. Addressing it will help in improvement.

4. Recognize good documentation:

A small appreciation can motivate the staff and promote them to engage in documentation compliance. Recognize them and give awards or certificate like best compliant department of month, this will help them pay closer attention to documentation quality.

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Annexures

Audit checklist	
FORM 1: Prescription	Chief Complaints
	Provisional Diagnosis
	Allergy
	Pain
	Physical Examination
	Systemic Examination
	Medicine in Capitals, Dose, Route, Frequency, and Legible
	No abbreviations
	Follow up advice
	Diet advice
FORM 2: Admission Form	Risk type/ Clinical condition
	Name of surgery/ Procedure
	Signature of admitting consultant
FORM 3: Triage Doctor Assessment	Triage Priority
	Allergy
	Chief Complaints
	History
	Physical Examination
	Systemic Examination

	Investigation
	Outcome: Admission/Discharge/Lama
	Date, Time, Name and sign of Transferring and Receiving Doctor
FORM 4: Doctor Initial Assessment	Chief Complaints and History of Present Illness
	Drug Allergy if any
	History of Present Illness
	Past History
	Past Family History
	Vitals
	Physical Examination
	Systemic Examination
	Current Medications
	Provisional Diagnosis
	Investigation
	Plan of Care with Goals
	Special Instructions (First diet order)
	Counter Signature of admitting consultant/team member within 24 hours of History taken
FORM 5: Treatment Sheet	Written Prescription for all medicines (Prior to indenting of the Medicines)
	Prescription: Dose, route, frequency of Medicine
	Standard time for Medication

	Prescription: Un approved Abbreviations
	Date of Prescription
	Antibiotics are written in its column only
	Stat order complete
FORM 6: Progress Note	Admitting Consultant/team member's note in every 24 hours
	Current Vitals
	Patients Condition
	Orders are complete and legible
	Blood Transfusion Notes with duration of transfusion
	Restrain orders
	Un Approved Abbreviations
	Date, Time, Name, Signature of doctor
	Date, Time, Name, Signature of nurse
FORM 7: Pre Operative Anaesthesia Assessment and Orders	Name of Surgery
	Diagnosis
	Allergy
	Diabetic Status
	Necessary medication orders
	Necessary Investigations
	Anaesthesia plan
	Name and Signature of Anaesthetist

	Date of Pre anaesthesia assessment conducted
FORM 8: Anaesthesia Record	All fields of Pre Induction assessment box
	Technique or mode of anaesthesia
	Vitals Monitored and noted in the graph as per fixed frequency
	Airway Management
	Start and Stop Time of Anaesthesia
	Ventilator setting instructions by Anaesthetist
	Post Anaesthesia Care notes
	Name and signature of all members of Anaesthesia Team
FORM 9: Surgical Safety Checklist	Time mentioned in sign - in
	Time mentioned in time - out
	Time mentioned in sign - out
	All criteria filled of "Sign in"
	All criteria filled of "Time out"
	All criteria filled of "Sign out"
	Signature of Circulatory Nurse
	Signature of Surgeon
	Signature of Anaesthetist
FORM 10: OT Notes	Date, Start, Time and End Time of Surgery
	Type of Surgery- Elective/Emergency
	Name of surgery

	Name of all surgeons
	Pre operative Diagnosis
	Post operative Diagnosis
	Brief Note Of surgery
	Important Post operative Instructions to ICU staff
	Specimen sent to Lab (if any) by nurse
	Signature of Chief Surgeon
FORM 11: Consent Forms	No short form or Abbreviation of Procedure/Surgery
	Name and signature of doctor
	Name and signature of Patient/Relative
	Witness signature
	Benefits mentioned in the consent Form
	Risk and alternatives mentioned in the consent form
	Possible results of non-treatment mentioned in the consent
	General Consent for admission
FORM 12: Triage Nursing Assessment	Triage code
	Mode of Arrival
	Allergies
	Pain score
	Vital sign

	Intervention done
	Patient transferred to
	Date, Time, Name and Sign of Transfer and Receiving Nurse
FORM 13: Nursing Admission Assessment	Patient status
	Allergy
	Nutritional screening
	Functional assessment
	Psychological assessment
	Fall risk assessment
	Pressure ulcer risk assessment
	Pain score
	Assessment of specific needs
	Signature of nurse
	Signature of attendant
	Signature of unit in charge
FORM 14: Daily Nursing Assessment	Daily Assessment
	Fall Risk Assessment
	Pressure Ulcer Risk Assessment
	Diabetic Flow sheet
	Input Output Monitoring
	Pain Assessment

	Nursing Care Plan
	Signature of nurse In charge/shift in charge
	Shift handover notes
	Countersign of shift in charge on handover
FORM 15: In house transfer Form	Part A is filled
	Reason of admission and diagnosis
	Condition at the time of transfer
	Vitals
	Handover and taken over signature by doctor
	Handover and taken over signature by nursing staff
FORM 16: Patient and Family education Record	PFE Assessment
	Patient and Family education Form filled by Nursing
FORM 17	Department of critical care Relative Communication record
FORM 18	Blood Transfusion Monitoring Form
FORM 19	Blood Transfusion consent - Name and quantity of component
FORM 20	Restrain consent
FORM 21	Cath lab procedure notes
FORM 22	Bundle of care checklist
FORM 23	Nutrition assessment is done within 24 hours of admission

FORM 24	Physiotherapy Assessment is performed by physiotherapist where applicable