

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

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MBA HM - 28 (1822)

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INTRODUCTION

- Medical records are the foundation of safe and effective hospital care. They serve as a written account of the patient's journey – capturing everything from admission details and diagnosis to treatment plans, daily observations, and discharge instructions.
- These records are essential not only for clinical decision-making but also for ensuring legal protection, smooth handovers, and accurate billing.
- When documentation is inconsistent or incomplete, it can lead to miscommunication, treatment delays, and even compromise patient safety.
- To maintain high standards, hospitals implement documentation protocols and conduct regular audits.
- An audit is a structured review of patient files that checks whether all required forms and entries are complete, accurate, and compliant with established guidelines.
- In the case of inpatient care, audits help identify which forms are being properly filled and where gaps exist, allowing hospitals to take corrective actions and improve the quality of care.

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 systematically evaluate documentation practices using a multi-parameter audit checklist comprising 24 forms.
- 2.To identify patterns of non-compliance in different departments and across various forms.
- 3.To propose evidence-based recommendations that can enhance compliance, accountability, and ultimately patient safety.

METHODOLOGY

STUDY DESIGN:

A retrospective descriptive cross-sectional study.

STUDY AREA:

Fortis escorts hospital jaipur

Departments - MICU, SICU, 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.

METHODOLOGY

➤ 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: 120 files

➤ 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

➤ DATA COLLECTION TOOL:

- 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”.
- 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

Form Name	Subcategories / Fields
Prescription	Diagnosis, Allergy, Diet Advice, Dose, Route, Frequency, Approved Abbreviations
Admission Form	Risk Type, Consultant Sign, Surgery Name
Triage Doctor Assessment	Chief Complaint, History Taken, Diagnosis, Outcome
Doctor Initial Assessment	HPI, Current Medications, Plan of Care, Diet Instructions, Systemic Examination
Treatment Sheet	Dose, Route, Time, Frequency, Signature
Progress Notes	Date, Time, Vitals, Clinical Notes, Doctor/Nurse Sign
Pre-op Anaesthesia Assessment	Diagnosis, Vitals, Anaesthesia Plan, Signature
Anaesthesia Record	Vitals, Airway, Start/Stop Time, Procedure Type
Surgical Safety Checklist	Sign-in Time, Team Sign, Sign-out Time, Site Marking
OT Notes	Surgery Name, Diagnosis, Specimen, Instructions
Consent Forms	Procedure, Risk/Benefits, Witness Sign, Patient/Guardian Sign
Triage Nursing Assessment	Vitals, Nursing Assessment, Disposition
Nursing Admission Assessment	Nutritional Screening, Pain Score, Fall Risk, Functional Status, Skin Integrity
Daily Nursing Assessment	I/O Monitoring, Pressure Ulcer Risk, Pain Assessment, Shift Handover
In-House Transfer	Diagnosis, Reason for Transfer, Vitals, Doctor/Nurse Sign
PFE Record	Assessment, Information Given, Staff Signature
Relative Communication Record	Relative Notified, Documentation of Communication
Blood Transfusion Monitoring	Component, Vitals, Time, Adverse Reaction
Blood Transfusion Consent	Component, Signature, Consent Explanation
Restraint Consent	Reason, Type, Guardian Consent
Cath Lab Procedure Notes	Diagnosis, Procedure Done, Signature
Bundle of Care Checklist	Central Line, VAP, CAUTI, Compliance Tick
Nutrition Assessment	Assessment within 24 hrs, Nutritional Plan
Physiotherapy Assessment	assessment sheet

ANALYSIS

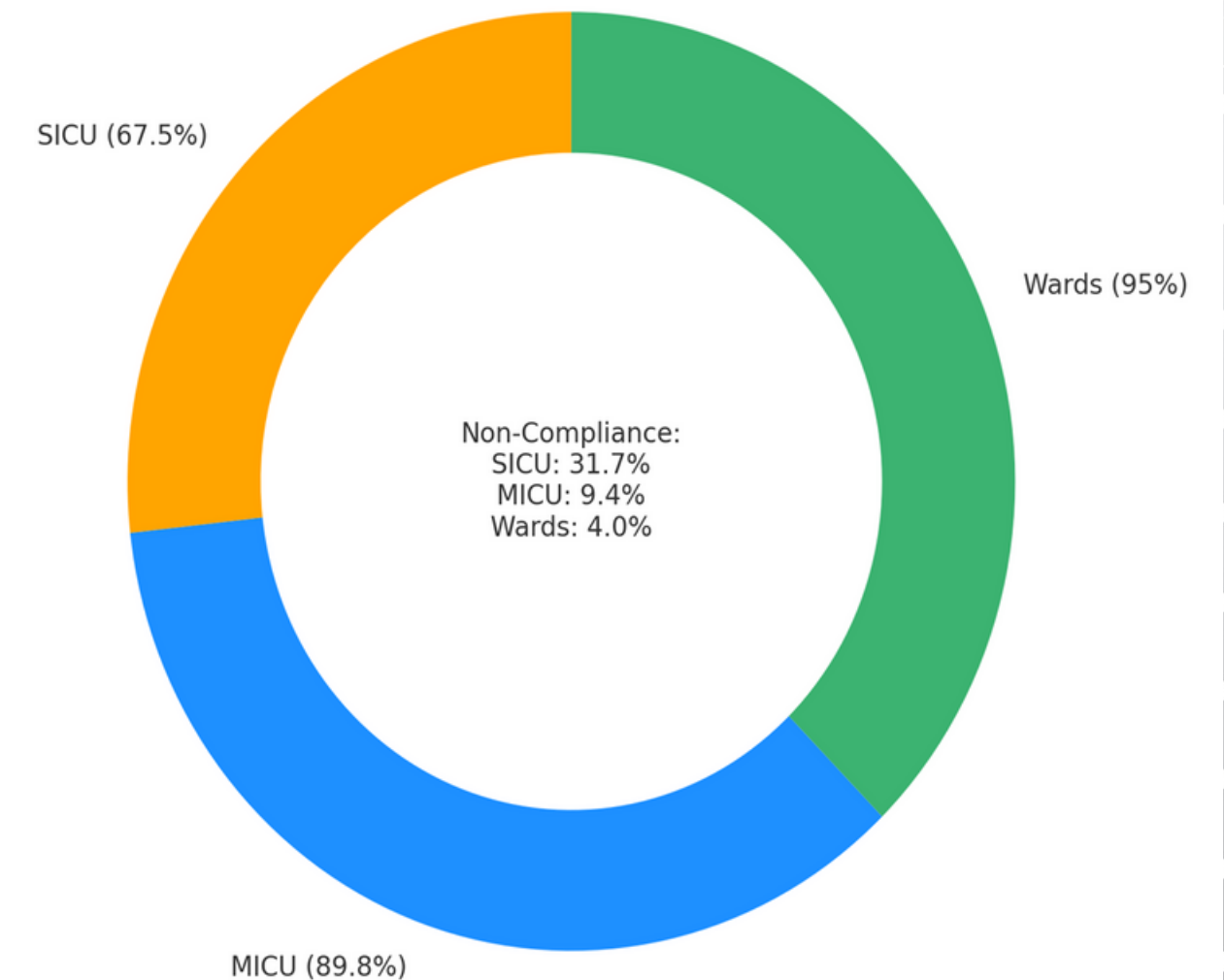
- Data analysis method: Data was analyzed using Microsoft Excel to derive trends in compliance and identify high-risk gaps across departments and forms.

RESULTS

- General Wards: Demonstrated the highest documentation compliance with 95% of forms fully compliant, reflecting routine-driven processes.
- MICUs: Achieved 89.8% compliance, revealing structured documentation despite a high-pressure environment.
- SICUs: Noted the lowest compliance rate at 67.5% with the highest percentage of non-compliant entries (31.7%), largely due to critical care pressures and handover inconsistencies.

These results indicate that departments with more predictable workflows tend to achieve better documentation standards.

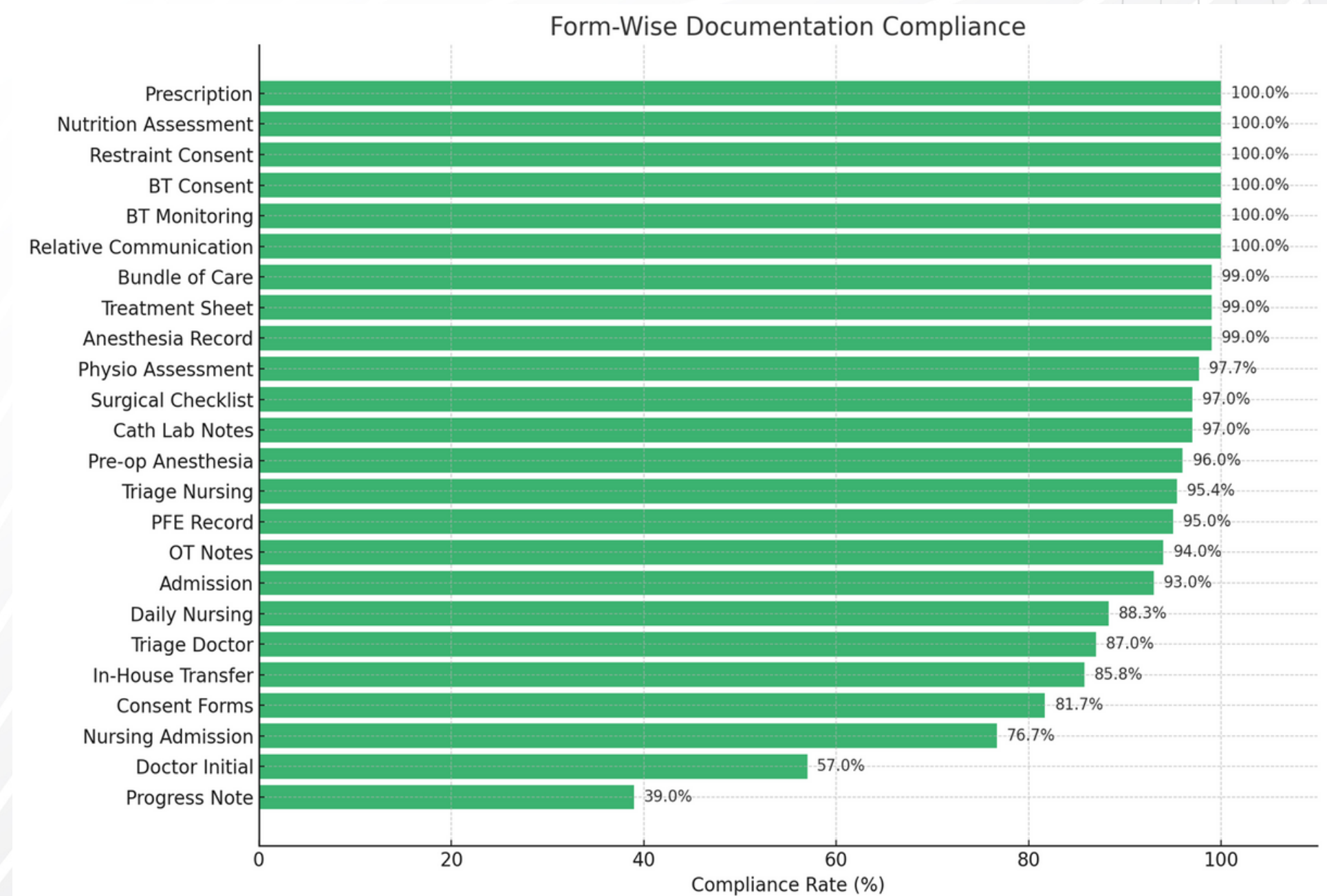
Department-Wise Compliance with Non-Compliance Values Inside



RESULTS

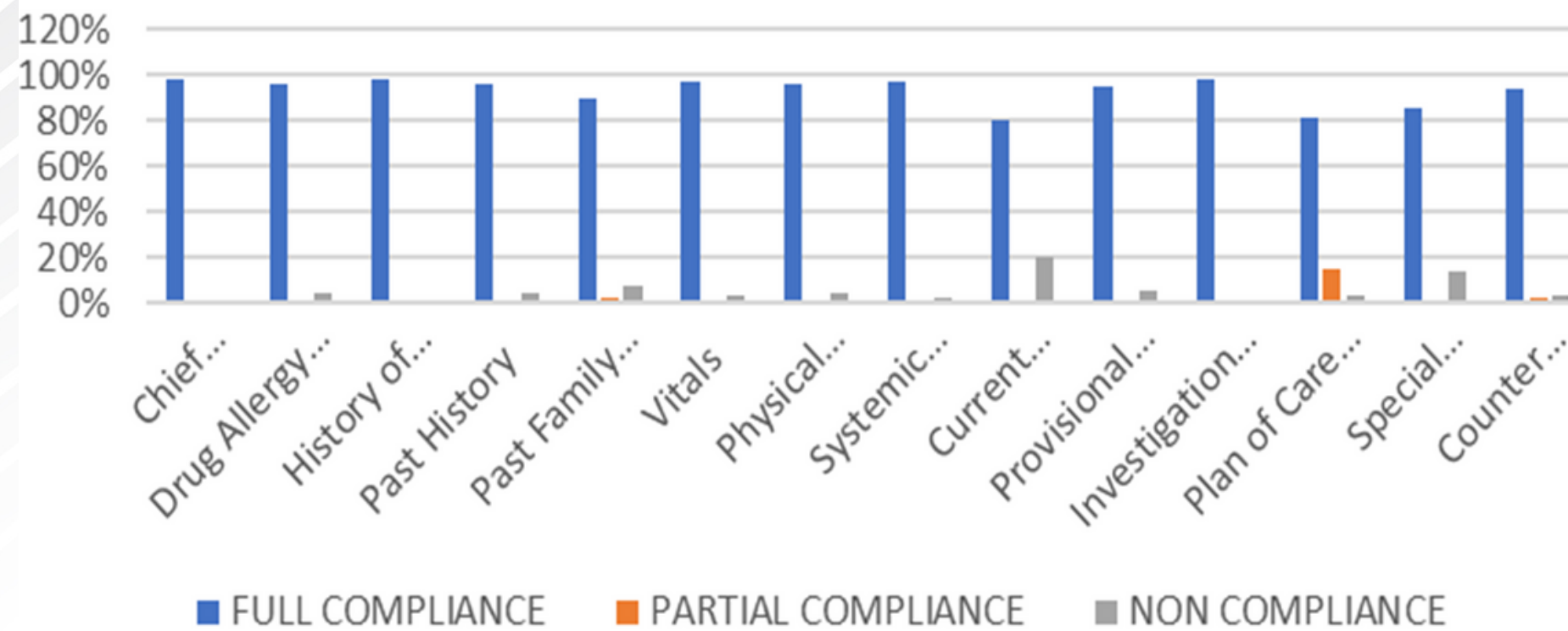
High Compliance Areas:

- Prescription Sheets (100%), nutrition assessment form, restraint consent, and Treatment Sheets (99%) were consistently well-documented.
- Anaesthesia records showed 99% compliance.

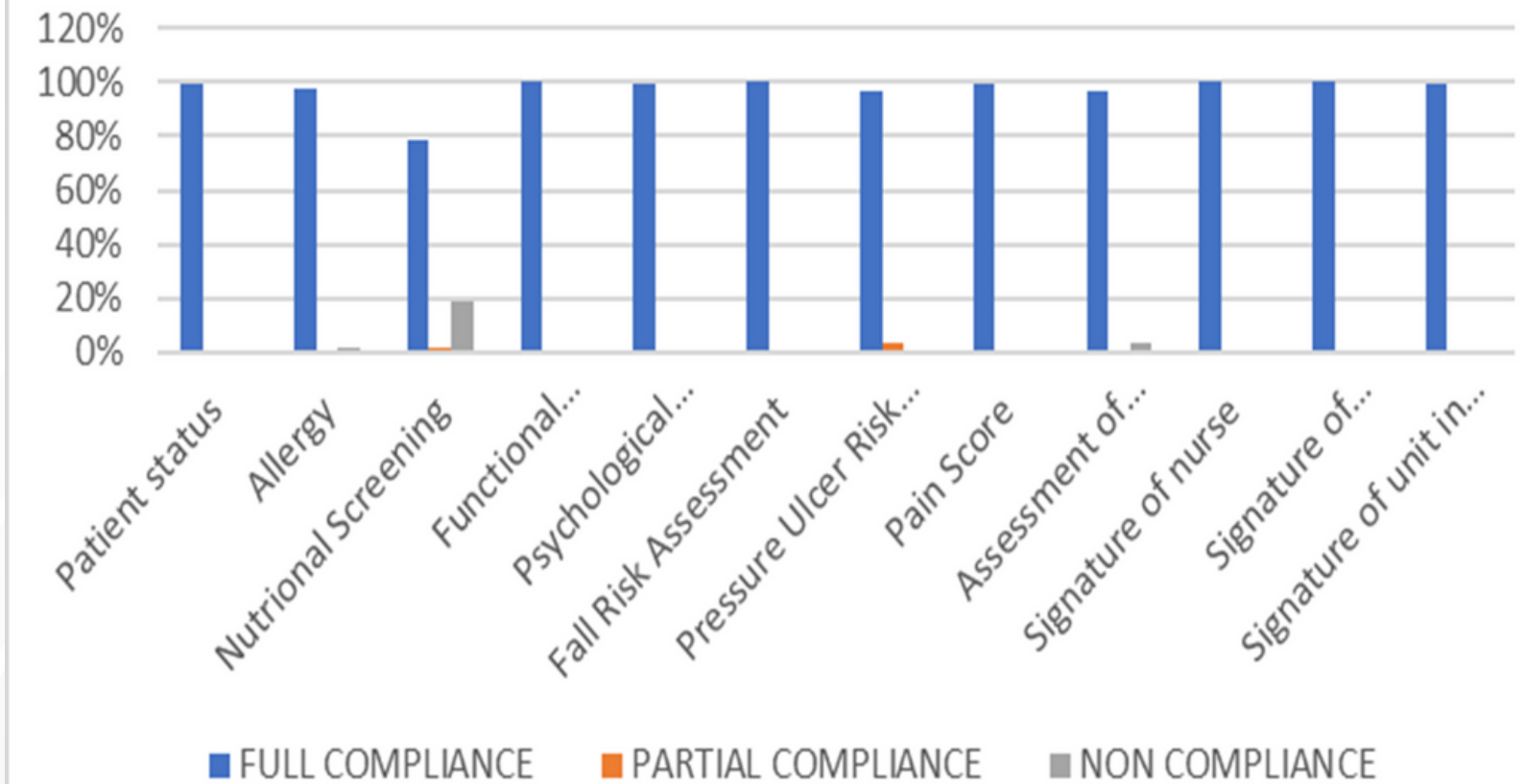


CATEGORY-WISE COMPLIANCE WITHIN FORMS

DOCTOR INITIAL ASSESSMENT



NURSING ADMISSION ASSESSMENT

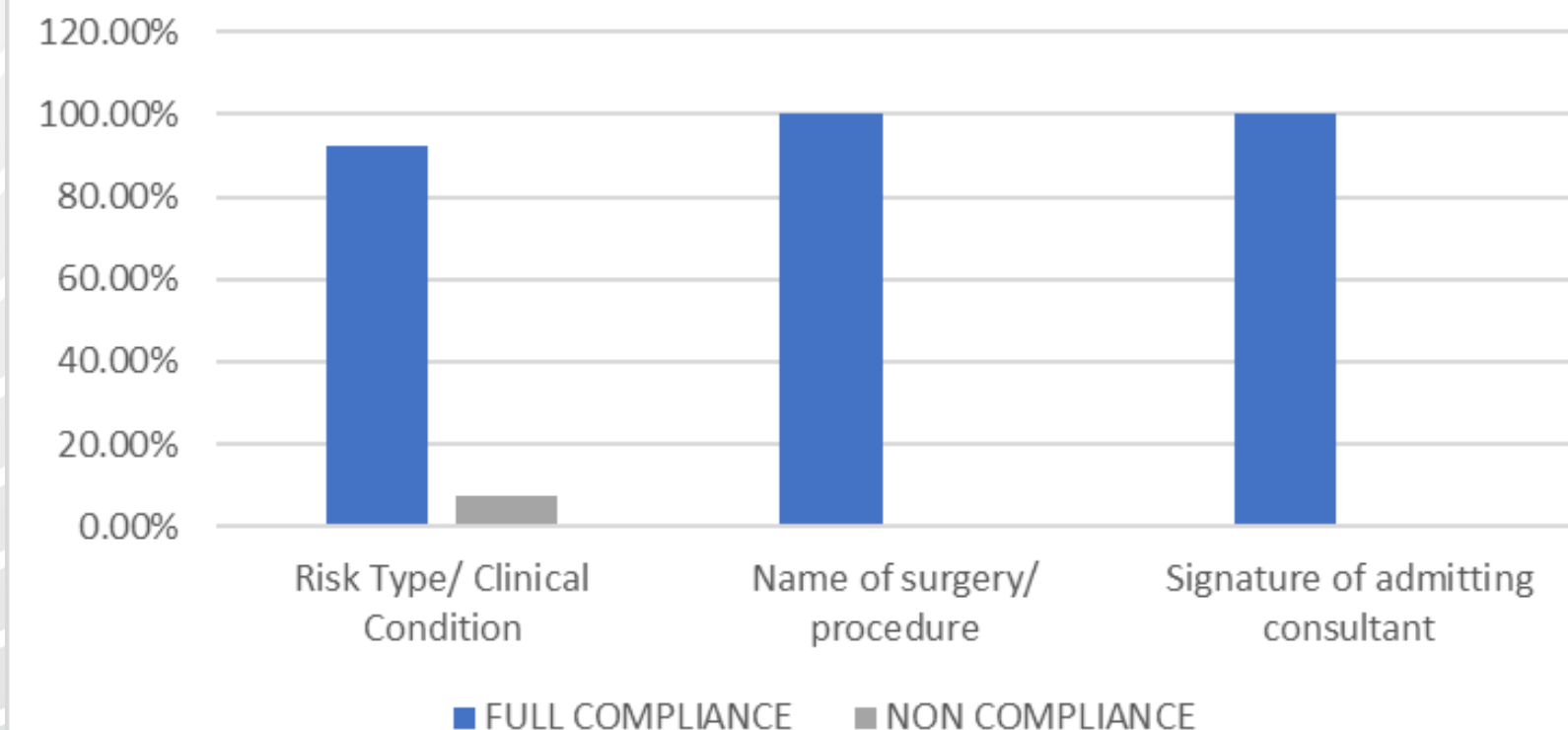


- Doctor Initial Assessment: Low compliance in ' Current Medications' (80%) and 20% non compliance and ' Diet Orders' (13% non-compliance).

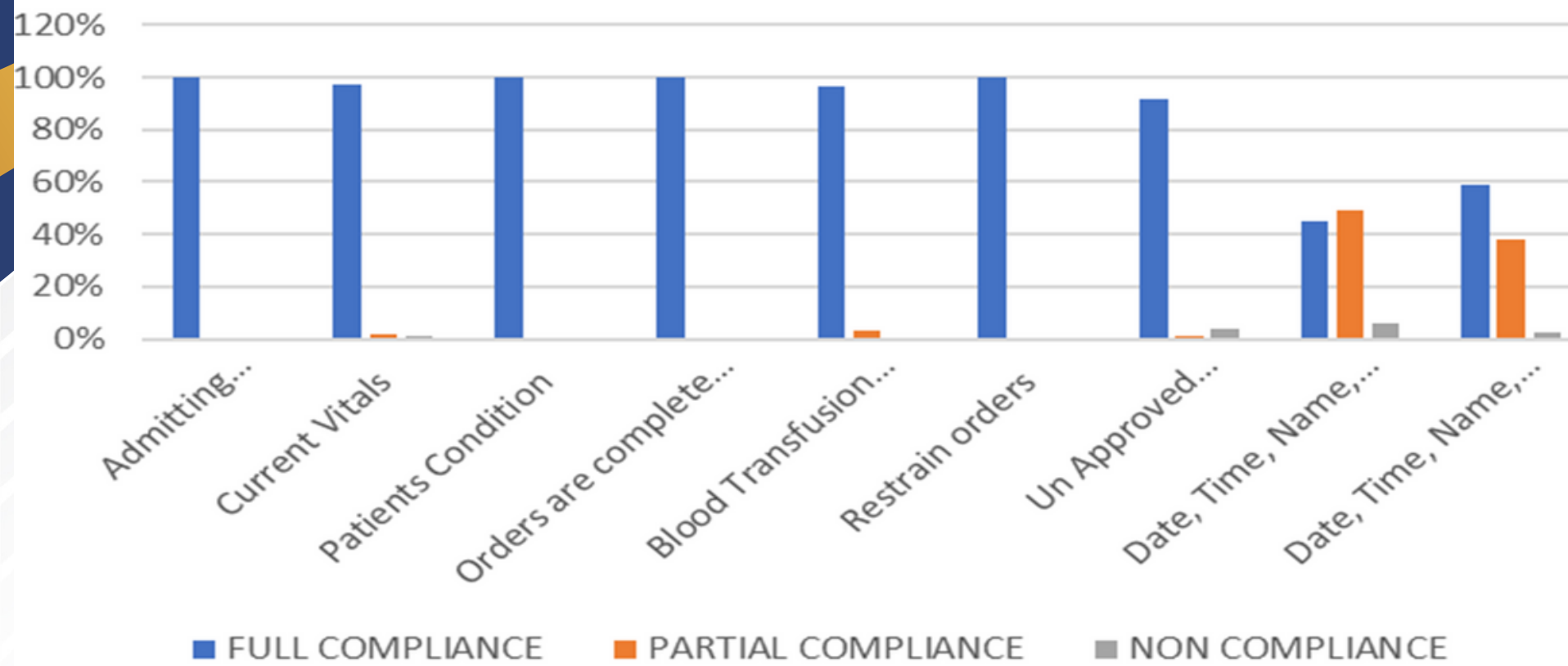
- Nursing Admission: ' Nutritional Screening' 79% compliance and 19% non compliance

- Admission form : Risk Type/Clinical Condition" showed a slightly lower compliance rate 92.5% with around 7.5% non-compliance

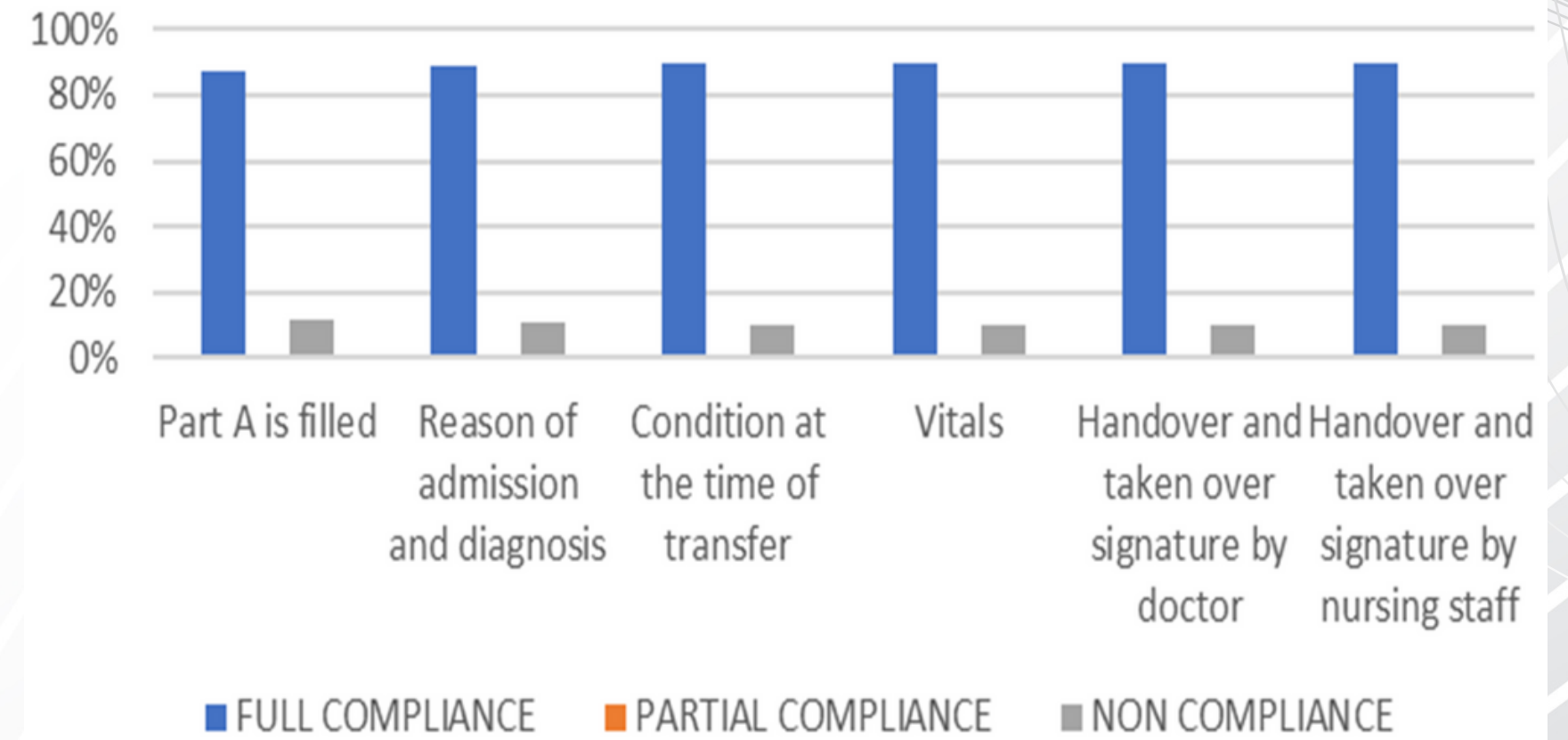
ADMISSION FORM



PROGRESS NOTE



INHOUSE TRANSFER FORM

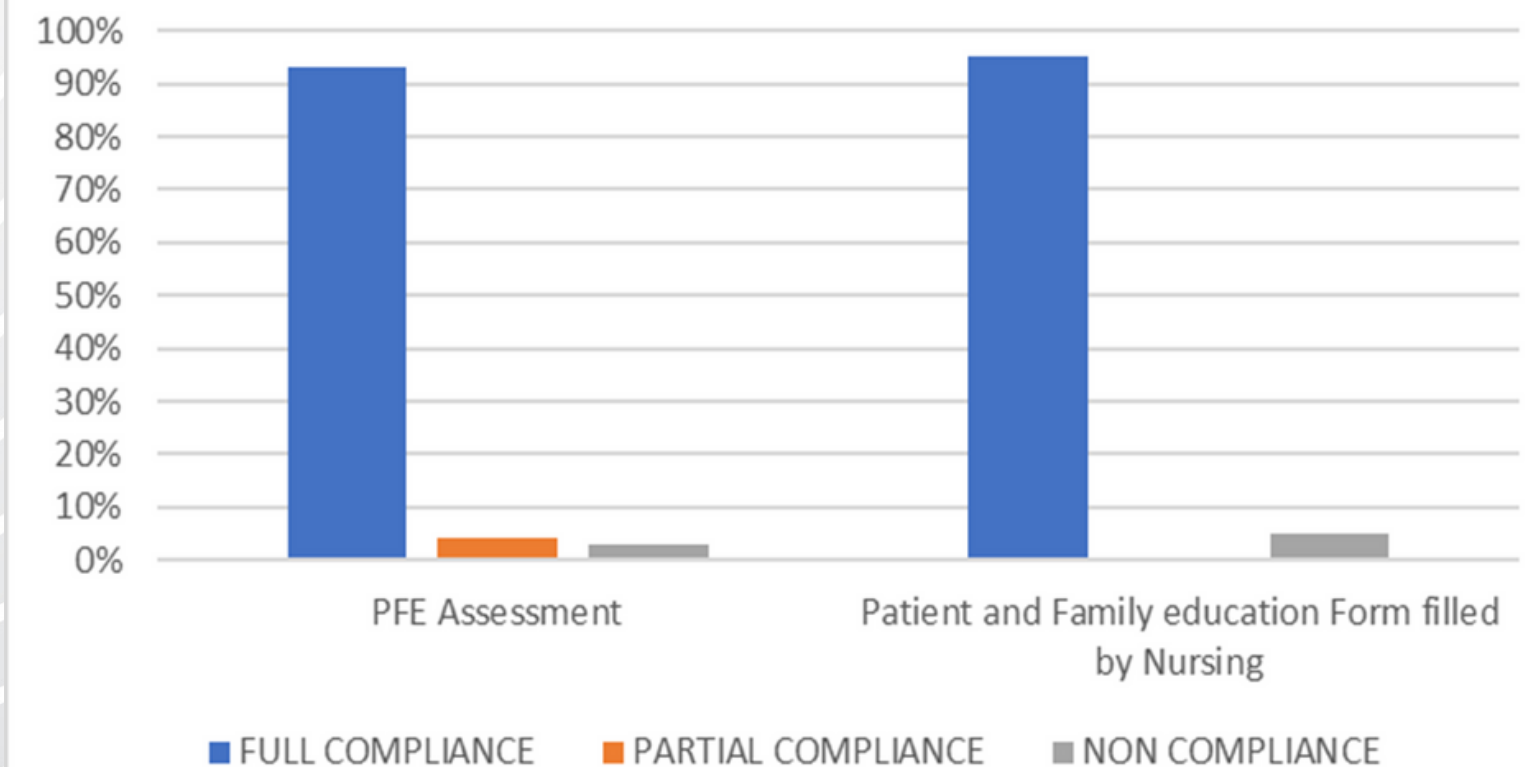


- Progress Notes: Only 45% doctor sign-offs compliance, 49% partial and 5% non compliance, 59% compliance for nurses, 38% partial and 2% non compliance.

- In-House Transfer: non-compliance (~10-12%) persisted in each category.

- PFE & Education: 4% partial compliance in PFE assessment, 5% non-compliance in patient education recording by nurse.

PATIENT AND FAMILY EDUCATION RECORD



AREAS OF CONCERN

1. Doctor Initial Assessment Form:

- Current Medication History: Often incomplete or skipped (~20% non-compliance)
- Diet Instructions: Frequently omitted (13% non-compliance)
- Plan of Care: Partially filled or vague (15% partial, 10% non-compliant)
- Systemic Examination: Left incomplete in several files

2. Progress Notes

- Daily Updates: Not recorded consistently; many entries were outdated or missing
- Signatures:
 - Only ~45% had proper doctor signatures
 - ~59% had nurse sign-offs
- Time & Date Entries: Often missed

3. Consent Forms

- Risk and Benefit Explanation: Missing in 6-8% of cases
- Witness Signatures: Frequently absent.

4. Nursing Admission Assessment:

- 77% full, 19% non-compliant
- Most lapses in nutritional screening and risk assessments (e.g., ulcer/fall risk)

5. Surgical Safety Checklists was missing in some files.

6. 4% non compliance in **daily nursing assessment** as care epic was not present in some files.

7. Some **inhouse transfer forms** were partially filled showing 10 -30% non compliance.

DISCUSSION

- High compliance was noted in structured forms like prescription (100%), treatment sheet (99%), and transfusion forms (100%), indicating strong process adherence when forms are integrated into routine workflows.
- Progress notes and doctor initial assessments showed the lowest compliance (39% and 57% respectively), primarily due to missing signatures, incomplete fields, and irregular updates.
- SICUs had the highest non-compliance (31.7%), likely due to fast-paced environments and shift-based responsibilities leading to gaps in documentation.
- Wards demonstrated best compliance (95%), suggesting better workflow balance and clearer delegation of documentation responsibilities.
- Common Trends Identified:
- Forms needing narrative input or interdisciplinary coordination, such as nursing assessments and progress notes, were often incomplete.
- Key information like drug allergies, nutritional risk, and plan of care were frequently under-documented, impacting care continuity.
- Signature compliance was a recurring gap, affecting both medico-legal validity and accountability of care.
- Root Causes:
- Time constraints, especially in critical care units.
- Perceived redundancy in certain fields (e.g., medication history, diet orders).
- Unclear ownership of form completion in shared responsibilities.

RECOMMENDATIONS

1. Institutionalize Monthly Documentation Audits:

Conduct structured reviews with transparent feedback to each unit, promoting awareness and accountability.

2. Digital Transformation with Smart EMR Forms:

Implement electronic documentation systems with mandatory fields and prompts to minimize errors and omissions.

3. Root-Cause Dialogues with Staff:

Go beyond data to understand why entries are missed. Engage teams to identify systemic bottlenecks and workflow inefficiencies.

4. Recognize and Reward Best Practices:

Introduce incentives such as "Best Compliant Unit" awards to build a positive reinforcement culture.

CONCLUSION

- This audit demonstrates that while some aspects of documentation are robust, critical gaps exist in narrative forms, risk assessments, and cross-disciplinary entries. Compliance is closely linked with workflow design, staff perception, and time-sensitive clinical environments.
- Improving documentation is not just a matter of enforcement, but of embedding quality into routine. By making documentation processes intuitive, supported by technology, and valued institutionally, we can improve patient safety, staff accountability, and organizational credibility. Hospitals must recognize documentation as a clinical function that holds power in shaping outcomes and trust.