SYNOPSIS

Assessing Inpatient Documentation Compliance Through a Multi-Parameter Audit: A Cross-Sectional Study to Enhance Care Continuity and Clinical Standards

INTRODUCTION

In the fast-paced environment of a hospital, maintaining proper documentation isn't just a matter of paperwork—it's a critical component of patient safety and quality care. Each form, note, and assessment serves as a link in the chain of communication between healthcare professionals. When even one part of that chain is weak or missing, the risk to patients increases. This study focuses on systematically auditing inpatient files across general wards, MICUs, and SICUs using a detailed checklist. By assessing the completeness and compliance of documentation after two days of patient admission, the goal is to identify gaps that could compromise care and propose meaningful improvements.

RESEARCH QUESTIONS

- 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?

OBJECTIVES

- To evaluate the quality and completeness of inpatient documentation using a structured, multi-point checklist.
- To identify patterns of non-compliance and missing records across different departments.
- To offer actionable feedback that can enhance the hospital's overall documentation practices and patient safety outcomes.

HYPOTHESIS

There are significant documentation deficiencies in inpatient records that can be effectively identified through structured audits, and these insights can guide improvements in care continuity and compliance with quality standards.

MATERIAL AND METHODS

STUDY DESIGN

A retrospective descriptive cross-sectional study.

STUDY AREA

The study will be conducted at Fortis Escorts Hospital, Jaipur, a 275-bed multi-specialty tertiary care facility. The audit will include patient files from General Wards, the Medical Intensive Care Unit (MICU), and the Surgical Intensive Care Unit (SICU).

STUDY POPULATION

Inpatient files of patients admitted for at least two days in the selected wards like MICU, SICU.

INCLUSION CRITERIA

- Files of patients who have completed 48 hours or more of admission.
- Patients currently admitted during the study period.

EXCLUSION CRITERIA

- Emergency and OPD case files.
- Files of patients discharged within 48 hours.

STUDY TOOLS

A structured audit checklist that evaluates documentation completeness for the following components:

- Admission Form
- Prescription
- Triage Doctor and Nursing Assessments
- Initial Doctor's Assessment
- Treatment Sheets and Progress Notes
- Pre-Operative Orders and Anaesthesia Records
- Surgical Safety Checklist
- Consent Forms
- Daily Nursing Assessments
- Patient and Family Education Record
- Critical Care Relative Communication Record
- Blood Transfusion Monitoring
- Restraint Consent

- In-house Transfer Forms
- Cath Lab Notes
- Bundle of Care Checklists
- Nutrition and Physiotherapy Assessments (within 24 hours or if applicable)

Checklist Validation

The checklist used for this audit is the one already in use at Fortis Hospital as part of its internal documentation standards. It has been designed based on the National Accreditation Board for Hospitals and Healthcare Providers (NABH) guidelines and includes all essential components expected in an inpatient file—from admission and clinical assessments to consent forms and nursing documentation. Since this tool is already a part of the hospital's quality assurance system, it was considered appropriate and reliable for this study. To ensure it was well-suited for the audit process, the checklist was reviewed and pilot-tested on a small sample of patient files before the main data collection began. This helped confirm that the format was clear, practical, and covered all the necessary documentation touchpoints.

DURATION OF STUDY

2 months.

SAMPLE SIZE

Approximately 120 files across MICUS, SICU AND Wards. A sample of 120 files allows balanced representation from each, improving the generalizability of findings within the hospital context. a reviewing 120 files was manageable without compromising the depth or accuracy of data collection.

SAMPLING TECHNIQUE

Stratified purposive sampling to ensure representation across wards.

DATA COLLECTION PROCEDURE

Files are reviewed on or after the third day of admission. Audits are conducted manually using the checklist, with on-site observations where necessary. No patient identifiers are collected. Findings are recorded electronically and categorized as "compliant," "partially compliant," or "non-compliant."

INTER-RATER RELIABILITY

To ensure consistency and accuracy of the audit findings, inter-rater reliability will be assessed. After the initial open file audit, the same set of patient files will be re-evaluated through a closed file audit after patient discharge. This second audit will be conducted independently to verify the consistency of documentation scoring. By comparing observations from both audits,

any discrepancies can be identified and addressed, thereby enhancing the overall reliability and validity of the study outcomes.

OPERATIONAL DEFINITIONS

- **Compliance**: Proper completion of all required documentation fields with correct signatures, dates, and entries.
- **Non-Compliance**: Missing forms, incomplete entries, or lack of authentication.
- **Continuity of Care**: The seamless and coordinated progression of patient management through accurate, timely documentation.

DATA ANALYSIS PLAN

Descriptive statistics (percentages, frequencies) will be used to analyse compliance rates. Data will be represented using charts and tables to highlight trends and ward-wise differences in documentation practices. MS excel will be used for analysis.

ETHICAL CONSIDERATIONS

- No personal identifiers or sensitive data will be collected.
- Audit findings will be shared with hospital administration only for quality improvement.
- Institutional permission will be obtained before the start of data collection.

IMPLICATIONS OF THE STUDY

This study will offer hospital administrators and clinical teams a clear view of how well documentation standards is being met in inpatient settings. It provides a foundation for corrective actions, targeted training, and long-term improvement in clinical quality. Strengthening documentation isn't just about compliance—it ensures that every patient receives informed, coordinated, and safe care.

REFERENCES

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