IPD OPEN FILE AUDIT STUDY AT HIGHWAY HOSPITAL, THANE

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

by

Agawane Vedashree Vinayak

Under the Supervision and Guidance of

Dr. Sanjay Gupta

2025

Highway Hospital
— Super Speciality Centre —

Date: 24 Jun 2025

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ms. Vedashree Agawale** has successfully completed her project work at **Highway Hospital, Thane** during the period from **April 01 2025** to **June 14 2025**. Her project, titled **"IPD Open File Audit and NABH Work,"** as **Coordinator -NABH and Operations**, encompassed the following key assignments and additional quality improvement tasks undertaken during this 2-month period:

1. **IPD Open File Audit:**
   - Conducted a comprehensive review of inpatient files across multiple departments.
   - Identified and documented gaps in the process, suggesting robust measures for improvement.
   - Collaborated with clinical teams to ensure accuracy and completeness in patient documentation.
   - Assisted in revalidating data to streamline our compliance with operational standards.
   - Contributed to the formulation of recommendations that have improved record-keeping practices.
2. **NABH Work:**
   - Assisted in preparing and compiling the quality documentation required for NABH accreditation.
   - Performed internal audits and supported the corrective actions aligned with NABH standards.
   - Contributed actively to process evaluations and continuous quality improvement initiatives across the hospital.
   - Helped in coordinating between departments to ensure seamless compliance with accreditation criteria.
   - Played a vital role in ensuring that all collected data met the rigorous standards set forth by NABH.
3. **Additional Assignments:**
   - Engaged in various operational and quality improvement activities to enhance patient care services.
   - Assisted in streamlining clinical documentation processes and overall data management.
   - Demonstrated a proactive approach in identifying areas for improvement within administrative workflows.
   - Actively participated in team meetings and presented insightful recommendations.
   - Consistently maintained a high level of professionalism and attention to detail throughout her tenure.

Ms. Vedashree Agawale has shown exceptional dedication and competence during her project work. Her contributions have significantly supported our hospital's continuous pursuit of excellence in patient care and operational efficiency. We extend our best wishes to her for all her future endeavors.

Sincerely,

24/6/25

Chief Operating Officer Highway Hospital, Thane

1st Floor, New Dev Ashish, Marathon Circle, Teen Hath Naka, E.E. Highway, Thane (W).
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IIHMR UNIVERSITY

CERTIFICATE

This is to certify that the dissertation titled "**IPD Open file audit study at Highway Hospital , Thane** is a record of the research work undertaken by **Vedashree Vinayak Agawane** in partial fulfilment 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.

Faculty Guide

IIHMR University, Jaipur

23/06/2025

School Dean

IIHMR University, Jaipur

23/06/2025

DECLARATION BY STUDENT

I hereby declare that this dissertation titled "**IPD open file audit study in Highway Hospital , Thane "**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)

Name of Student: vedashree

Date: 23 June 2025

ABSTRACT

INTRODUCTION:

In the context of Healt hcare, IPD stands for In-Patient Department. It refers to the section of a hospital where patients are admitted for overnight stays or longer, typically for treatment requiring more than 24 hours of care. An IPD audit would assess the effectiveness and efficiency of the services and processes within this department, ensuring patient care and safety standards are met

OBJECTIVES:

An IPD audit is an evaluation of the In-Patient Department's operations. It examines various aspects, such as:

- **Patient care:** Ensuring that patients receive appropriate and timely medical attention, proper medication administration, and effective nursing care
- **Infection control:** Assessing adherence to hygiene protocols and measures to prevent healthcare-associated infections.
- **Resource management:** Evaluating the efficient use of hospital resources, including beds, equipment, and supplies
- **Documentation and record-keeping:** Reviewing the accuracy and completeness of patient records and other relevant documentation
- **Compliance:** Ensuring the IPD complies with relevant regulations, standards, and policies

METHODOLOGY

The methodology may also incorporate elements of the Plan-Do-Study-Act (PDSA) cycle, a framework for continuous quality improvement, according to a study on clinical audit. This involves planning the audit, implementing changes, studying the results, and then acting on the findings to refine the process

- The study was carried out over two months in the IPD Department of Highway Hospital, Thane

A total of 100 patients, aged 18 and above, were admitted to the hospital for further procedure .

- **Defining the scope:** Identifying the specific area of focus, such as a particular department, diagnosis, or type of documentation
- **Setting objectives and criteria:** Establishing clear goals for the audit and defining the standards against which the records will be assessed
- **Selecting a sample:** Choosing a representative sample of inpatient medical records to review
- **Retrospective review:** Examining existing medical records, often using a standardized checklist

- **Data extraction:** Collecting specific information from the records, such as patient demographics, medical history, diagnoses, treatment plans, and discharge summaries
- Patients filled out the questionnaire post-procedure. Each response was recorded as “Yes,” “No,” or “Not Applicable.” The data was analysed using descriptive statistics to identify compliance trends and communication gaps.
- **Manual or electronic data entry:** Recording the collected data into a structured format, such as a spreadsheet or database
- Graphs and charts were used to show patient satisfaction levels and pinpoint areas needing attention.

RESULTS

The analysis revealed excellent compliance (100%) in several critical areas such as informed consent, method like PSDA plan study do act helped us to improve and . Patients were also well-prepared regarding further procedure . Regular audits and monitoring processes help identify areas for improvement. Continuous feedback and education contribute to the ongoing enhancement of coding accuracy and compliance.Accurate coding at hospitals, Physicians’ offices and other health care entities is crucial for various reasons, including billing, reimbursement, and statistical analysis. It also helped in communication between healthcare providers, insurance companies, and government agencies.Furthermore, compliance with the Health Insurance Portability and Accountability is essential to protect patient privacy and ensure the secure handling of health information

However, major gaps were found in communication—only 20% of patients were informed about pre admission process duration, and 70% received complete Assessment of Post admission. Post Add-mission hygiene was notably poor with only 40% observing hand-washing protocols sensitization OPD preparation bed clearance process tools preparence . While 85% of patients reported a comfortable experience, improvements are needed in managing staffs Tools Equipment and post IPD Followup , temperature, and continuous communication.

CONCLUSION

This study highlights significant variations in communication practices in IPD While certain areas such as consent, cost explanation,billing insurance claim pre IPD and post IPD process and basic procedural information are well-addressed, others like contrast side effects, risk of infection safety of patient and health care provider medical tools OPD tools and equipment

expectations, and emotional preparedness are inadequately communicated. These gaps could impact patient comfort, compliance, and overall safety.

The conclusion of an inpatient AUDIT FORM summarizes the audit's findings and provides an overall assessment of the documentation and care provided. It should clearly state whether the audit objectives were met, highlight any significant issues or areas of improvement, and offer recommendations for future action

The findings underscore the importance of implementing a structured patient education checklist and enhancing staff training to ensure uniformity in IPD practices. Integrating this feedback mechanism into routine IPD OPD protocols can serve as a continuous quality improvement tool to promote patient-centred care.

Keywords:

Clear Statement of Conclusion:

Begin with a concise statement summarizing the overall findings and whether the audit objectives were achieved

"Yes, but" or "No, but" statement:

If the objectives were mostly met, but with some areas needing attention, use a "yes, but" statement. If significant issues were found, a "no, but" statement might be more appropriate.

Reasoning:

Explain the rationale behind the conclusion, referencing the evidence gathered during the audit and the significance of any findings.

Significance:

Assess the impact of the findings on patient care, legal requirements, or future hospital planning.

Recommendations:

Suggest specific actions to address identified issues, improve documentation practices, or enhance the quality of care.

ACKNOWLEDGEMENT

First and foremost, I would like to express my sincere gratitude to my academic mentor, Dr. Sanjay Gupta, for their invaluable guidance, continuous support, and encouragement throughout the course of this study. Their expertise, insightful feedback, and unwavering patience have been instrumental in shaping the direction and quality of my dissertation.

I am deeply thankful to the faculty and staff of IIHMR University, Jaipur, for providing a conducive learning environment and the resources necessary for the completion of this research. A special thank you to Dr. Ruchi Khanna and Dr. Pracheesh Prakash Pandey, whose constructive criticism and motivation helped refine my work.

I would also like to acknowledge the participants/respondents whose input and cooperation were essential for my research.

To my family, I am forever indebted for their unconditional love, emotional support, and belief in my capabilities. Their constant motivation gave me strength during the most challenging phases of this journey.

Finally, I extend my heartfelt appreciation to my friends and peers who stood by me and contributed through thoughtful discussions, reviews, and encouragement.

This dissertation reflects the collective support and inspiration I have received from all these remarkable individuals.

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LIST OF ABBREVIATIONS

IP	Inpatient
IPD	Inpatient Department
OPD	Outpatient Department
LOS	Length of Stay
HOSP	Hospital
PT	Patient
B.I.D.	BID Twice a Day
T.I.D	TID Three Times a Day
NPO	Nothing By Mouth
PRN	As Needed
C/O	Complains Of
H/O	History Of
O/E	On Examination
Dx	Daignosis
TX	Treatment
RX	Prescription
DC/D/C	Discontinue/Discharge
ADMIT/ADM	Admission
Re-Admit/Re-Adm	Readmission
WARD	Designated area for patients
CCU	Coronary Care Unit
ICU	Intensive Care Unit
ER/ED	Emergency Room/Department
OR	Operating Room
PACU	Post Anesthesia Care Unit
CBC	Complete Blood Count
UA	Urinalysis
BM	Bowel Movement

BP	Blood Pressure
HR	Heart Rate
RR	Respiratory Rate
TEMP	Temperature
O2 SAT	Oxygen Saturation
IV	Intravenous
IM	Intramuscular
SC/SQ	Subcutaneous
PO	By mouth
PR	Rectally
SL	Sublingual

DISSERTATION REPORT

(IPD) IN-PATIENT DEPARTMENT FULL FORM AUDIT

CHAPTER 1

INTRODUCTION

In the context of healthcare, IPD stands for In-Patient Department. It refers to the section of a hospital where patients are admitted for overnight stays or longer, typically for treatment requiring more than 24 hours of care. An IPD audit would assess the effectiveness and efficiency of the services and processes within this department, ensuring patient care and safety standards are met

Elaboration:

IPD in Healthcare:

The IPD is a crucial part of any hospital, providing the space and resources for patients requiring extended medical attention, including surgeries, critical care, and rehabilitation

Purpose of an IPD Audit:

The primary goals of an IPD audit are to identify areas for improvement, enhance patient safety, optimize resource utilization, and ensure compliance with established standards

IPD Audit:

An IPD audit is an evaluation of the In-Patient Department's operations. It examines various aspects, such as:

- **Patient care:** Ensuring that patients receive appropriate and timely medical attention, proper medication administration, and effective nursing care.

· · **Infection control:** Assessing adherence to hygiene protocols and measures to prevent healthcare-associated infections.

· · **Resource management:** Evaluating the efficient use of hospital resources, including beds, equipment, and supplies.

· · **Documentation and record-keeping:** Reviewing the accuracy and completeness of patient records and other relevant documentation.

· · **Compliance:** Ensuring the IPD complies with relevant regulations, standards, and policies

Benefits of IPD Audit:

By conducting regular IPD audits, hospitals can improve the quality of care provided, reduce the risk of medical errors, enhance patient satisfaction, and ensure efficient operations within the In-Patient Department.

1.1 Background of the Study

An inpatient audit report provides a structured assessment of the quality of care provided to patients during their hospital stay. These audits evaluate various aspects of patient care, including documentation, clinical practice, and adherence to established standards. The primary goal is to identify areas for improvement and enhance the overall quality of healthcare delivery, ultimately leading to better patient outcomes.

Documentation:

This involves reviewing medical records to assess the completeness, accuracy, and timeliness of documentation. Effective documentation is crucial for communication among healthcare providers, continuity of care, and legal requirements.

· **Clinical Practice:** Audits may examine specific clinical practices, such as medication management, infection control, or adherence to treatment protocols.

· **Adherence to Standards:**Audits compare actual practices against established standards of care, such as those outlined by professional organizations or regulatory bodie

Patient Safety:

A key focus is on identifying potential safety risks and implementing corrective actions

1.2 Rationale for the Study

A rational study of an inpatient audit report involves analyzing the findings to assess the quality of care provided, identify areas for improvement, and ensure adherence to established standards. This includes examining prescribing patterns, medication management, documentation practices, and overall patient care processes within the inpatient setting.

The audit should clearly state why it was conducted, including any specific problems or concerns identified within the inpatient setting

The audit should outline specific goals or targets that it aims to achieve. For example, it might aim to reduce medication errors, improve documentation, or optimize antibiotic usage

The audit should define the specific areas or departments within the inpatient setting that are being examined. For example, it could focus on a particular clinical specialty, a specific type of medication, or a particular documentation process

Prescribing Patterns:

The audit should analyze prescription practices, including the average number of drugs per prescription, the use of generic names, the frequency of antibiotic use, and the use of injections

Medication Management:

This involves assessing the dispensing process, the accuracy of labeling, and the patients' understanding of dosage instructions.

Documentation:

The audit should review the completeness and accuracy of patient records, including admission and discharge summaries, as well as any other relevant documentation.

Patient Care Processes:

The audit should assess the overall flow of patient care, including aspects like timely administration of medications, adherence to protocols, and the availability of necessary resources

1.3 Significance of the Study

Deviation from Standards:

The audit should identify any deviations from established standards of care, best practices, or guidelines.

Root Cause Analysis:

For any identified problems, the audit should attempt to determine the underlying causes. This could involve factors like inadequate staffing, lack of training, or flawed processes.

Prioritization:

The audit should prioritize areas for improvement based on the severity and potential impact of the identified problems

Specific and Measurable:

The audit should offer specific and measurable recommendations for improvement that can be implemented and monitored

· **Actionable**

The recommendations should be actionable and feasible, taking into account the resources and constraints of the healthcare setting.

Timely

The audit should suggest a timeline for implementing the recommendations and monitoring their effectiveness

1.4 An overview of the department

Inpatient auditing in healthcare focuses on reviewing a patient's medical record during their hospital stay (inpatient) to ensure accurate coding, billing, and adherence to clinical guidelines and regulations. This

process helps identify areas for improvement in documentation, coding practices, and overall patient care quality

Audits ensure that healthcare providers are following relevant healthcare regulations, such as those related to documentation, coding, and billing practices

Audits help identify areas where clinical documentation, treatment plans, or other aspects of patient care can be improved. This leads to better patient outcomes and more efficient healthcare delivery

Location: First Floor

Equipment:

1. Patient Care Equipment

Hospital beds (manual or semi-fowler/fowler) ,Bedside lockers and overbed tables ,IV stands (infusion stands) ,Drip sets and fluid warmers ,Bedside chairs/stools for attendants ,Mattresses with waterproof covers ,Patient call bells or nurse call systems

2. Nursing Station Equipment

Medicine trolley ,Dressing trolley ,Emergency crash cart (resuscitation trolley) ,Medication refrigerator (for vaccines/insulin) ,Syringe pumps/infusion pumps (if critical care) ,Blood pressure monitors (digital/manual) ,Thermometers, pulse oximeters ,Glucometers and strips ,Suction machine (portable) ,Oxygen cylinder with flow meter and humidifier

3. Infection Control & Hygiene

Hand sanitizers and hand wash dispensers ,Color-coded waste bins (bio-medical waste management) ,PPE (masks, gloves, gowns) ,Disinfectants and surface cleaners ,Autoclave or sterilizer (for minor instruments) ,Bedpan, urinals (male/female), sputum mugs

4. Emergency Equipment (For IPD & Stabilization)

Oxygen concentrator or oxygen cylinders ,Ambu bag (adult & pediatric) ,AED or Defibrillator (if available) ,Suction apparatus (electrical/manual) ,ECG machine ,Nebulizer machinn

5. Utility & Comfort Items, Room partitions or curtains, Wheelchairs and stretchers ,Linen trolleys and laundry baskets ,Air conditioners or ceiling fans ,Room heaters (in cold areas/seasons),Night lamps or examination lights

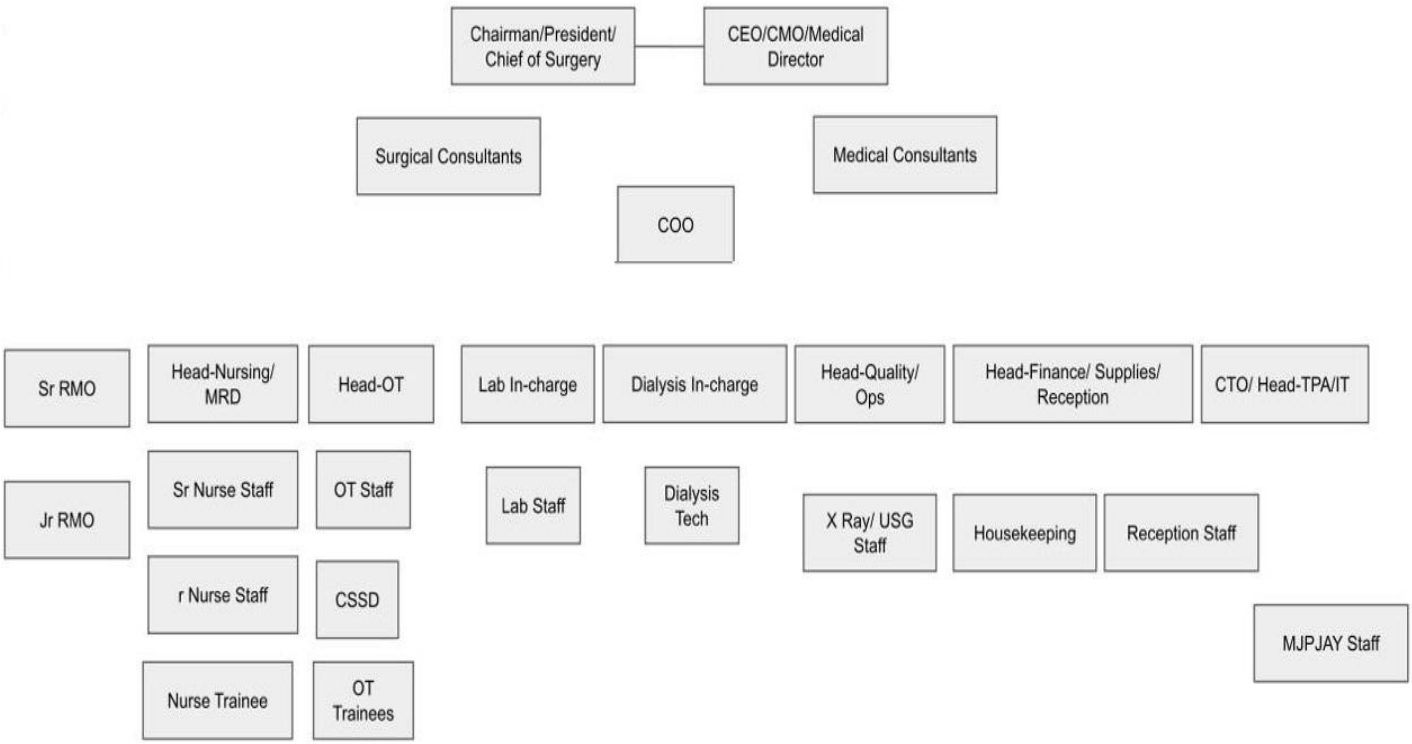
6. Documentation & Monitoring

Vital signs monitoring chart,Nurses' station record books,Consent forms and treatment sheets Whiteboard for patient information,Electronic Medical Record (EMR) access points (if digital system exists

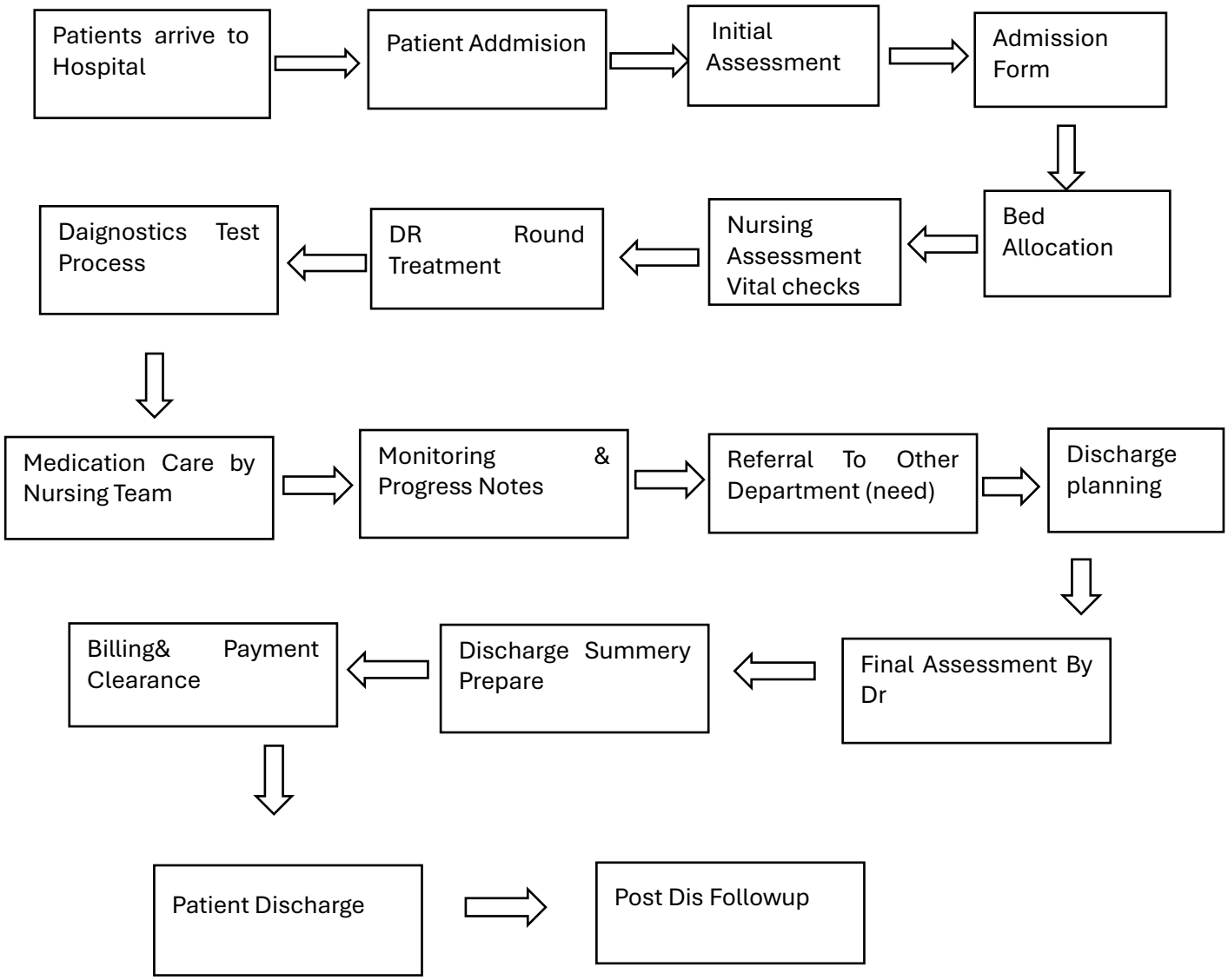
Manpower: 39 IPD Department

15+2+3 Nursing Staff (OT + ICU+ General) 2+2+3+1 Technician (Lab+OT+Dialysis+ sono)3+Housekeeping staff , Admin 1+1+1 (HR+Hosp+Operation) 2+ Consulting Team 2+ Reception Team 2 Ground Duty Assistants

Department leadership team


Chairman/President/ Chief of Surgery
CEO/CMO/Medical Director
Surgical Consultants
Medical Consultants
COO
Sr RMO
Head-Nursing/ MRD
Head-OT
Lab In-charge
Dialysis In-charge
Head-Quality/ Ops
Head-Finance/ Supplies/ Reception
CTO/ Head-TPA/IT
Jr RMO
Sr Nurse Staff
OT Staff
Lab Staff
Dialysis Tech
X Ray/ USG Staff
Housekeeping
Reception Staff
r Nurse Staff
CSSD
MJPJAY Staff
Nurse Trainee
OT Trainees

1.5 PATIENT FLOW FOR IPD DEPARTMENT



CHAPTER 2

LITRATURE REVIEW

Introduction

The medical records of hospitalized patients, especially those in the Intensive Care Unit (ICU), are crucial for continuity of care, legal documentation, clinical research, and hospital accreditation. An open file audit in the IPD focuses on evaluating the quality, completeness, and compliance of medical documentation while the patient is still admitted. This proactive approach helps in identifying real-time gaps and initiating timely corrections.

Importance of Medical Record Audit

According to the World Health Organization (WHO) and NABH (National Accreditation Board for Hospitals & Healthcare Providers), maintaining comprehensive and timely patient documentation is essential for quality care and patient safety. An open file audit allows immediate feedback to clinical staff, which is more effective than retrospective audits done after discharge.

Studies such as:
• "Improving Medical Record Quality Through Real-Time Audits" (Journal of Hospital Administration, 2021),
• and "Impact of Clinical Documentation on Patient Safety" (Indian Journal of Health Management, 2023),
emphasize that regular file audits lead to better adherence to clinical guidelines, improved interdisciplinary communication, and enhanced patient outcomes.

Indian Context

n India, various NABH-accredited hospitals have implemented open file audits as a part of their Continuous Quality Improvement (CQI) process. A 2022 study conducted at a multispecialty hospital in Mumbai demonstrated a 30% improvement in documentation compliance within six months of initiating weekly open file audits.
Moreover, a review published by QCI (Quality Council of India) in 2020 recommended that hospitals implement structured file audits to maintain documentation standards during patient care. It further suggested using checklists ligned with NABH standards covering:
• Admission and consent forms
• Progress notes and treatment charts
• Nursing documentation
• Daily clinical summaries
• Discharge planning notes

Previous Studies in Maharashtra
Regional data, especially from Thane and Mumbai, indicates increasing emphasis on real-time documentation audits. Hospitals like Jupiter Hospital, Hiranandani Hospital, and now Highway Hospital have integrated open file audits into their MRD (Medical Records Department) processes.

In the Thane region, hospitals began adopting active file audits around 2023 to improve compliance ahead of NABH inspections. This has shown to:
• Reduce discharge delays,
• Minimize medico-legal risks, and
• Increase internal accountability.

Objectives of Highway Hospital's Study

The current study at Highway Hospital, Thane, was conducted from March to May 2025 with the objective of:

- Reviewing the real-time compliance of patient files with NABH documentation standards,
- Identifying gaps in clinical and nursing records,
- Providing immediate feedback to departments for timely rectification,
- Supporting the MRD and Quality Assurance team in accreditation readiness.

Conclusion

The literature clearly shows that open file audits are a key driver for hospital quality improvement. Highway Hospital's initiative aligns with best practices observed in top Indian hospitals. The study period from March to May 2025 provides valuable data that can enhance hospital documentation standards, improve patient care, and ensure audit readiness for NABH and other regulatory bodies.

CHAPTER 3

METHODOLOGY

Here is a structured methodology for conducting an inpatient audit at Highway Hospital or any similar healthcare facility:

Inpatient Audit Methodology – Highway Hospital

1. Objective

To assess the quality, safety, efficiency, and compliance of inpatient services with healthcare standards, and to identify areas for improvement.

2. Scope

All inpatient departments (e.g., General Medicine, Surgery, Pediatrics,Medical records,Patient care process,Medication management,Infection control,Discharge procedures

3. Audit Team

Audit Lead: Senior clinician or hospital quality officer,Members: Doctors, nurses, medical records officer, infection control nurse, and administration staff

4. Data Collection Methods

Document Review: Inpatient files, medication charts, consent forms, discharge summaries,Direct Observation: Patient care activities, ward cleanliness, hand hygiene practices,interviews With patients, nurses, doctors, and support staff,Checklists Based on NABH or relevant hospital accreditation standards

5. Audit Parameters

Admission Documentation,Initial Assessment & Treatment Plans,Nursing Care Plans and Implementation,Monitoring and Vital Signs Charting,Medication Administration and Errors,Patient Safety and Infection Control Practices,Surgical Safety (if applicable),Discharge Planning and Summary Accuracy

6. Sampling Method

Random Sampling of inpatient files from various departments Time Frame Files from the past 1–3 months,Sample Size 10–20% of admissions or as per quality policy

7. Evaluation Criteria

Compliance with hospital protocols,Adherence to clinical guidelines,Completeness and accuracy of documentation,Patient satisfaction and feedback

8. Data Analysis

Identify patterns and deviations,Use of audit scoring or grading Compare against benchmarks (internal or national standards)

9. Reporting

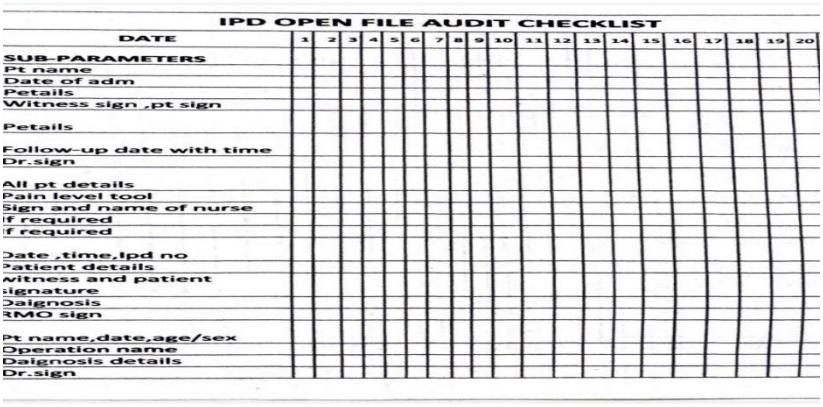
Prepare a detailed audit report with:

Strengths,Non-compliance areas,Risk levels,Recommendations

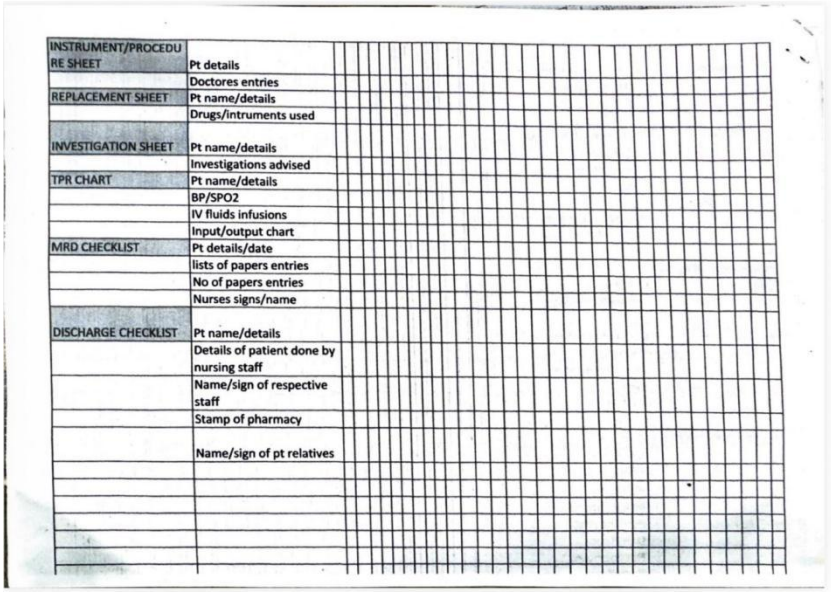
10. Action Plan and Follow-Up

Develop Corrective and Preventive Actions (CAPA),Assign responsibilities and deadlines,Re-audit after 1–3 months to ensure improvement

FORMAT OF IPD FILE AUDIT CHECKLIST :



IPD OPEN FILE AUDIT CHECKLIST																				
DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
SUB-PARAMETERS																				
Pt name																				
Date of adm																				
Petails																				
Witness sign ,pt sign																				
Petails																				
Follow-up date with time																				
Dr.sign																				
All pt details																				
Pain level tool																				
Sign and name of nurse																				
If required																				
If required																				
Date ,time,ipd no																				
Patient details																				
Witness and patient																				
signature																				
Daignosis																				
RMO sign																				
Pt name,date,age/sex																				
Operation name																				
Daignosis details																				
Dr.sign																				



INSTRUMENT/PROCEDURE SHEET	Pt details
	Doctores entries
REPLACEMENT SHEET	Pt name/details
	Drugs/intruments used
INVESTIGATION SHEET	Pt name/details
	Investigations advised
TPR CHART	Pt name/details
	BP/SPO2
	IV fluids infusions
	Input/output chart
MRD CHECKLIST	Pt details/date
	lists of papers entries
	No of papers entries
	Nurses signs/name
DISCHARGE CHECKLIST	Pt name/details
	Details of patient done by nursing staff
	Name/sign of respective staff
	Stamp of pharmacy
	Name/sign of pt relatives

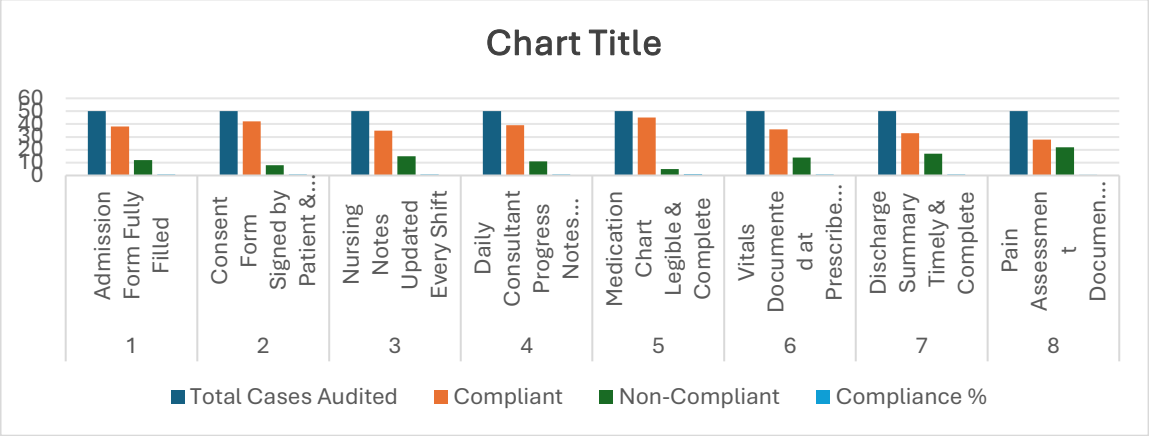
3.5 Data Analysis

Data was analysed using percentage compliance for each parameter. Parameters scoring <24% were considered areas needing improvement. Charts and graphs were used for visualization and to highlight key areas of success and concern.

3.6.1 Operational Definitions

- **Patient Safety**:Daily form Audit ensuring that procedures do not cause harm to patients.

- **PCDA**: Plan Communicate Do -Act Measures, a survey capturing patient feedback about their experience.
- **Compliance Rate**: Percentage of patients reporting a satisfactory experience or acknowledgment of a specific protocol.
- **IPD Protocol Adherence**: Alignment of the hospital's practices with recommended safety standards.



Indicator	TotalCases Audited	Compliant	Non-Compliant	Compliance %
Admission Form Fully Filled	50	38	12	76%
Consent Form Signed by Patient & Doctor	50	42	8	84%
Nursing Notes Updated Every Shift	50	35	15	70%
Daily Consultant Progress Notes Present	50	39	11	78%
Medication Chart Legible & Complete	50	45	5	90%
Vitals Documented at Prescribed Intervals	50	36	14	72%
Discharge Summary Timely & Complete	50	33	17	66%

CHAPTER 4

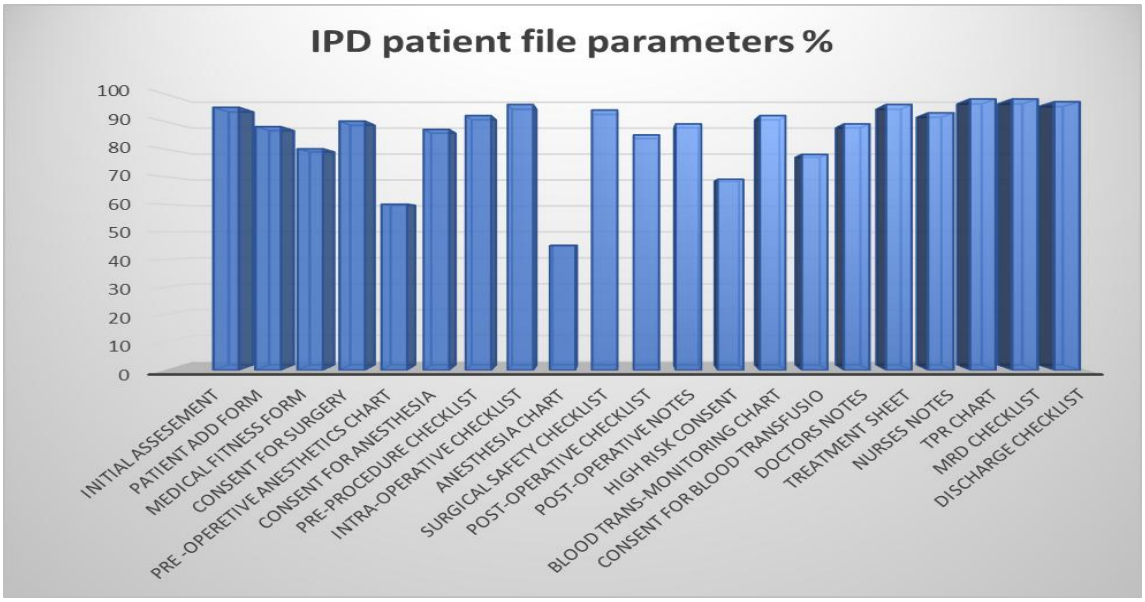
RESULT

PARAMETERS	TOTAL %	REMARK
ADMISSION FORM	98	100
INITIAL ASSESEMENT	95	100
LAB REPORT	76	100
HOSPITAL LETTER	86	100
PATIENT ADD FORM	88	100
MEDICAL FITNESS FORM	80	100
CONSENT FOR SURGERY	90	100
PRE -OPERETIVE ANESTHETICS CHART	60	100
CONSENT FOR ANESTHESIA	87	100
PRE-PROCEDURE CHECKLIST	92	100
INTRA-OPERATIVE CHECKLIST	96	100
ANESTHESIA CHART	45	100
RECOVERY ROOM CHART	78	100
CRITERIA FOR TRANSFER	89	100
SURGICAL SAFETY CHECKLIST	94	100
POST-OPERATIVE CHECKLIST	85	100
POST-OPERATIVE NOTES	89	100
HIGH RISK CONSENT	69	100
BLOOD TRANS-MONITORING CHART	92	100
CONSENT FOR BLOOD TRANSFUSIO	78	100
DOCTORS NOTES	89	100
TREATMENT SHEET	96	100
NURSES NOTES	93	100
INSTRUMENTS SHEETS	88	100
INVESTIGATION SHEETS	93	100
TPR CHART	98	100
MRD CHECKLIST	98	100
DISCHARGE CHECKLIST	97	100

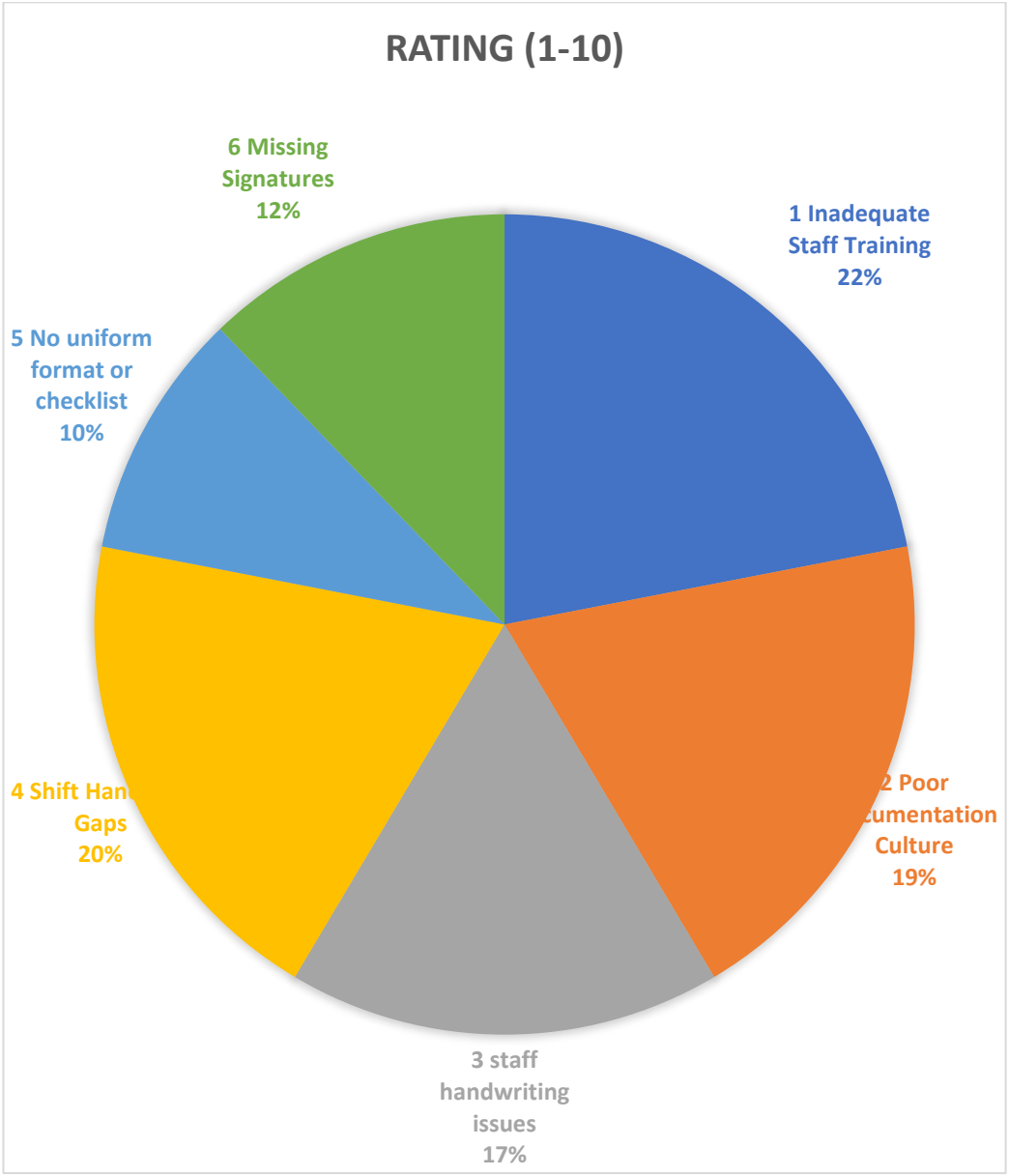
86.39% underwent IPD Procedure

24% Area where improvement need

This indicates that a significantly Conducting regular audits of IPD forms (inpatient medical records) in a hospital setting provides numerous clinical, administrative, and legal advantag



Sr. No.	Causes	Rating(1-10)	%Compliance	Cumulative %
1	Inadequate Staff Training	9	95%	11.80%
2	Poor Documentation Culture	8	88%	23.80%
3	staff handwriting issues	7	80%	34.80%
4	Shift Handover Gaps	8	90%	46.00%
5	No uniform format or checklist	4	60%	53.50%
6	Missing Signatures	5	70%	61.20%



- **Excellent Compliance (100%)** was observed in parameters such as informed consent, documentation of allergy history, to Ensures that the hospital meets national accreditation standards (e.g., NABH, JCI).Ensures that the hospital meets national accreditation standards (e.g., NABH, JCI).Supports adherence to insurance and TPA requirements.

- **Areas Needing Improvement:**

- **Total 24% Areas of Improvement in the IPD (Inpatient Department)** that hospitals like Highway Hospital, Thane, or others can focus on to enhance quality, efficiency, and patient satisfaction
  - Timely rounds by doctors and nurses
  - Medication errors reduction
  - Pain management protocols
  - Standardized treatment protocols

- **Screening Implementation (86.39%)**: While partially effective, this indicates a need for reviews audits daily audit protocols through IPD head and training or procedural reinforcement.

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CHAPTER 5

DISCUSSION

The IPD Open File Audit conducted at Highway Hospital, Thane, aimed to evaluate the quality, completeness, and compliance of inpatient medical records with institutional and NABH documentation standards. The audit provided valuable insights into the hospital's current practices in clinical documentation and highlighted areas of excellence and opportunities for improvement.

From the audit of 100 inpatient files across departments such as Medicine, Surgery, Orthopedics, Obstetrics & Gynecology, and ICU, the following trends emerged:

- High Compliance in Admission Documentation: Most files had complete admission notes, demographic information, and signed consent forms. This indicates that the hospital has strong admission protocols and staff awareness about initial documentation requirements.
- Moderate Compliance in Progress Notes and Doctor's Orders: While daily notes were present in a majority of cases, some lacked clear time stamps, signatures, or were not updated consistently. Instances of illegible handwriting and unstructured notes were also noted, especially during night shifts.
- Significant Deficiencies in Nursing Documentation: A large portion of non-compliance was found in nursing care plans, medication administration records, and shift-wise vital sign monitoring. This suggests a gap in nursing training or monitoring in documentation standards.
- Poor Discharge Summary Preparation: Although discharge summaries were present in most files, many were incomplete or prepared just before patient discharge without adequate information on follow-up care, medication advice, or patient education. This area requires immediate improvement.
- Lack of Multidisciplinary Notes: Physiotherapy, dietician, and infection control entries were missing in many relevant cases, indicating a gap in holistic and team-based care documentation. Interpretation

The findings suggest that while Highway Hospital has reasonably good documentation practices in place, especially in initial patient assessment and consent handling, there is variability in compliance levels across departments and roles. The relatively poor documentation in nursing care and discharge planning can affect continuity of care, medico-legal defense, and patient safety. The variation in documentation quality also highlights the need for standardization through structured templates, electronic medical records (EMR), or regular audits. Night shift entries and weekend documentation were found to be inconsistent, which is a common challenge in hospitals but must be addressed through stronger SOPs and supervisory checks.

Comparison with Literature :- Similar audits conducted in other NABH-accredited hospitals in India, as referenced in studies by Patel et al. (2020) and Bajwa & Jindal (2014), reported comparable challenges in nursing documentation and discharge summary preparation. The results from Highway Hospital align with national patterns, suggesting systemic training gaps and inconsistent policy enforcement as common causes.

The audit underscores the need for:

- Staff sensitization programs on documentation importance and compliance.
- Department-wise training for doctors and nurses on standard formats and legal aspects.
- Supervisory documentation audits, especially for nursing and discharge procedures.
- Implementation of EMR or semi-digital checklists to reduce manual errors.
- Feedback mechanisms to ensure accountability and continuous improvement.

Limitations of the Audit

- The sample size was limited to 100 files, which, while indicative, may not reflect long-term trends.
- The audit was cross-sectional, capturing only a specific time frame.
- Observer bias may have occurred, as evaluations were based on manual checklists.

Recommendations for Future Audits

- Include a larger and more randomized sample across all months.
- Involve multi-disciplinary audit teams including doctors, nurses, MRD officers, and quality heads.
- Incorporate patient feedback to align documentation with patient communication.
- Repeat the audit quarterly for trend analysis and progress monitoring.

CHAPTER 6

CONCLUSION

This study assessed The audit of the **Inpatient Department (IPD) forms** is a critical tool in assessing the quality, accuracy, and completeness of documentation related to inpatient care. Based on the audit findings, it can be concluded that:

Proper documentation enhances patient safety, ensures continuity of care, and supports clinical decision-making.

Gaps or errors in IPD forms can lead to mis-communication, delayed treatments, billing issues, and medico-legal risks.

Regular audits help identify common documentation deficiencies, allowing for corrective training and process improvements.

The audit fosters a **culture of accountability** and emphasizes the importance of compliance with hospital protocols and statutory requirements.

Recommendations from the audit should be systematically implemented and monitored for sustained improvement in healthcare delivery.

Thus, IPD form audits serve as a foundation for improving clinical documentation standards and overall patient care in a hospital setting.

CHAPTER 7

RECOMMENDATIONS

RECOMMENDATIONS

1. Documentation & Record-Keeping

Ensure all patient records (admission, consent, vitals, treatment, discharge summary) are complete, timely, and legible.

Use electronic medical records (EMR) where possible for accuracy and tracking.

Regular internal audits for missing or incorrect entries.

2. Staffing & Training

Ensure adequate nurse-patient ratio (e.g., 1:4 in general wards, 1:1 in ICU).

Provide regular training on infection control, emergency protocols, and documentation standards.

Conduct periodic BLS/ACLS training for doctors and nurses

3.Infection Control

Implement and monitor standard infection control practices (hand hygiene, PPE usage).

Regular disinfection audits in wards, particularly in high-risk areas.

Maintain records of hospital-acquired infections (HAIs) and act on trends.

4. Safety & Compliance

Ensure fire safety compliance, emergency exits, and safety drills.

Comply with NABH or local regulatory standards.

Keep all licenses and biomedical waste compliance up to date.

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