IPD
Open File Audit

SUBMITTED BY:
VEDASHREE AGAWANE
IIHME University, Jaipur

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EXECUTIVE SUMMARY

The Hospital Project is predicated on IPD Department. My seven-week research study helped me gain a better understanding of the protocols for handling IPD FULL AUDIT FORM at Highway Hospital locatedinTHANE (MAH)

In the course of the project study, information was gathered by tracking and marking the entire duration from the patients admitted in the hospital from day one till their discharge processes without interacting with any individuals. This data was gathered when patients arrived for registration in the hospital outpatient department building.

All of the recommendations made in this presentation have the potential to improve how the hospital handles the IPD if they are implemented. A succinct summary of all the rules for handling and overseeing the registration procedure is given by the study.

Suggestions have been made about the development of training programs for the IPD departmental staff members who oversee the patient admission process Throughout the study, . The necessary recommendations were made as a consequence of cross-referencing the data with real process observation.

To gain a better understanding of our areas for improvement and how to better manage the hospital registration process so that patients receive the highest-quality care possible, we analyze the approximate proportion of the patient registration process during the designated time and its rotations overall using a graph chart.

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AIM & OBJECTIVES OF THE STUDY

Aim of the study

To evaluate the accuracy, completeness, and compliance of IPD documentation with established hospital standards, thereby ensuring quality patient care, legal safety, and continuous improvement in healthcare delivery.

Objectives of the study

- To assess the completeness of patient records in the IPD, including admission details, progress notes, treatment orders, and discharge summaries.
- To evaluate the accuracy and legibility of entries made by healthcare professers
- To ensure compliance with institutional, legal, and accreditation standards for inpatient documentation. (IPD department)

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METHODOLOGY

- **Study Design:** Cross-sectional Descriptive observational study
- **Study Setting: IPD (In patient department)** of Highway Hospital Thane mumbai
- **Study duration: 12** weeks

  (9 weeks- data collection, 3 weeks- Data Analysis)
- **Sample Size: 83** active IPD files (randomly selected)
- **Tools:** Structured audit checklist based on NABH and hospital standards
- **Data collection process:**

  Developing a SMART Corrective plan : specify who will address and what by mean,and also action might include staff training updating documentaion formats,stremlining admission to discharge protocols

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GAPS IDENTIFIED IN THE WORKING AREA.

- Incomplet or delayed documentation and admission forms are not fully filled .
- Non-Adherence to clinical protocols during vital checks and lack of pain score documentation or monitoting ,
- poor infection control was seen and inadequate hand hygiene practice also improper waste segregation in diff wards
- Staff shortage and training gaps, casual approche of staffs understaffing in night shifts

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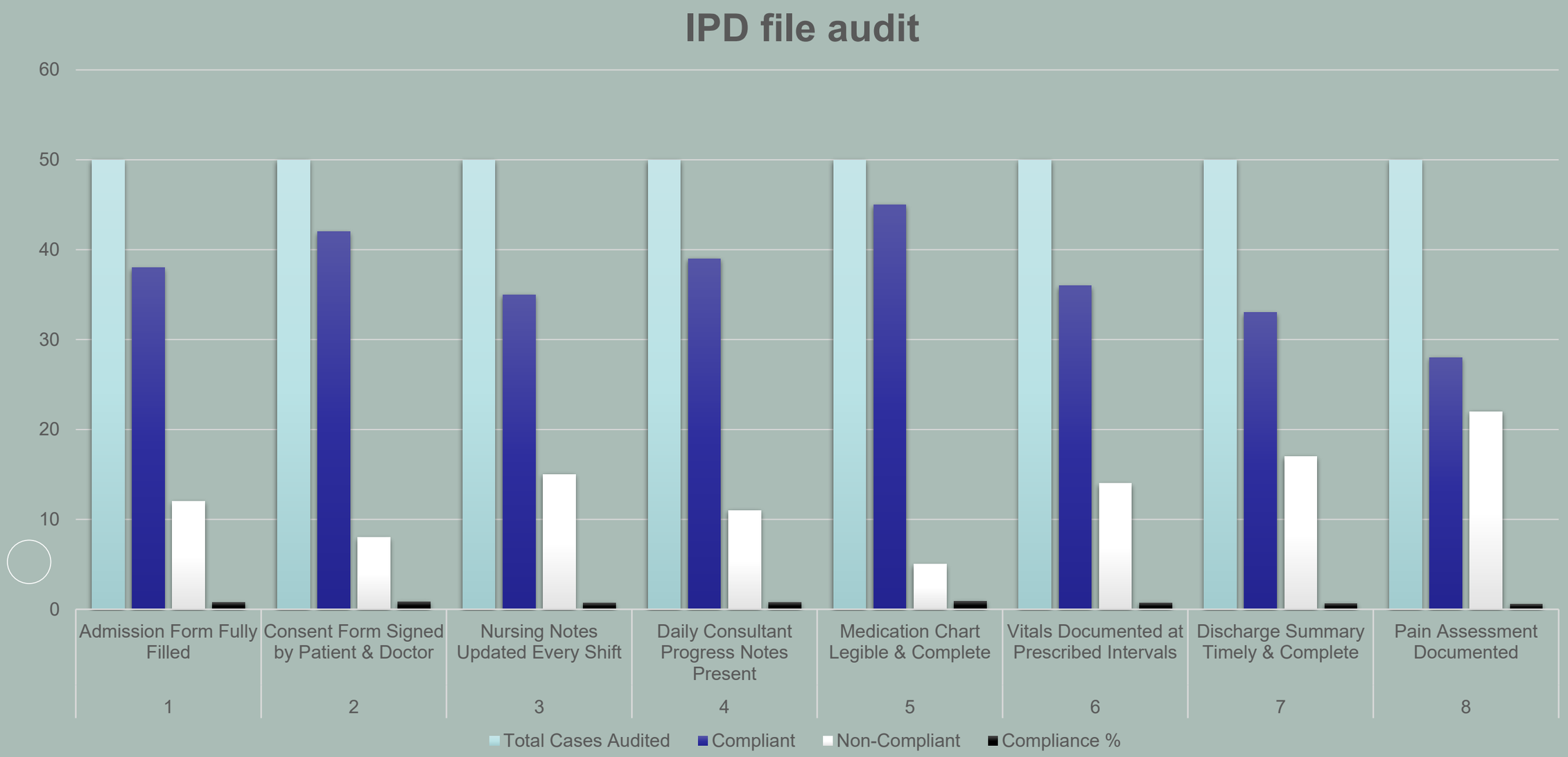
DATA ANALYSIS

SR	Indicator	Total Cases Audited	Compliant	Non-Compliant	Compliance %
1	Admission Form Fully Filled	50	38	12	76%
2	Consent Form Signed by Patient & Doctor	50	42	8	84%
3	Nursing Notes Updated Every Shift	50	35	15	70%
4	Daily Consultant Progress Notes Present	50	39	11	78%
5	Medication Chart Legible & Complete	50	45	5	90%
6	Vitals Documented at Prescribed Intervals	50	36	14	72%
7	Discharge Summary Timely & Complete	50	33	17	66%
8	Pain Assessment Documented	50	28	22	56%

CHART


IPD file audit
60
50
40
30
20
10
0
Admission Form Fully Filled
Consent Form Signed by Patient & Doctor
Nursing Notes Updated Every Shift
Daily Consultant Progress Notes Present
Medication Chart Legible & Complete
Vitals Documented at Prescribed Intervals
Discharge Summary Timely & Complete
Pain Assessment Documented
1
2
3
4
5
6
7
8
Total Cases Audited
Compliant
Non-Compliant
Compliance %

FINDINGS AND OBSERVATIONS

SR	Observation Area	Findings	Remarks
1	Admission Forms	76% of forms were completely filled; 24% had missing fields	Mostly missing diagnosis or contact details
2	Consent Forms	16% forms lacked either doctor or patient signature	Risk of medico-legal non-compliance
3	Daily Progress Notes	22% of files lacked complete consultant notes	Irregular entries seen in medicine ward
4	Nursing Assessment	30% of cases showed incomplete nursing notes	Mostly night shifts affected
5	Medication Charts	10% had illegible handwriting or missed doses documentation	ICU and surgical wards most affected
6	Vital Signs Charting	Inconsistent documentation in 28% of files	Especially during late night hours
7	Pain Score Documentation	44% of patients had no pain scale recorded	Often missed in non-surgical patients
8	Discharge Summary	34% of discharge summaries were incomplete or delayed	Diagnosis or treatment history missing

RECOMMENDATION & SUGGESTIONS

- Develop a real-time audit tracker for nursing supervisors and medical officers to monitor documentation compliance.
- Conduct monthly training sessions on proper documentation protocols, especially for:
- Implement a standardized documentation checklist to be attached to every IPD file.
- Ensure daily medical and nursing notes are completed and countersigned during every shift.
- Introduce a pre-discharge checklist to verify completeness of discharge summaries and treatment history.
- Designate documentation champions in each ward for compliance verification.

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Thank you