

FORMAT OF SYNOPSIS

1.TITLE:- IPD OPEN FILE AUDIT IN HIGHWAY HOSPITAL,THANE MUMBAI

2. INTRODUCTION:

Inpatient Department (IPD) documentation plays a pivotal role in patient care, continuity, legal defines, medical audits, insurance claims, and quality assurance. An “open file audit” is a real-time evaluation of ongoing inpatient medical records to assess compliance with clinical documentation standards, completeness, accuracy, and timeliness of entries by healthcare professionals.

Highway Hospital, Thane, a multi-specialty healthcare provider, aims to enhance documentation standards in line with NABH (National Accreditation Board for Hospitals & Healthcare Providers) guidelines. Conducting an IPD open file audit provides a framework to monitor the quality of medical records, ensure protocol adherence, and identify areas for training and process improvement. The findings will contribute toward improving clinical documentation practices and supporting patient safety and accreditation readiness.

3. RESEARCH QUESTION:

How compliant are the IPD medical records in Highway Hospital, Thane with standard documentation practices, and what are the common deficiencies observed during the open file audit?

4. OBJECTIVES:

Primary Objective:

- To assess the completeness and quality of inpatient medical records in Highway Hospital through an open file audit.

Secondary Objectives:

- To identify common documentation errors or non-compliances.
- To evaluate adherence to NABH documentation standards.
- To recommend strategies for improving documentation quality and compliance

5. HYPOTHESIS:

- **Null Hypothesis (H_0):**
There is no significant non-compliance in IPD documentation practices in Highway Hospital, Thane.
- **Alternative Hypothesis (H_1):**
There is significant non-compliance in IPD documentation practices in Highway Hospital, Thane.

6. MATERIAL AND METHODS:-

STUDY DESIGN:

This will be a **cross-sectional descriptive study** based on real-time data collected from open files of current inpatients in the IPD during the audit period. The study will adopt both quantitative and qualitative audit tools based on predefined checklists.

SETTING:

The study will be conducted at Highway Hospital, Thane—a medium-sized, NABH-aligned healthcare facility with active inpatient departments including General Medicine, Surgery, Orthopaedics, Obstetrics & Gynaecology, and ICU.

STUDY POPULATION:

The study population includes **all current inpatients** admitted in the IPD during the audit period (March 2025 – May 2025) whose medical records are available for real-time review

DURATION OF STUDY:- from 10 march 2025 to 31 may 2025

SAMPLE SIZE:

A purposive sample of **100 inpatient files** will be audited over a 3-month period. This size is adequate for identifying patterns and drawing actionable conclusions while remaining feasible for manual audit.

SAMPLING TECHNIQUE:

Purposive sampling will be used, selecting patient files based on department representation (Medicine, Surgery, ICU, etc.) and length of stay (minimum 48 hours), ensuring diversity and relevance.

DATA COLLECTION PROCEDURE:

- A structured **audit checklist** will be developed based on NABH guidelines and hospital policy.
- Key parameters will include:
 - Admission notes
 - Consent forms
 - Doctor's progress notes
 - Nursing care plans
 - Medication orders
 - Diagnostic and laboratory records
 - Surgical notes (if applicable)

- Discharge planning documentation
- Each file will be reviewed in the ward without removing it from the hospital premises.
- Scores will be assigned for completeness, accuracy, legibility, and timeliness.
- Observations will be entered into a standardized data collection form.

OPERATIONAL DEFINITIONS:

- **Open File Audit:** Evaluation of medical records while the patient is still admitted, focusing on ongoing documentation.
- **Compliance:** Adherence to documentation standards as per NABH or hospital protocols.
- **Non-compliance:** Missing, illegible, incomplete, or late entries, or absence of required forms or signatures.

7. DATA ANALYSIS PLAN:

- Data will be entered into **Microsoft Excel** and analysed using **basic descriptive statistics** (frequency, percentage, mean).
- Compliance levels across departments will be compared.
- Major deficiencies will be categorized and presented in graphical formats (bar charts, pie charts).
- If appropriate, a Chi-square test may be applied to determine the association between compliance and departments or healthcare professional categories.

8. ETHICAL CONSIDERATIONS:

- The study will ensure **confidentiality** and **anonymity** of patient information.
- No personal identifiers will be recorded.
- Permission will be obtained from the **Hospital Ethics Committee**.
- As this is a non-interventional audit, there is minimal ethical risk.
- All hospital staff involved in data access will be informed and oriented toward confidentiality protocols.

9. IMPLICATIONS OF RESEARCH:

This audit will:

- Provide real-time feedback on medical record documentation practices.
- Support **quality improvement initiatives** in the hospital.
- Help prepare for **NABH accreditation or reaccreditation**.

- Identify areas for **staff training** (e.g., proper charting, documentation timing).
- Influence policy changes in **medical records handling** and documentation protocols.
- Establish a **baseline** for future audits and long-term documentation performance monitoring.

10. REFERENCES:

1. NABH Guidelines on Hospital Accreditation Standards, 5th Edition, 2020.
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6. Highway Hospital Documentation Policy, Internal Quality Documents, 2024.