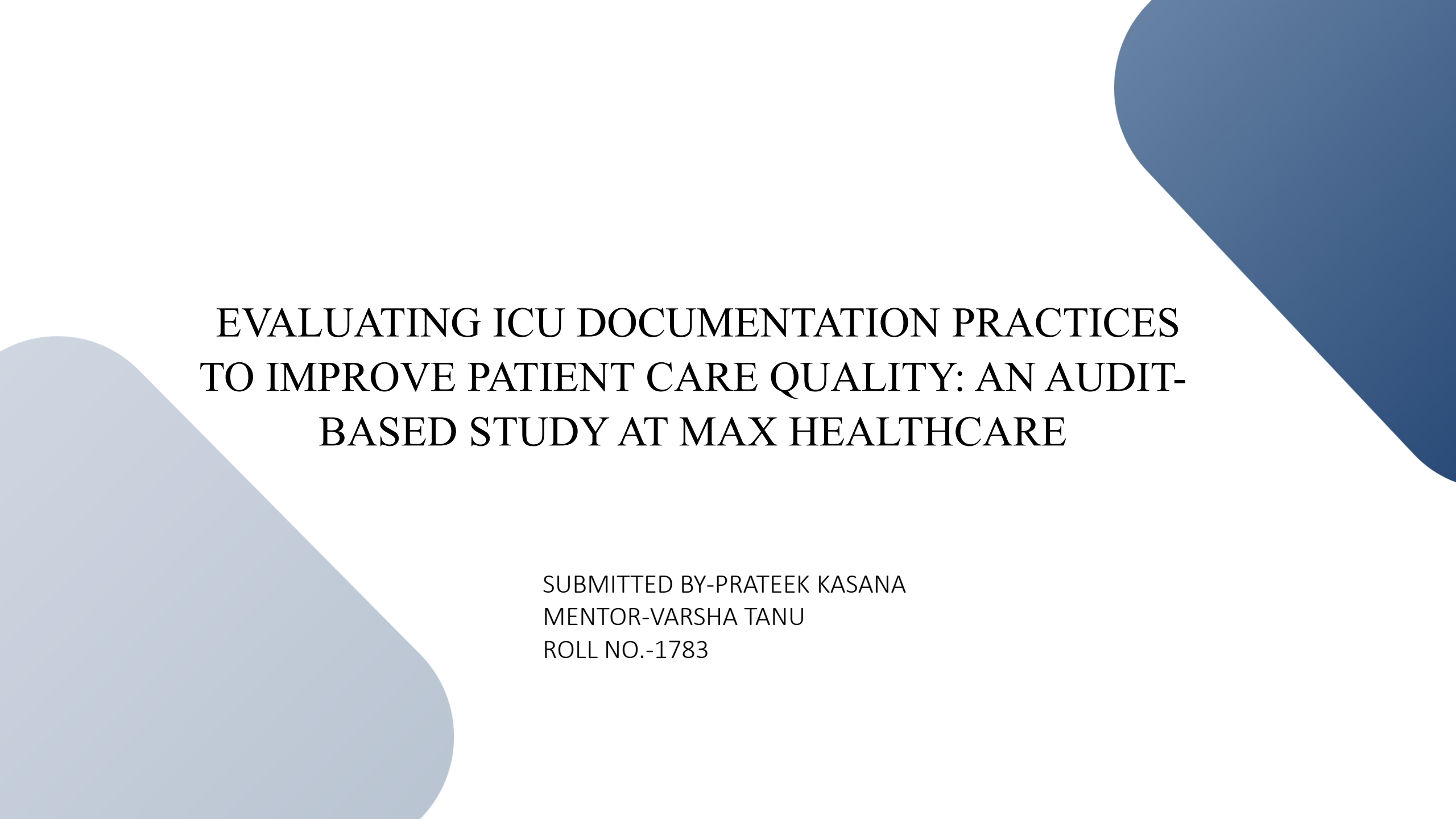




# EVALUATING ICU DOCUMENTATION PRACTICES TO IMPROVE PATIENT CARE QUALITY: AN AUDIT- BASED STUDY AT MAX HEALTHCARE

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# INTRODUCTION

## **What is an Audit?**

- A systematic and structured review process
- Aimed at evaluating compliance with predefined standards and protocols
- Involves objective examination of records, processes, or systems

## **Purpose of Audits in Healthcare**

- Ensure patient safety and high-quality care
- Verify adherence to accreditation standards (e.g., NABH, JCI)
- Identify gaps, errors, or inconsistencies in documentation
- Promote accountability and continuous improvement

# INTRODUCTION (cont.)

## TYPES OF CLINICAL AUDITS

- **Active Audits (Live Audits):**  
Conducted during ongoing patient care for real-time feedback and correction
- **Passive Audits (Retrospective Audits):**  
Conducted post-discharge to assess overall documentation compliance

## KEY FOCUS AREAS IN ICU DOCUMENTATION AUDITS

Initial assessments  
Progress notes  
Consent forms  
Operation notes

# AIM

- To assess the efficiency of patient record documentation audits in ensuring enhanced patient outcomes and overall operational effectiveness

# OBJECTIVE

- Assess the quality and completeness of clinical documentation in ICU patient records through real-time (active) audits.
- Determine the level of compliance with national and institutional documentation standards, including NABH and JCI guidelines.
- Identify gaps, errors, and inconsistencies in key clinical documents such as initial assessments, progress notes, consent forms, and operative notes.
- Analyze departmental performance across multiple ICU units (General Surgery, Neurosurgery, Obstetrics & Gynaecology, and Surgical Oncology) in terms of documentation adherence.
- Recommend corrective and preventive actions (CAPA) to improve documentation practices and promote accountability among healthcare providers.

# METHODOLOGY

## **1 Study Design**

→ Descriptive and observational audit-based study

## **2 Study Setting**

→ ICU departments at Max Healthcare

## **3 Study Duration**

→ March 2025 to May 2025

## **4 Study Population**

→ ICU patient records ( $n = 125$ )

## **5 Sampling Technique**

→ Purposive sampling

# METHODOLOGY

## **6 Audit Approach**

→ Real-time active audits vs. passive audits

## **7 Tools Used**

→ NABH/JCI-based structured audit checklists

→ Microsoft Excel for data tracking and analysis

## **8 Key Documentation Parameters Audited**

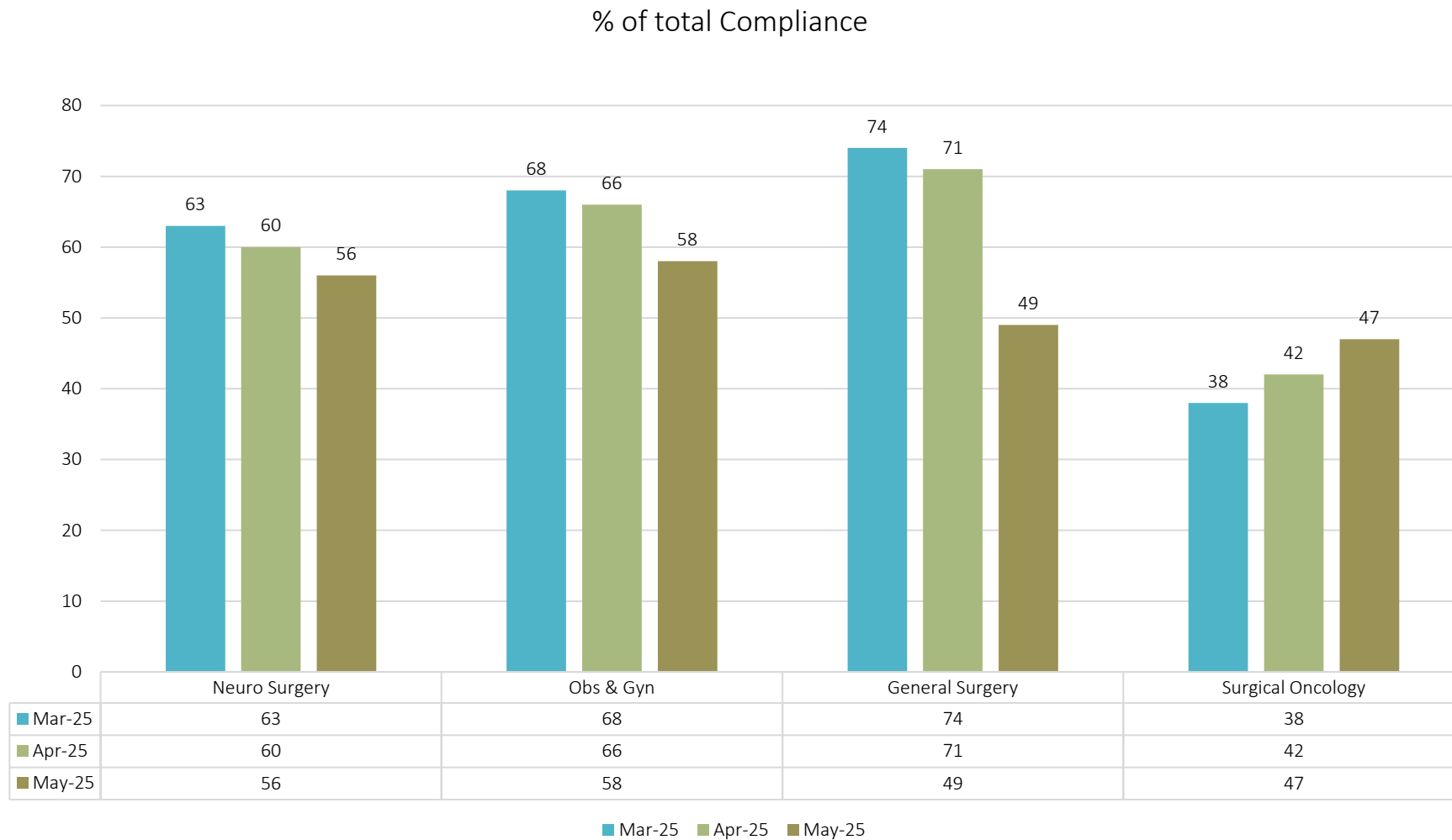
→ Initial assessment

→ Progress notes

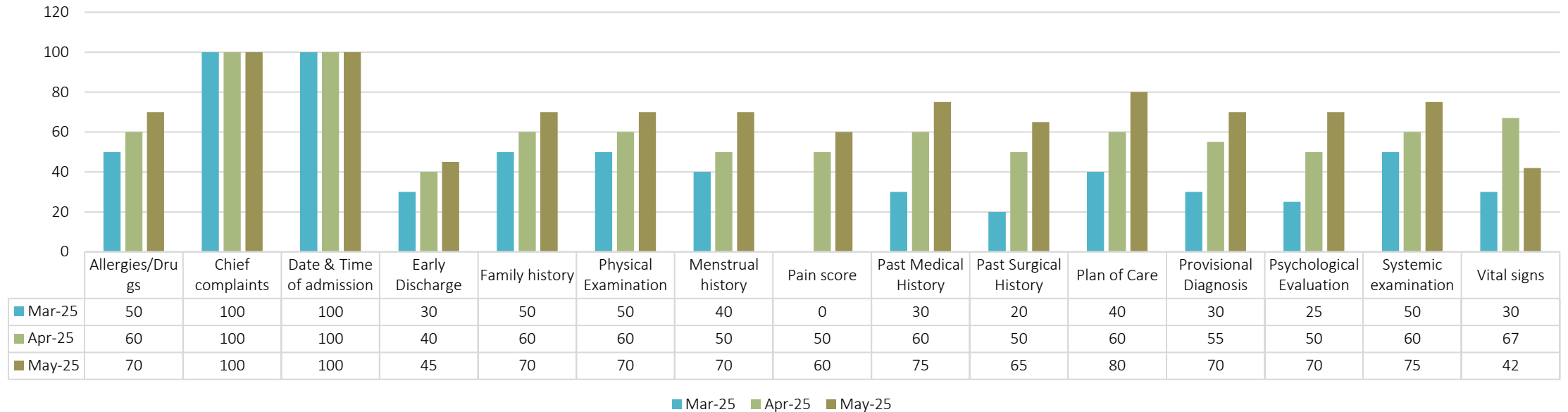
→ Consent forms

→ Operation notes

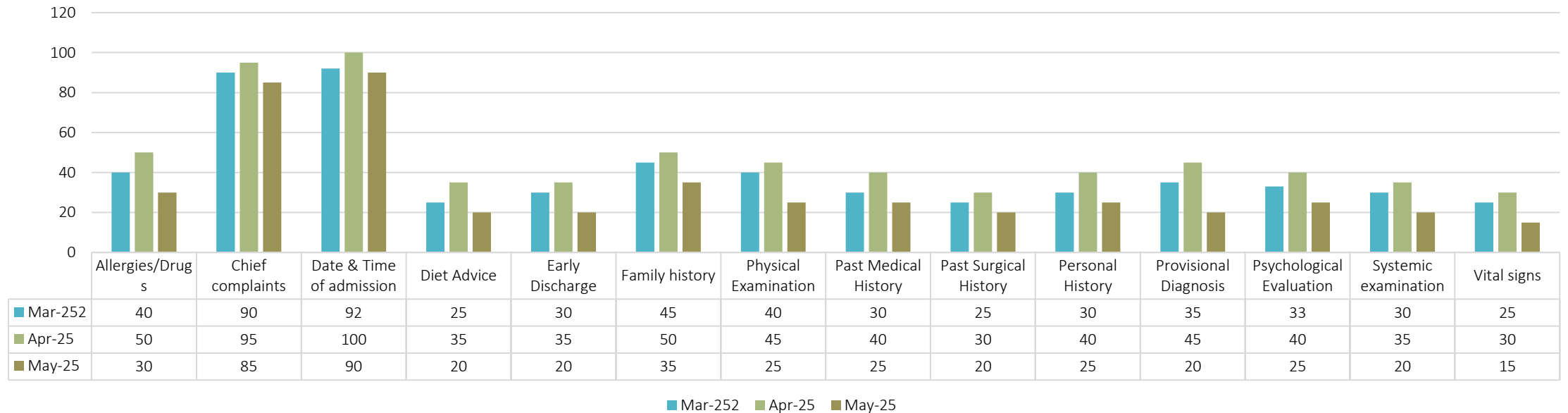
# INITIAL ASSESMENT



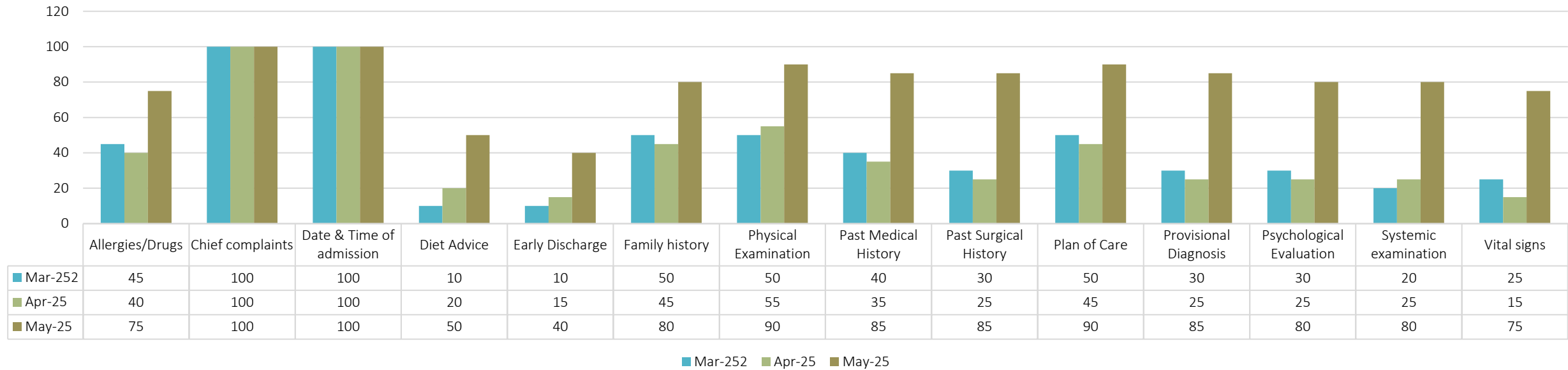
## Neurosugery



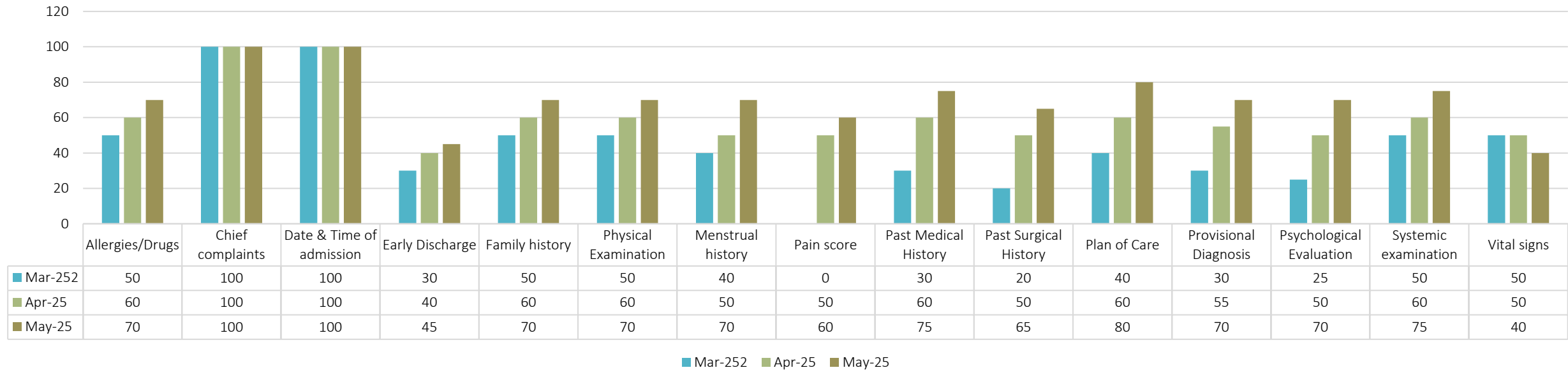
## surgical oncology



## general surgery



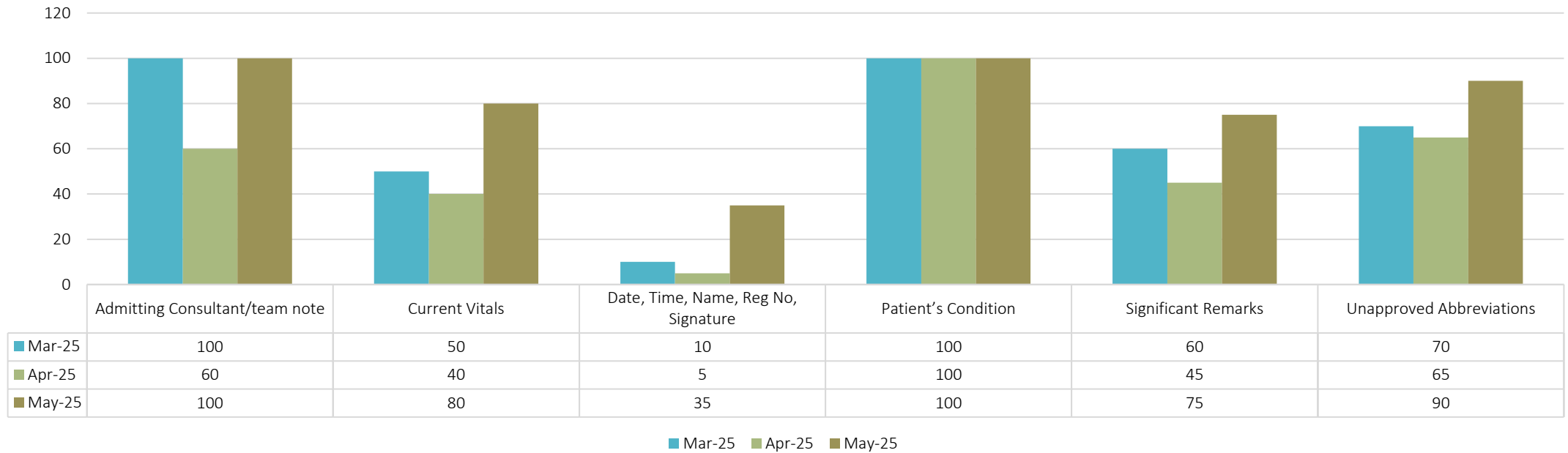
## Obs & Gynae



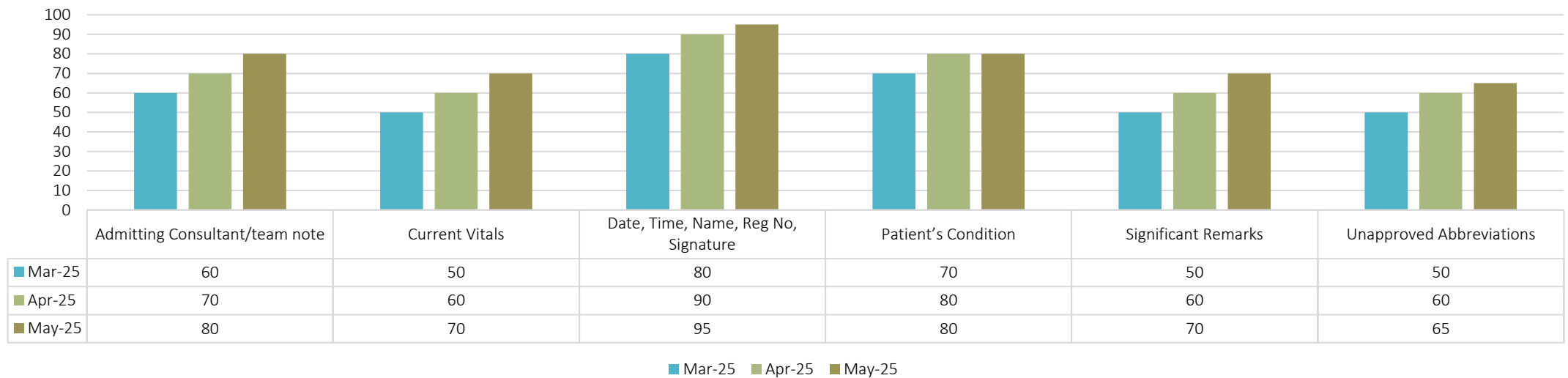
# PROGRESS NOTES

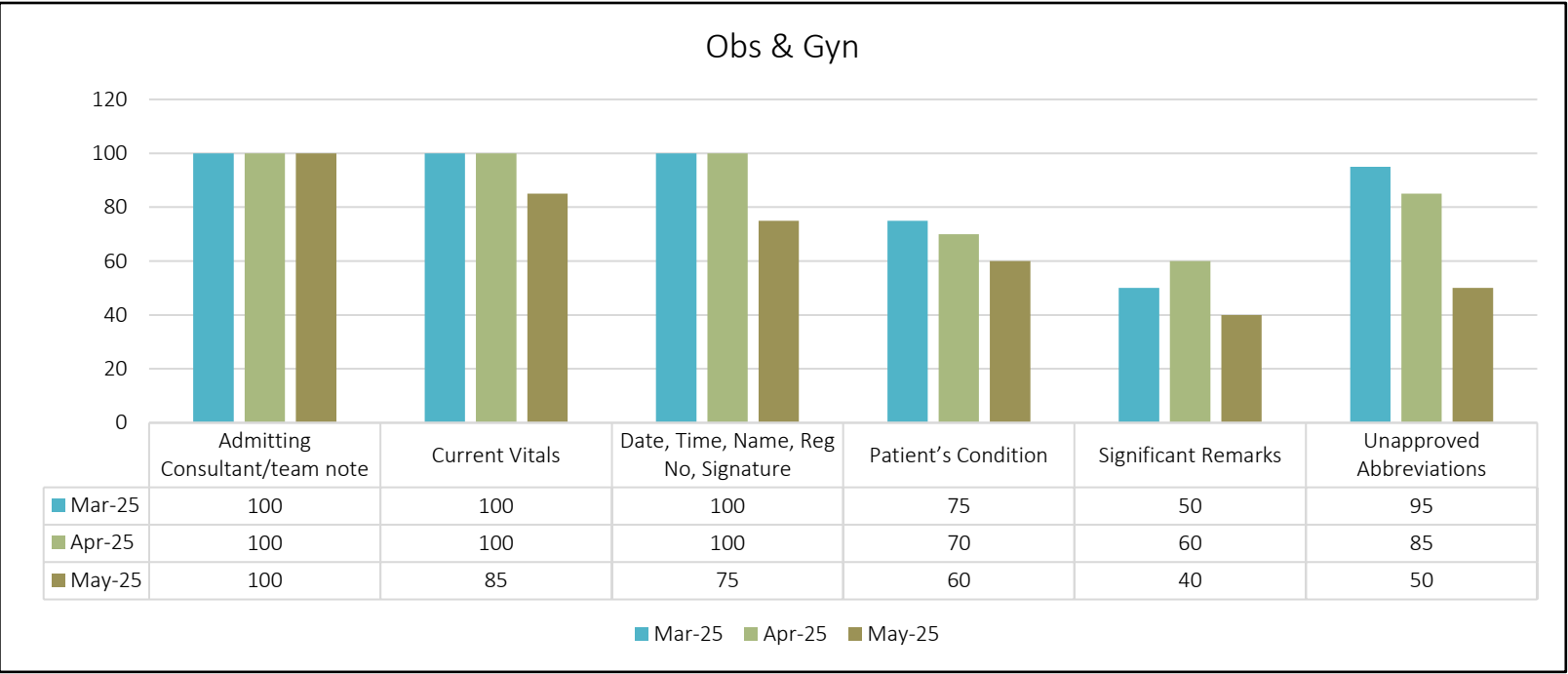
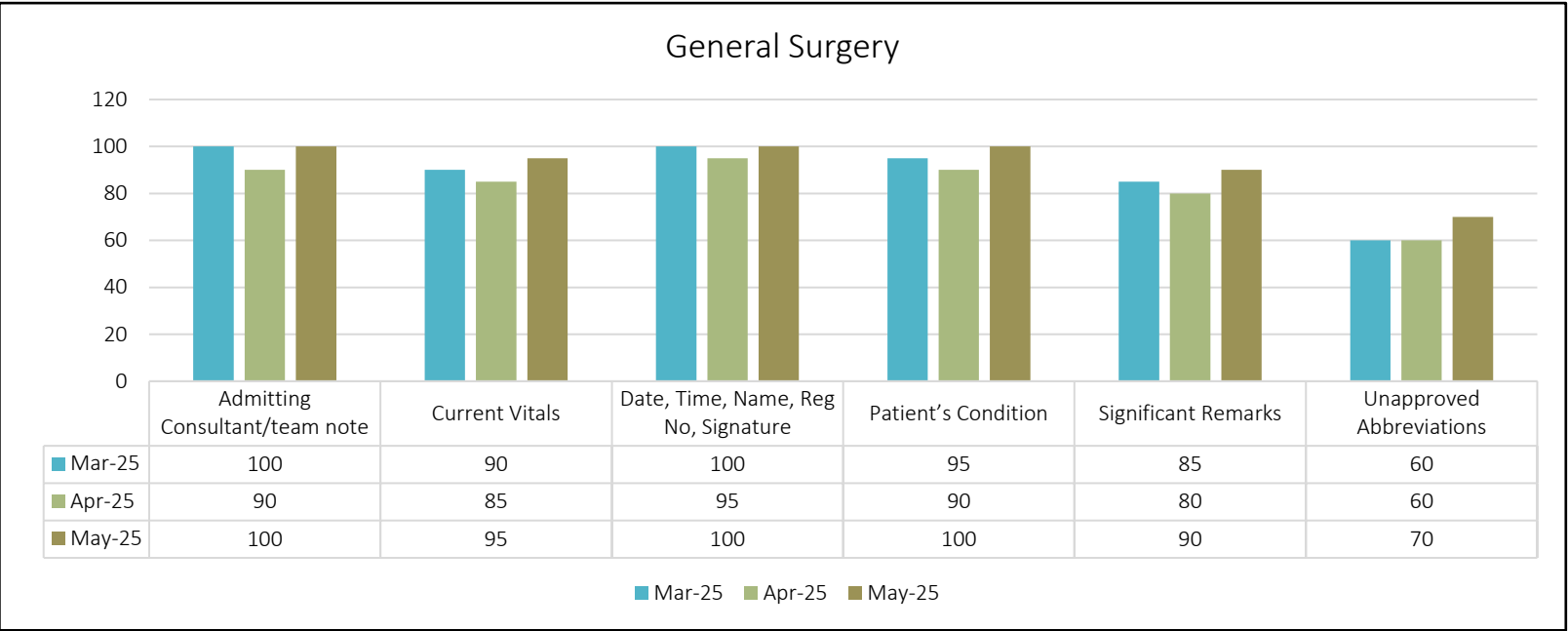


## Neuro Surgery



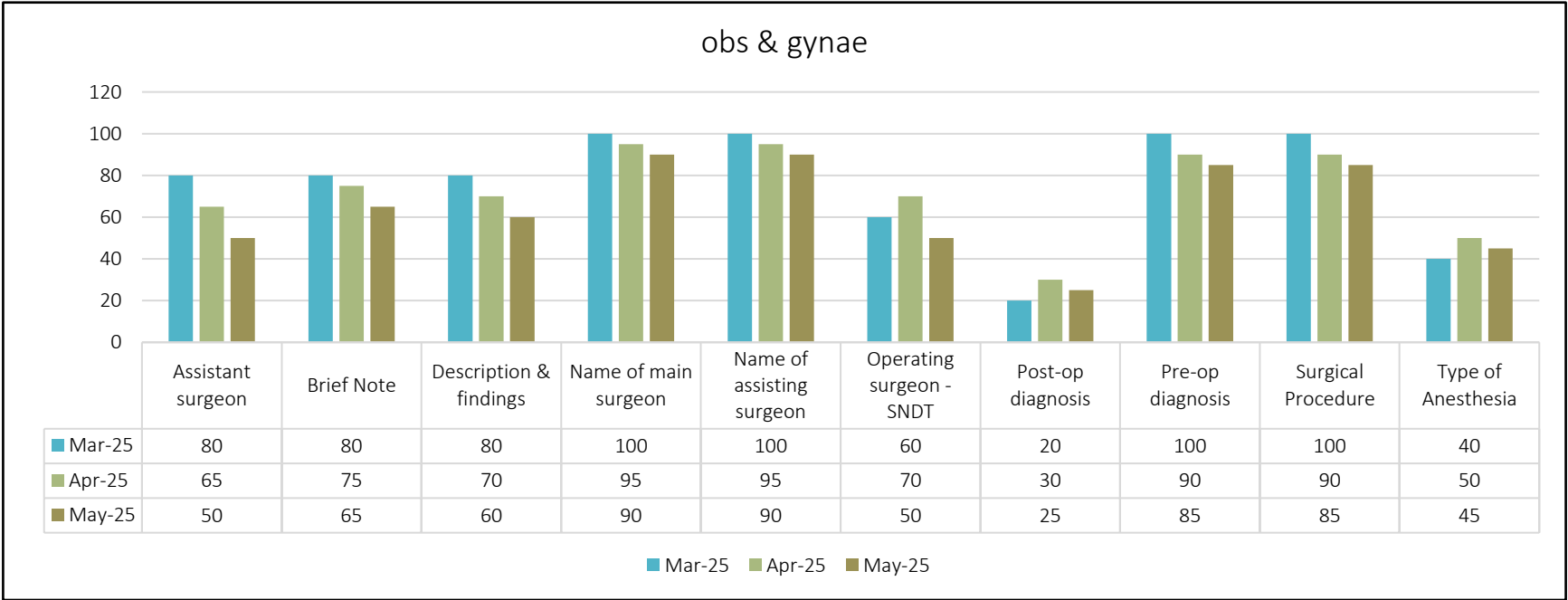
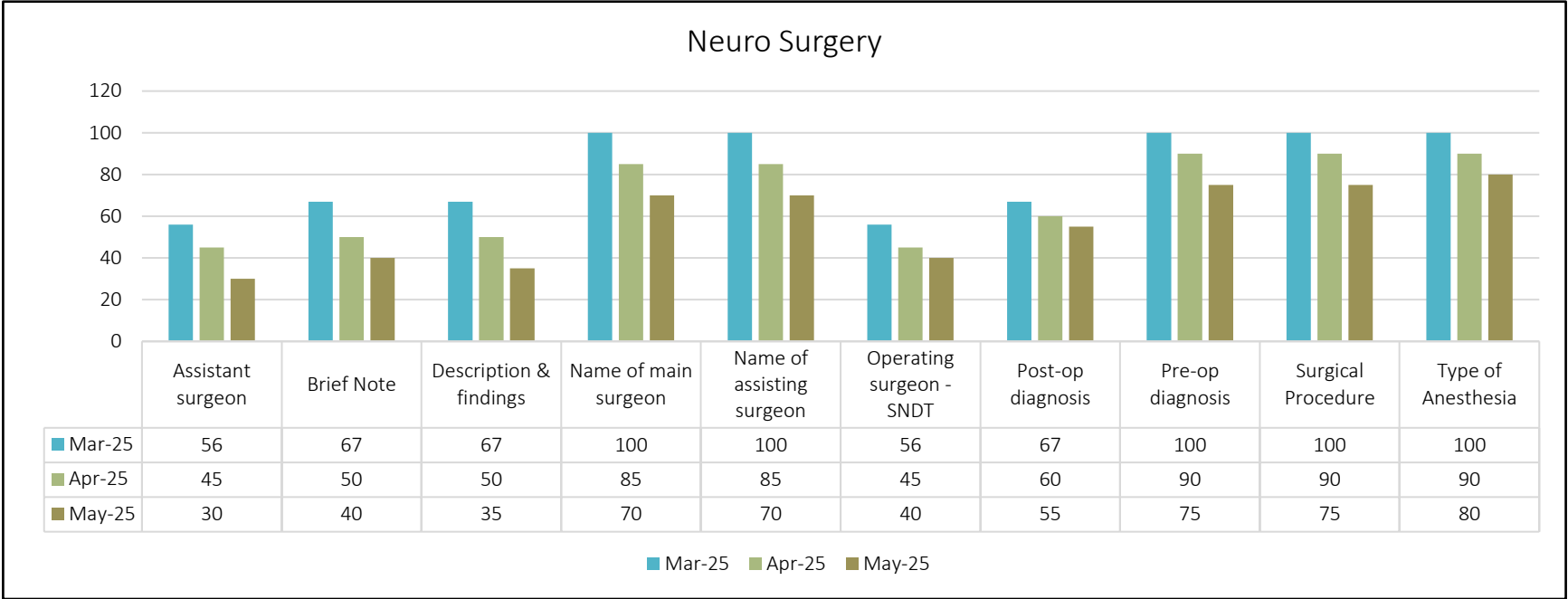
## Surgical Oncology

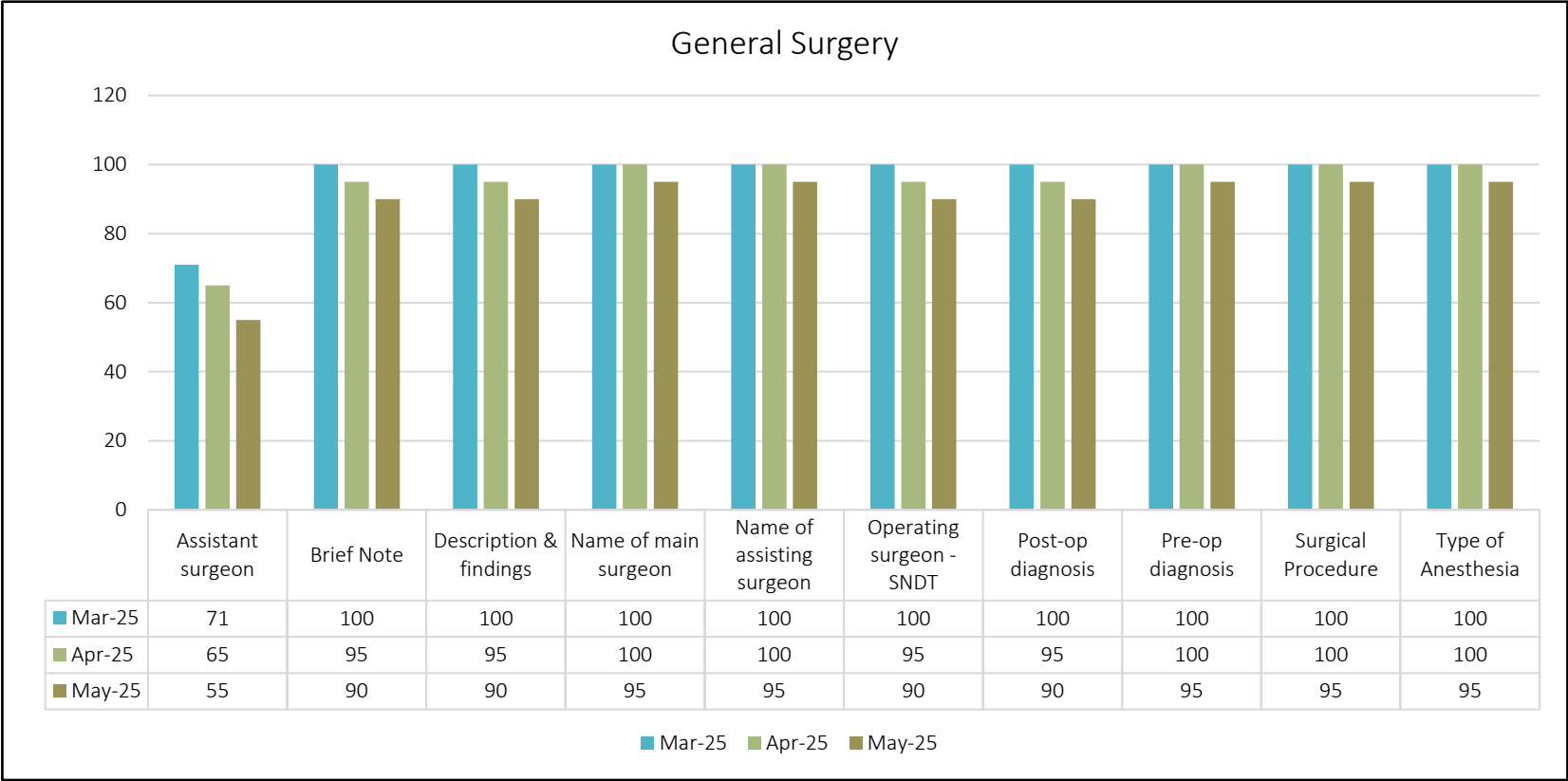




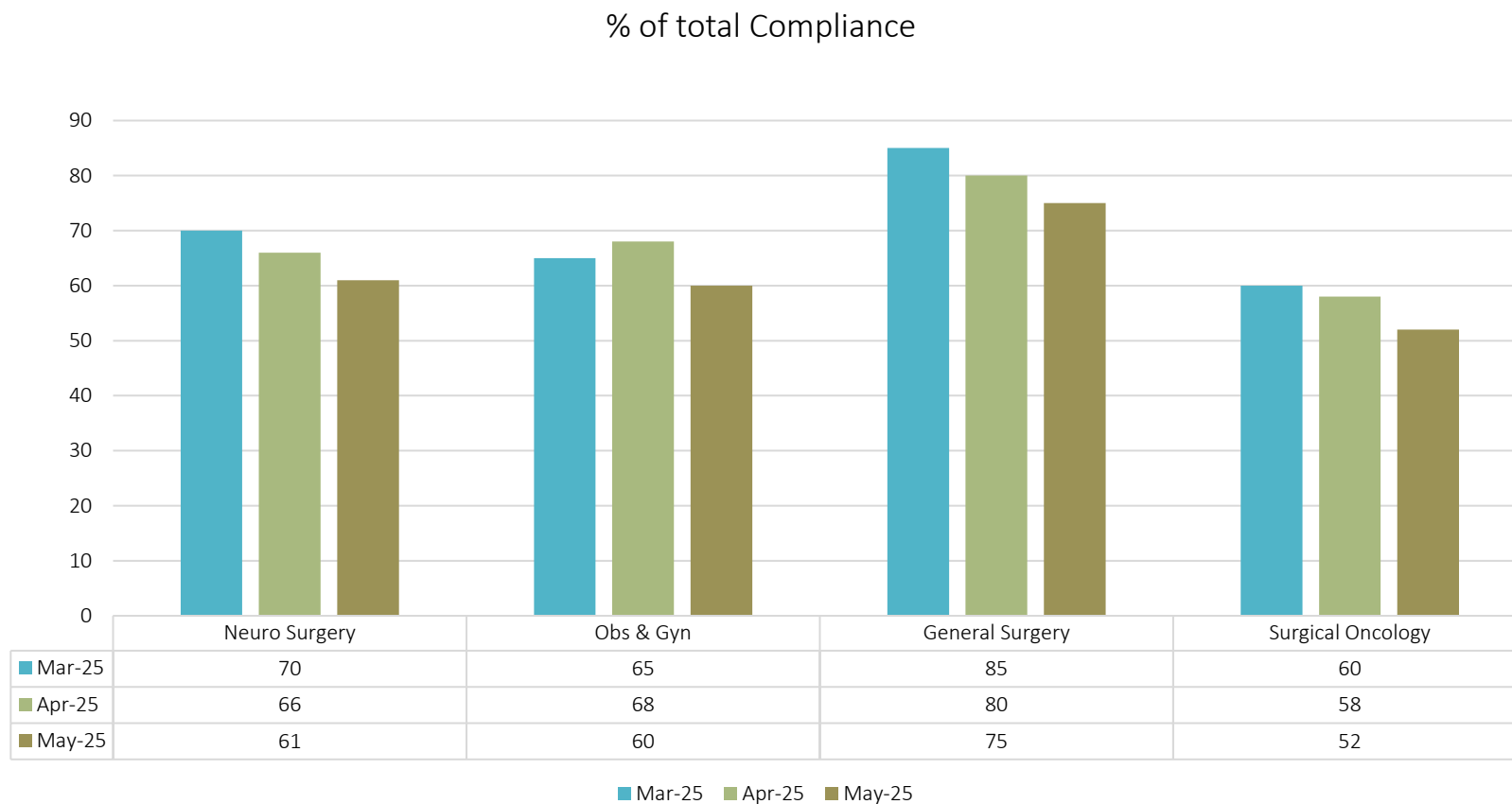
# OPERATION NOTES



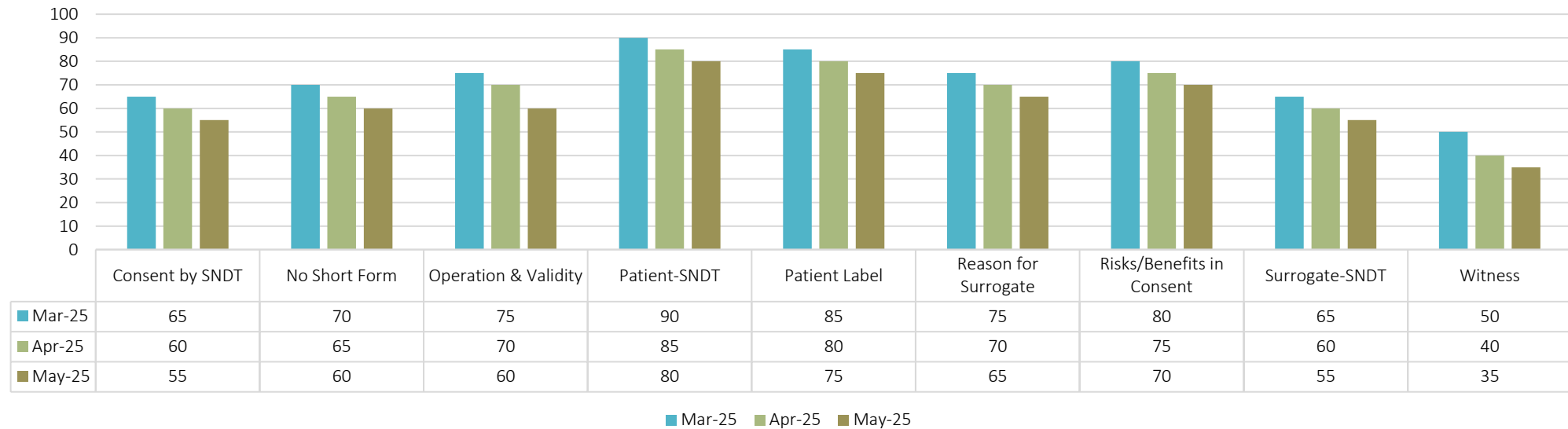




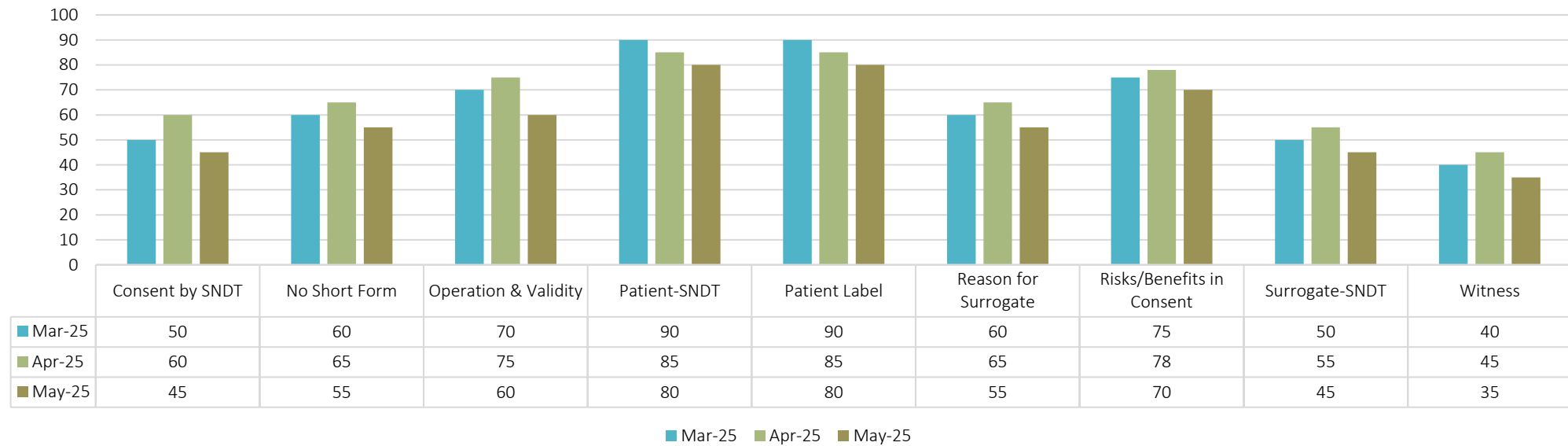
# CONSENT FORMS



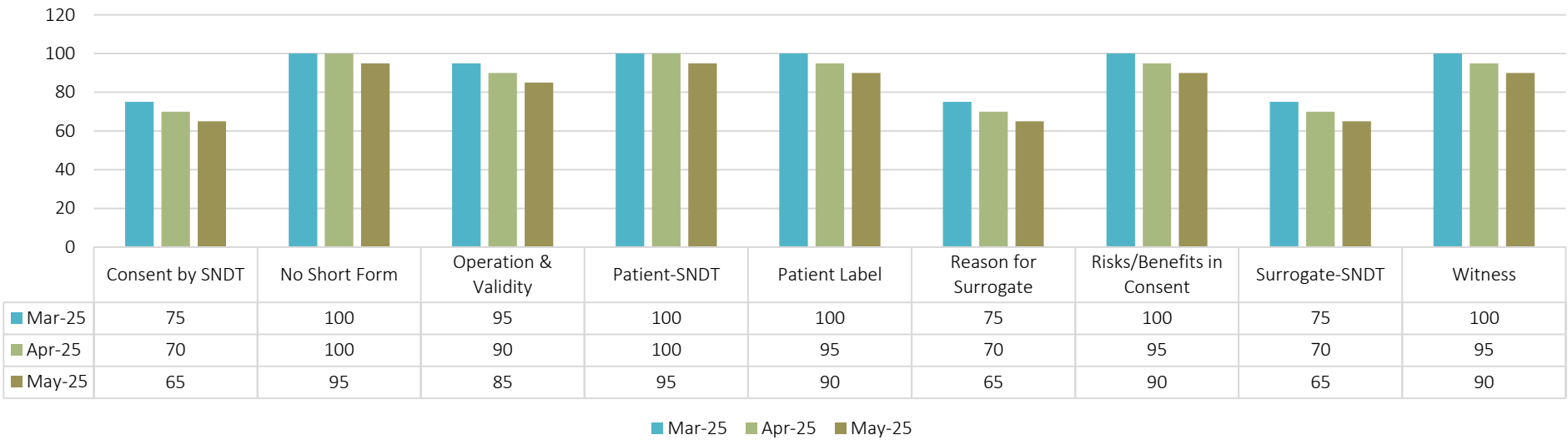
## Neuro Surgery



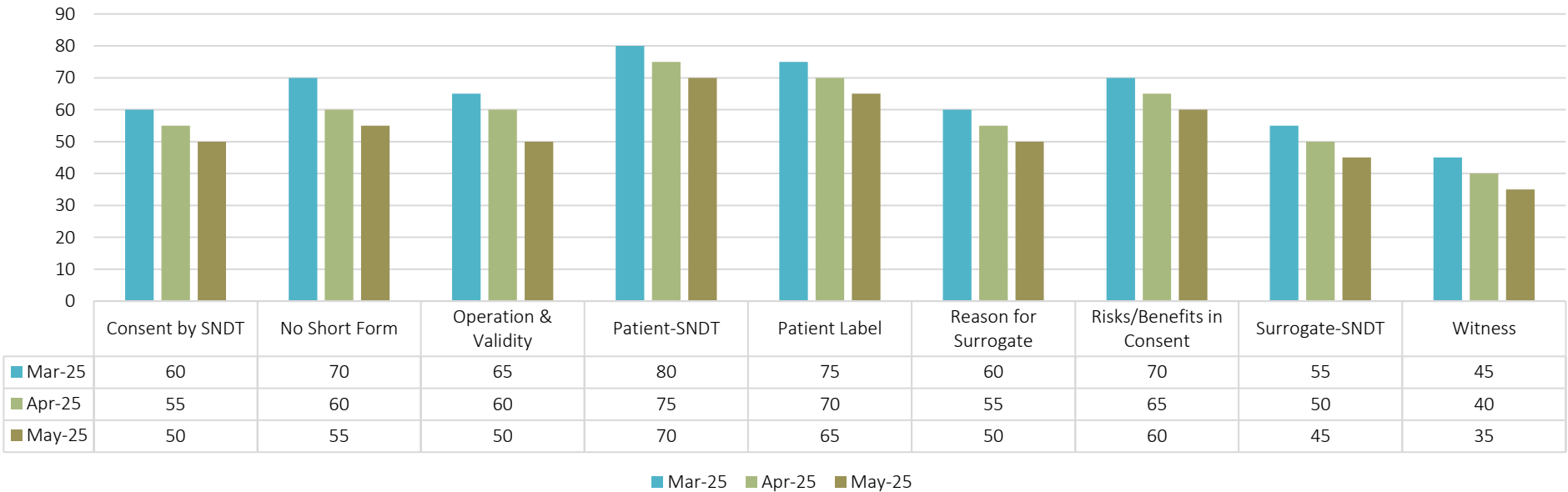
## Obs & Gyn



General Surgery

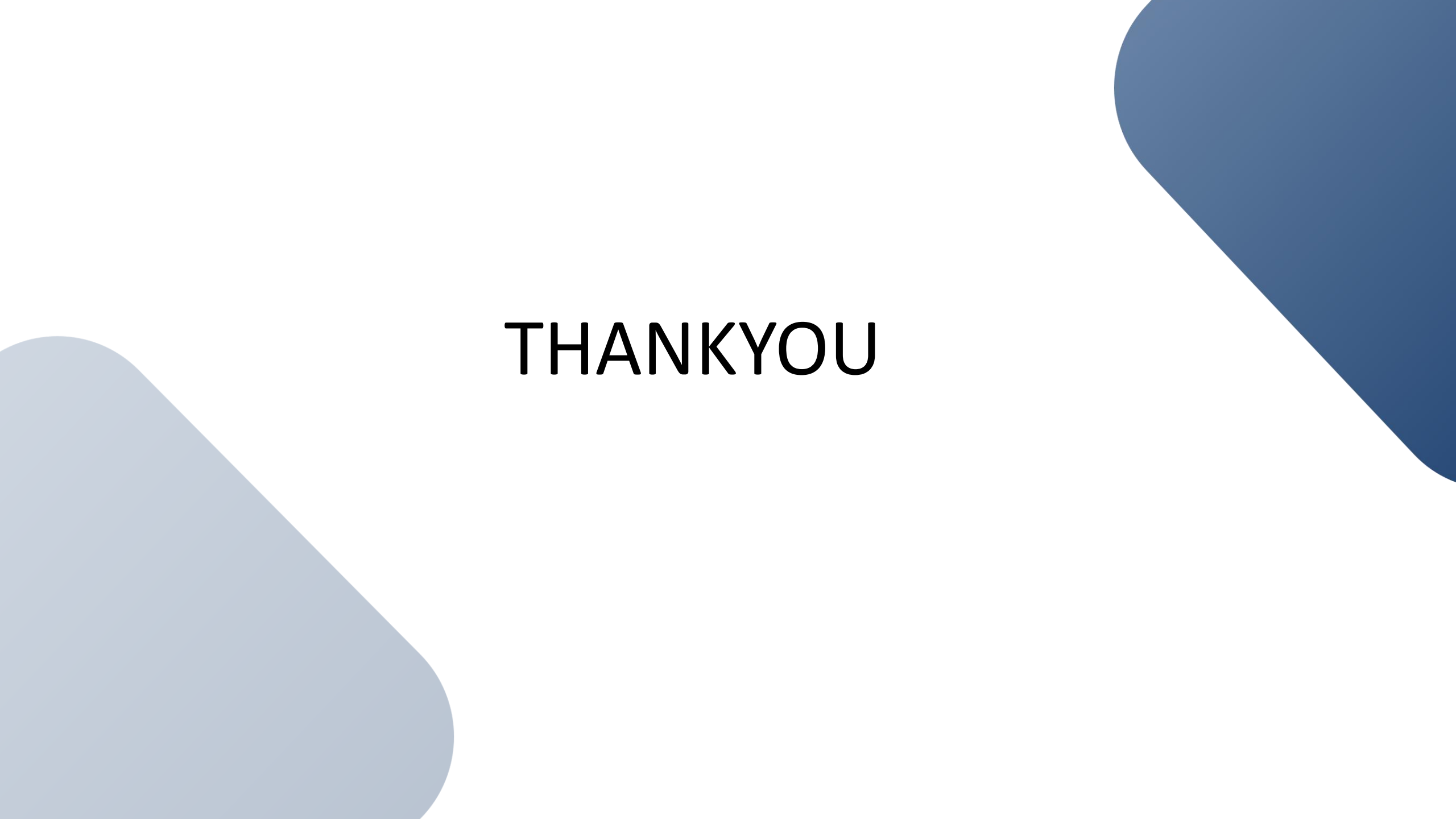


Surgical Oncology



# CONCLUSION

- Active (real-time) documentation audits are effective in identifying gaps and driving immediate improvements in ICU record-keeping.
- General Surgery consistently showed the highest compliance, while Surgical Oncology demonstrated notable improvement over time.
- Common deficiencies included incomplete psychological assessments, missing physician signatures, and poor surrogate consent documentation.
- Interdisciplinary collaboration between clinical staff and quality teams enhanced audit outcomes and accountability.
- Structured checklists and feedback mechanisms helped standardize documentation and reduce variability across departments.
- Documentation quality directly impacts patient safety, legal compliance, accreditation, and overall care delivery.
- Audits should be institutionalized as continuous quality improvement tools—not just compliance checks.



THANKYOU