PROJECT SYNOPSIS

TITLE OF THE PROJECT: “Evaluating ICU Documentation Practices to Improve Patient Care Quality: An Audit-Based Study at Max Healthcare"

1. BACKGROUND AND RATIONALE:

Effective clinical documentation is foundational to patient safety, medico-legal integrity, and hospital accreditation, especially in high-risk environments like Intensive Care Units (ICUs). Given the complexity of care and multidisciplinary coordination required in ICUs, documentation must be timely, complete, and compliant with NABH and JCI standards.

This study was undertaken at a NABH-accredited tertiary hospital to evaluate the real-time quality of ICU documentation across key domains—Initial Assessments, Consent Forms, Progress Notes, and Operation Notes—through active live audits. The rationale stems from the need to verify if audit-driven feedback mechanisms can genuinely elevate compliance, minimize risk, and promote a documentation culture within high-dependency units.

2. AIM OF THE STUDY

To study the effectiveness of patient record documentation audits in improving clinical outcomes and enhancing overall healthcare operational efficiency

3. OBJECTIVE OF THE STUDY

The primary objective of this internship was to establish basic knowledge and cultivate skills in auditing medical records, in this scenario, a high- risk, high-dependency unit such as the ICU. Due to the high complexity of ICU care, documentation within this unit needs to be comprehensive, timely, and accurate. Secondary objectives are as follows:

- To acquire hands-on experience in active auditing of ICU records, comprehending the justification behind every form and check-list utilized.
- To establish an understanding of NABH and JCI standards regarding documentation, especially those being applicable to critical care.
- To evaluate the level of compliance of ICU records with institutional and accreditation standards.
- To determine gaps, errors, or inconsistencies in patient records and recommend improvements to maximize record-keeping and patient

4. METHODOLOGY:

- **Study Design:** Descriptive observational analysis using a mixed-method approach
- **Setting:** Max Healthcare (Multispecialty, Tertiary Level Hospital)

- **Sampling Technique:** Purposive sampling
- **Sample Size:** 125 ICU patient files (March: 41, April: 45, May: 39)
- **Tools Used:** NABH/JCI-based structured audit checklists; Microsoft Excel for scoring, trend analysis, and chart generation
- **Audit Types:** Live audits of open ICU files and passive review for validation
- **Scoring System:** "Complete," "Partial," and "Not Documented" converted to compliance percentages

5. KEY FINDINGS:

- General Surgery ICU consistently performed best with compliance ≥90% in most parameters, reflecting excellent documentation culture.
- Neuro Surgery and Obstetrics & Gynaecology ICUs showed moderate compliance (~70–80%), with notable gaps in vitals and plan-of-care entries.
- Surgical Oncology ICU exhibited the lowest compliance initially (~60%) but demonstrated an upward trend due to audit feedback and staff sensitization.
- Weak points across departments included: Pain Scoring, Psychological Evaluation, Allergies, and Surrogate/Witness fields in consent forms.

6. SIGNIFICANCE OF THE STUDY:

The findings of this study reaffirm the value of structured live documentation audits as an effective quality assurance mechanism. The study provides actionable insights into where compliance lags and informs CAPA (Corrective and Preventive Action) strategies to mitigate documentation-related risks in ICUs. It contributes to better training, standardization, and accreditation-readiness.