Evaluating the Accuracy and Completeness of Inpatient Medical Records: A Medical Audit at SDMH

Brief History & Description About the organization-

SDMH Jaipur was founded by Padma Shri Khailshankar Durlabhji in 1971 in memory of his mother. It is the first private multispecialty hospital of Rajasthan and a non-profit charitable trust. The Prime Minister, Smt. Indira Gandhi, inaugurated the hospital and initially catered to the Armed Forces during the Indo-Pak war. With 525 beds, SDMH provides tertiary level care and stands for excellence in diagnostics, surgery and critical care. It also operates some philanthropic ventures such as Avedna Ashram ,Limb Fitting Centre and Project Prayatna and has one of the finest blood banks in the nation. The hospital is committed to delivering ethical, low-cost and humane health care to everyone

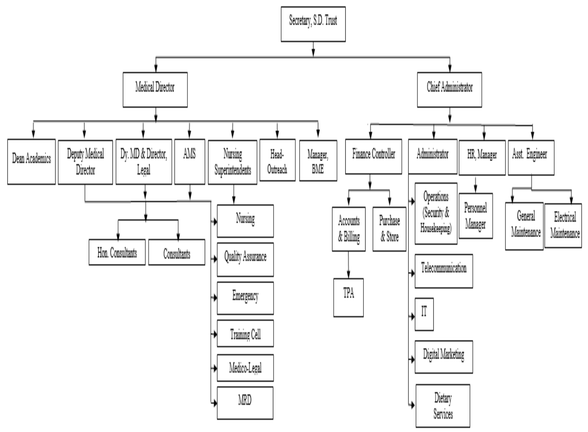
Vision

SDMH shall be an integrated quaternary healthcare hub for delivery of affordable quality medical care in an economically viable, regionally, nationally and internationally positioned institutional environment.

Mission

SDMH Is committed to providing high quality healthcare at most affordable rates, ensuring that all sections of society regardless of caste, creed or color have access to compassionate care. We dedicate our energy and efforts to making this a reality keeping the well.

Organizational Structure



SWOT Analysis

S Strength

1. Not-for-profit tertiary care hospital committed to quality healthcare.
2. Trusted healthcare provider with over 50 years of service.
3. Top blood bank serving Rajasthan and neighbouring states.
4. NABH accredited; listed among World's Best Hospitals 2024.
5. Experienced senior doctors and skilled clinical teams ensure high quality patient care.

W Weakness

1. Limited digitization; manual paperwork still common.
2. Occasional delays in discharge processing.
3. Feedback scanner difficult for elderly or illiterate patients.
4. Irregular housekeeping with poor record-keeping.
5. Some nurses struggle with digital tools, causes delays.

0 Opportunities

1. Technological upgradation.
2. Expanding medical tourism.
3. Digital Health Expansion supports continuity of care beyond hospital visits.

T Threats

1. Rising competition from other private hospitals.
2. Aggressive Marketing by other hospitals.
3. Retention of skilled healthcare professionals.
4. Advanced infrastructure available in other hospitals.

Aim

To measure and compare the accuracy and completeness of inpatient medical records in different wards, rooms and ICUs of SDMH through a structured quality audit.

Objectives-

1. To assess adherence to documentation standards in inpatient medical records across wards, rooms, and ICUs.
2. To evaluate the overall level of compliance in record-keeping practices at SDMH.
3. To identify the specific areas in documentation that frequently show non-compliance.
4. To compare trends of compliance at wards, rooms and ICUs using pre-defined parameters.

Methodology

1. Study Design:
A cross-sectional observational study of inpatient medical records in wards,private rooms and ICUs of Santokba Durlabhji Memorial Hospital (SDMH), Jaipur was carried out

2. Sample Size:
Wards: 75 patient files
Rooms: 50 patient files
ICUs: 50 patient files
Simple random sampling was used to include files to avoid bias in representation of medical records.

3. Audit Tool:
The documentation in every file was evaluated with a structured checklist consisting of 31 parameters. Of these, 24 parameters were identified as largely consistent across settings. Thus, the focus was placed on 8 parameters that showed frequent non-compliance and could be particularly important to the accuracy and completeness of the record.These include:

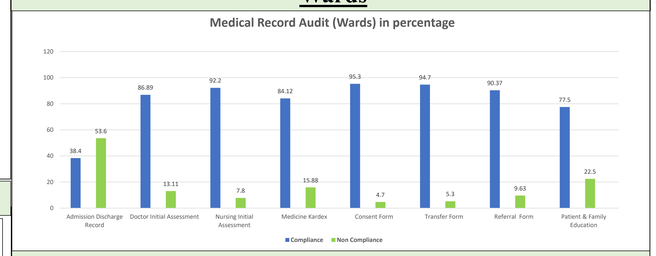
- Admission & Discharge Record
- Doctor's Initial Assessment
- Nursing Initial Assessment
- Consent Forms
- Medication Kardex
- Transfer Forms
- Referral Forms
- Patient & Family Education

5. Data Collection:
Each file was manually reviewed, and scores were recorded as compliance or non-compliance based on checklist parameters.

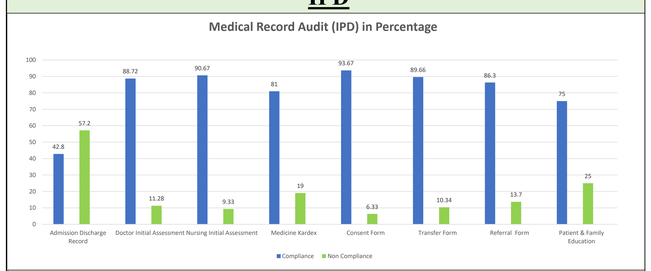
6. Data Analysis:

- Non-compliance/compliance percentages were calculated for each of the 8 selected parameters.
- Comparative graphs were created to analyze trends across wards, rooms, and ICUs.
- Key areas of documentation gaps were identified for further quality improvement.

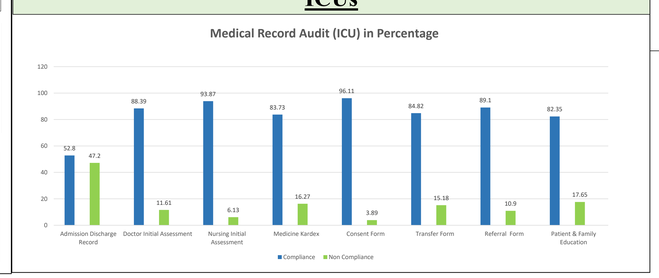
Wards



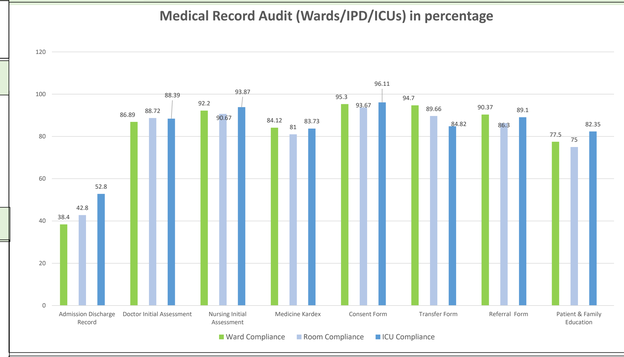
IPD



ICUs



Comparison b/w Wards, IPD, ICUs



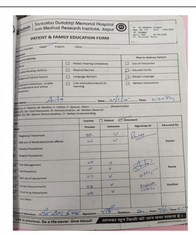
	Ward Compliance	Room Compliance	ICU Compliance
Admission Discharge Record	38.4	42.8	52.8
Doctor Initial Assessment	86.89	88.72	88.39
Nursing Initial Assessment	92.2	90.67	93.87
Medicine Kardex	84.12	81	83.73
Consent Form	95.3	93.67	96.11
Transfer Form	94.7	89.66	84.82
Referral Form	90.37	86.3	89.1
Patient & Family Education	77.5	75	82.35

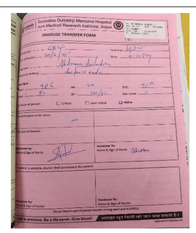
Key observations-

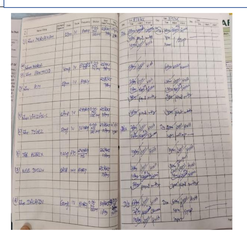
1.Admission & Discharge Record has the lowest compliance. This is the most critical gap area across all settings.
2.**Consent Form** shows highest compliance.
3.**Other Parameters** are mostly above **80–90%**, but still shows a need for improvement, especially in wards and rooms.
4. ICUs generally performed better in most parameters, showing higher consistency in documentation.

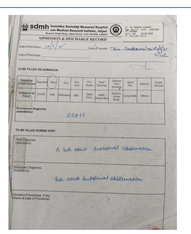
5. Non-Compliant Areas & Suggested Improvements-

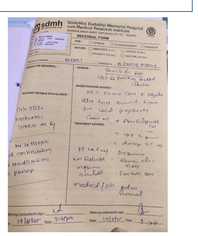
Parameter	Lowest Compliant Area	Possible Reasons	Suggestions for Improvement
Admission & Discharge	Wards (38.4%)	Manual entry delays, workload, lack of real-time updates during patient transfer	• Staff training, introduce a checklist or reminder for completing this section during admission/discharge. • Implement a cross-verification system by the nursing incharge.
Medicine Kardex	Rooms (81%)	medication changes not recorded, in some files verbal order not signed, drug sensitivity test not completely recorded.	• Reinforce double-checking after every shift change, • Ensure timely signature of verbal orders by doctors .
Transfer Form	ICUs (84.82%)	Urgency in patient shift, incomplete handover	• Use pre-printed formats, checklist before transfer
Patient & Family Education	Rooms (75%)	In most cases entries were completed by the dietician and nursing staff while documentation by the doctor was often missing in some files.	• Regular awareness for nurses/doctors about the importance of educating patients and families, conduct random checks and counselling sessions to improve compliance
Referral Form	Rooms (86.3%)	Referral not always documented or signed	• Make it mandatory in workflow











Challenges Faced During Internship :

1. In some files, only a curvy line was present instead of a proper signature or name. This lead to confusion about whether it should be marked as compliance or non-compliance.
2. Adjusting to hospital routines and aligning with staff schedules for effective data collection.

Major Learnings During Internship

1. Gained hands-on experience in clinical documentation standards and audit procedures.
2. Acquired the ability to review patient records and detected inconsistencies.
3. Understood the role of documentation in quality care.
4. Improved interpersonal and communication skills while coordinating with nursing staff.
5. Realization of the gap between ideal practices and practical implementation, and the need for continuous training and monitoring

Suggestions for the Organization (SDMH):

1. Increase or encourage digitization to improve efficiency and accessibility.
2. Promote timely filling and signing of all the necessary form by the relevant personnel.
3. Promote team discussions to share best practices in documentation & compliance.
4. Digitize audit checklist to reduce paperwork & improve monitoring.
5. Conduct regular infection control training sessions and enforce stricter monitoring to ensure proper glove usage and hand hygiene practices among staff.

Difference between Practical Exposure at SIP Organization and Theoretical Understanding from IIHMR University -

Aspect	Theoretical Understanding (IIHMR University)	Practical Exposure (SDMH Hospital)
Documentation Standards	Learned about ideal formats, complete records, and NABH compliance requirements.	Observed few incomplete records, missing signatures, and variation in compliance across departments.
Quality Management	Theoretical knowledge of continuous quality improvement , checklists, and audit protocols.	Participated in real-time audits; noticed gaps in checklist usage.
Use of Technology	Exposure to concepts like EMRs	Limited use of EMRs; much of the documentation and auditing was still manual.
Patient-Centered Care	Emphasis on patient safety, dignity, and engagement in care decisions.	Observed good clinical care.
Team Coordination	Studied interdisciplinary teamwork for quality and patient outcomes.	Coordination between nursing, doctors, sometimes may lacked clarity and consistency.
Infection Control Practices	Emphasis on strict adherence to hand hygiene, PPE use (like gloves), and standard precautions.	Observed that gloves were not consistently used by some nursing staff during minor procedures or file handling, especially in general wards.

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