Clinical Audit Compliance in Inpatient Areas as per NABH Guidelines at a Tertiary Care Hospital (CMRI Hospital)

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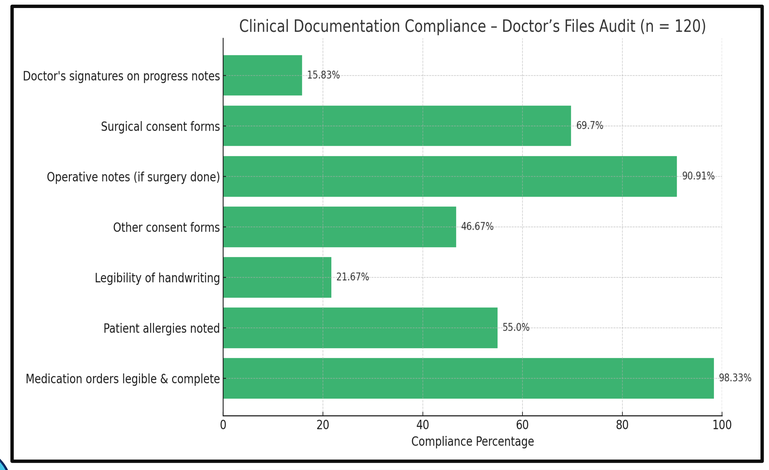
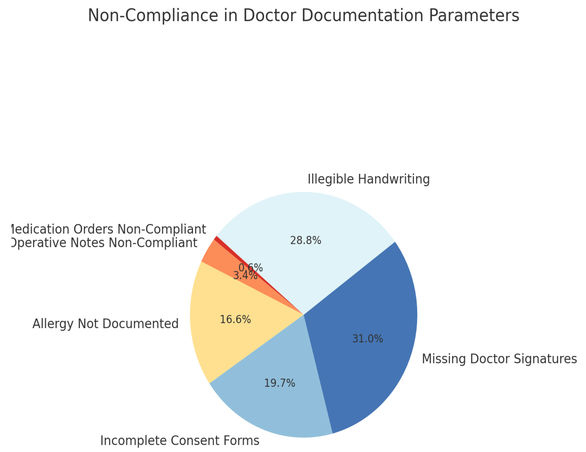
🔷 Introduction

- CMRI was established in 1969, a leading multi-specialty hospital in Eastern India.
- Offers advanced care in:
  - Critical Care, Pulmo Care, Oncology, Neurosciences, Renal Transplants, etc.
- **Key Facilities:**
  - Robotic-assisted surgeries: Urology, Gynae, Joint Replacement, GI
  - 256-Slice CT, 1.5T MRI, 64-Slice CT
  - CR and PACS radiology systems
  - Advanced Cath Labs, Neuro ICU, Organ Transplants
  - Cosmetic/Reconstructive surgery
  - Psychiatry, pathology, international services, insurance, PG medical programs





Theoretical Learning

- Acquired knowledge of NABH 5th edition documentation guidelines.
- Understood the significance of clinical documentation in patient safety and legal protection.
- Learned the organization and elements of full inpatient records.
- Learned about the impact of poor documentation on accreditation and quality measures.
- Applied the DMAIC model of quality improvement step by step.
- Understood important audit parameters such as consent, allergy status, medication orders.
- Learned to calculate percentages of compliance and interpret audit data.
- Reviewed the effect of compliance on hospital processes and patient experience.
- Learned to prepare Corrective and Preventive Action (CAPA) plans.
- Reviewed literature and quality manuals regarding healthcare documentation.

📋 Clinical Documentation

Accurate, real-time medical history, treatment, and care recording
Ensures:
- Patient safety
- Continuity of care
- Medicolegal compliance

Aim: Audit compliance of doctors' documentation practices in IPD
Involves: Doctors, nurses, allied health professionals
Support CMRI's NABH preparation and continuous quality improvement

Methodology:

The research was a **cross-sectional observational audit over 6 weeks at CMRI Hospital**. 120 inpatient records were selected **by Convenient sampling** to give representation from various specialties.

Active inpatient files available in the wards during the audit time were the inclusion criteria. Discharged files unavailable at the real-time were the exclusion criteria.

Specifically developed " File Audit Toolkit" was used to collect data. All files were scanned against NABH documentation requirements for the following parameters:

- Progress notes (name, date, time)
- Consent forms
- Operative notes
- Legibility of handwriting
- Documentation of allergy status
- Medication orders

Daily audits were conducted under supervision with cross-checking done by the Quality Team. The findings were displayed graphically in the form of bar graphs. Confidential treatment of patient data was ensured, and hospital permissions were obtained for access to files.

ANALYSIS

The findings of the audit were compared against NABH 5th edition documentation standards to measure the levels of compliance against critical parameters. Gaps were notably seen in the following areas**:**

- **Doctor signatures missing**
- **Illegible or incomplete progress notes**
- **Unrecorded status of allergy**
- **Incomplete consent documents**
- **Illegible handwriting in records**

A bar chart and pie graph were created to graphically depict the rate of compliance and identify critical areas of weakness. These graphics helped problem areas be easily seen and enabled targeted corrective measures.
Presented via bar graph and pie chart

📊 SWOT Analysis

Strengths
- Availability of a customized checklist tailored to NABH standards
- Strong intent for quality documentation at CMRI
- High compliance was observed in medication orders and operative notes
- Presence of a dedicated medical admin/quality team

Weaknesses
- Poor legibility in handwritten notes
- Missing signatures and incomplete consent forms
- Lack of standardized training on documentation
- Documentation is often seen as a clerical task, not a clinical responsibility

Opportunities
- Integration of EMR with built-in compliance prompts
- Development of dashboards for real-time monitoring
- Use of mobile apps for spot audits and data collection
- Embedding documentation in doctor KPIs and appraisal system

Threats
- Medico-legal risks due to incomplete or illegible records
- Patient safety concerns from unrecorded allergies or vague orders
- Resistance from clinicians to new documentation workflows
- Compliance fatigue or lack of buy-in from clinical teams

📌 Key Findings(RESULTS)

- ✔ 120 inpatient records audited
- ✔ Medication Orders compliance: **98.33%**
- ✔ Operative Notes completed: **90.91%**
- ❌ Allergy status missing: **45%**
- ❌ Consent forms incomplete: **53.33%**
- ❌ Initial Assessment signed with time: **15.83%**
- ❌ Handwriting legibility poor in **78%**

✅ Recommendations (High-Priority)

- Appoint Documentation Champions – Senior resident per department
- Mobile-Based Audit Tracker – Google Forms or a simple app for spot checks
- Quarterly Dept-wise Reviews – Review documentation, retrain as needed
- Compliance Dashboard – Department-level tracking & reporting
- Mandatory Pre-Discharge Checklist – On-duty doctor sign-off on documentation
- Include in Doctor KPIs – Link documentation to performance
- EMR Real-Time Audit Integration – Smart prompts, auto-alerts for gaps

MY LEARNINGS

- Importance of accurate clinical documentation
- NABH documentation standards
- How to conduct live file audits
- Use of the random stratified sampling method
- Role of Doctors, nurses, and the Quality team in maintaining documentation standards.
- Linking documentation compliance to doctor KPIs improves seriousness.
- Use of EMR systems to reduce manual errors
- Hands-on exposure to quality assurance, audit processes, and hospital workflow.
- Discharge summary preparation and full discharge process.
- How to Audit Medical Typist Records

Practical Exposure

- Performed real-time audits of 120 inpatient records with a standardized checklist.
- Located documentation deficiencies such as incomplete signatures and poor handwriting.
- Worked with physicians, quality officers, and medical admin for data gathering.
- Involved in documentation review based on NABH guidelines.
- Applied the DMAIC framework practically to evaluate and enhance documentation adherence.
- Made compliance reports and visual data presentations (bar graphs).
- Recommended implementable solutions such as dashboards, audits, and training modules.
- Witnessed multidisciplinary collaboration in patient care and documentation.
- Assisted in quality discussions and clinical rounds.
- Learned how documentation affects discharge readiness and hospital ratings.

Challenges faced by me

- Challenge in retrieving inpatient real-time files because of patient confidentiality measures.
- Lack of complete or missing documentation rendered the analysis challenging.
- Ink or messy handwriting made it challenging to interpret accurately.
- Resistant or reluctant coordination from overworked clinical staff.
- Different documentation styles between departments resulted in inconsistency.
- Challenge in adapting real-life practices to perfect NABH standards.
- Few digital tools with fast audit capabilities (manual verification took long).
- Having to ensure professional communication while indicating compliance deficiencies.
- Handling and presenting a high volume of audit information succinctly and clearly.

Conclusion:

Audit of 120 records using structured checklists.
High compliance in;
- Medication orders (98.33%)
- Operative notes(90.91%)

Low compliance in :
- Signature on progress notes.
- Allergy documentation
- Handwriting legibility
- Issues: Incomplete signatures, consent gaps, illegibility, - Medicolegal risk
- DMAIC Framework enabled structured gap analysis.
- Visualized compliance data supports targeted interventions.

Final Summary:

- Supports CMRI's goals of patient safety and clinical excellence.
- Embedding:
- Micro Audits.
- Standardized templates
- Doctors training
- Drives long-term quality gains.
- Performance-linked compliance encourages accountability.