A Checklist-Based Audit to Identify Documentation Gaps in Inpatient Medical Records in the Departments of OBGY, Medicine & Surgery at AIIMS Bhopal

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ABOUT ORGANIZATION

AIIMS Bhopal, established in 2012 under Pradhan Mantri Swasthya Suraksha Yojana PMSSY, is a leading medical and teaching institute modeled after AIIMS Delhi. With a 1,250-bed modern hospital, it offers advanced care including robotic surgeries, organ transplants, cancer and cardiac treatments. The facility features 20 modular OTs, ICUs, digital records, and dedicated zones for trauma, maternity, and emergencies. It also runs community clinics and supports national health programs. Backed by expert departments and modern infrastructure, AIIMS Bhopal is a key center for healthcare, research, and outreach in Central India.

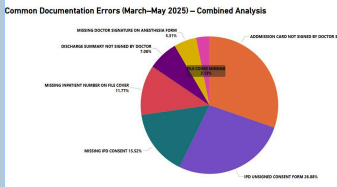
Vision

To provide good and affordable healthcare in all regions, train skilled doctors and staff, and support research on important health problems in India.

Mission

To become a top medical institute by providing quality education, research, and caring healthcare with a scientific approach.

President, Governing Body
↓
Director
↓
| Dean (Academics) | Dean (Research) | Dean (Examination) |
↓
Associate Deans in respective domains
↓
Medical Superintendent (Hospital Operations)
↓
Heads of Departments (Clinical & Non-Clinical)
↓
Administrative Heads:
- Additional Director (Administration)
- Financial Advisor
- Registrar
- Chief Security Officer
- Dy. Director (IT)
- Sr. Store Officer
- Superintendent Engineer
↓
Supporting Staff:
- Department Officers (HR, Finance, Stores, Maintenance, etc.)



INTRODUCTION TO PROJECT

Inpatient medical records are an important part of patient care, as they help ensure safety, support treatment decisions, and maintain legal protection. But in high load departments like Medicine, OBGY, and Surgery, errors are still common. Many files are found with missing consent forms, unsigned admission details, or incomplete discharge summaries. Through this study, I tried to identify these documentation gaps by using a checklist aligned with NABH standards to help improve overall record quality. The project was carried out through a manual audit of closed inpatient files, focusing on discharge records accessed from the Medical Records Department.

OBJECTIVE

- To assess the completeness and accuracy of inpatient medical records
- To identify documentation gaps across selected departments (OBGYN, Medicine, Surgery)
- To recommend improvements in inpatient documentation practices

METHODOLOGY

Study Design & Setting: A descriptive retrospective audit conducted at AIIMS Bhopal, a tertiary care teaching hospital.

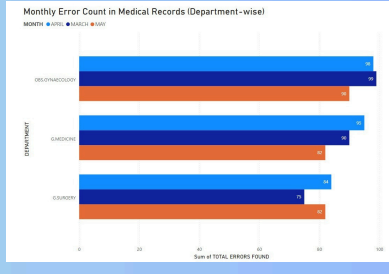
Departments Covered: Obstetrics & Gynaecology, General Medicine, and General Surgery.

Duration: March–May 2025 (3 months).

Sampling: Continuous monthly sampling based on NABH guidelines.

Tool Used: A structured checklist assessing completeness, timeliness, legibility, consent, discharge summaries, and signature/date compliance.

Data Collection & Analysis: Manual review of inpatient records; data entered in Excel and analyzed using Excel & Power BI for dashboard-based visualizations.



MAJOR LEARNINGS DURING INTERNSHIP

- Learned how tocollect, clean & manage hospital data from physical files.
- Used Power BI for data visualization and analze data for the first time.
- Understood MRD workflow and real documentation practices
- Gained experience in audit of inpatient records.
- Realized the role of proper records in patient care & hospital efficiency.

DIFFERENCE BETWEEN PRACTICAL EXPOSURE AND THEORETICAL KNOWLEDGE

- Theoretical Understanding:
Learned structured concepts of hospital management, documentation standards, and team coordination in class.

- Practical Exposure:
Realized that effective work needs more than theory — it requires leadership, communication, planning, adaptability, and handling on-ground challenges.

- Theory taught how things should work
Practice showed how things actually work — with manpower gaps, delays, and efforts done just to keep the system running, not always for patient satisfaction.

SUGGESTIONS

- Strengthen Verification of Documentation Checklists
- Introduce Dual Sign-Off for Medical Records
- Conduct Random File Audits Weekly
- Highlight Incomplete Files with Color Tags or Stickers

CHALLENGES FACED DURING INTERNSHIP

- Difficulty in Locating Department-Wise Files
The major challenge was locating patient files department-wise in the MRD, where records were poorly organized and not arranged by IPD or CR numbers.
- Communication Barriers with MRD Staff
Coordinating with MRD staff was difficult at times due to limited availability and lack of clarity in communication.
- Adjusting to a New Work Environment
It took time to adapt to the hospital setting, work culture, and administrative processes in a busy tertiary care institution.
- Learning Power BI for Data Visualization
As a first-time user of Power BI, understanding its interface and using it effectively for creating charts and analyzing results was a steep learning curve.

SWOT ANALYSIS

S — Efficient initial segregation and routing of records through assigned counters ensures operational clarity and accountability.

W — Digitization of records has been suspended since January 2025 due to the absence of a vendor, resulting in complete reliance on manual documentation and increasing the risk of delays and inefficiencies.

O — The organization can bring back scanning by either hiring a new vendor or building its own digitization system. This will make records easier to find and help meet compliance requirements

T — Relying only on paper records can lead to lost data, slower patient care, and problems meeting legal and accreditation requirements.

RESULT

- Obstetrics & Gynaecology reported the highest documentation errors, peaking at 99 in March. • General Medicine showed fluctuating errors, with a high of 95 in April. • General Surgery had the lowest errors, ranging from 75 to 84 over three months. • The most common documentation gaps were: • Admission card not signed by doctor (30.3%) • IPD unsigned consent form (26.9%) • Missing IPD consent form (15.5%) • Other frequent issues included Missing IPD Number on Cover File Missing Consent Forms, Anesthesia Signatures, and File Cover Missing Information.