Audit and analysis of medication records in inpatient settings at SDMH

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BRIEF HISTORY AND DESCRIPTION –

SDMH Is a Private, Trust-managed, Autonomous, Fee-for-services And Not-for-profit Hospital. It Is a Multidisciplinary, 525-bed, Tertiary Care Hospital. It Houses Several Wards, Operation Theatres, ICUs, Laboratories, Utility Services, Specialties and Super Specialties, Including One of The Best Blood Banks in The Country, Catering to The Entire State of Rajasthan and To Neighboring States as Well.

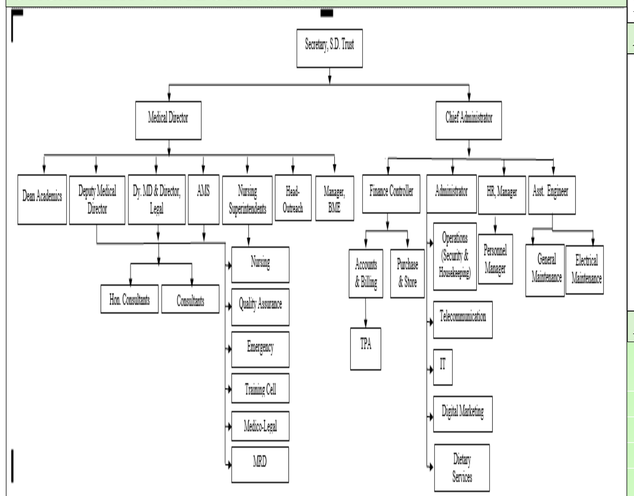
VISION –

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 wellbeing of our patient as our highest priority.

ORGANIZATIONAL STRUCTURE –



SWOT ANALYSIS

Strengths

- Well-trained nursing staff.
- Well known for delivering quality patient care.
- Availability of well-established training programs.

Weaknesses

- More paperwork.
- Directional signages were not proper in some areas.
- Small waiting area in IPD.

Opportunities

- Spread use of EMR.
- Increase patient counselling.
- Convenient parking.

Threats:

- Rising competition from private hospitals.
- Rising patient expectations in terms of service quality and digital convenience.
- Limited online visibility or branding.

AIM–

To assess the medication records and identify medication errors in inpatient departments (wards, rooms, and ICUs).

OBJECTIVES–

1. To review medication records for identifying actual medication errors in inpatient departments.
2. To compare the frequency and type of medication errors between wards, rooms, and ICUs.
3. To suggest improvements for reducing medication errors and enhancing patient safety.

METHODOLOGY–

Study Setting: Santokba Durlabhji Memorial Hospital (SDMH), Jaipur.

Study Design: Descriptive cross-sectional study (audit-based).

Duration of study: 1 Month

Sample Size:

Wards – 80 patient files

Rooms – 40 patient files

ICUs – 40 patient files

Sampling Method: Random selection of files from each area.

Data Collection Method: Primary data collected through audit.

AUDIT PROCESS–

Randomly selected patient files

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In medication administration record checked all parameters of medication safety through checklist

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Fill the medication safety audit checklist

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Analysis and submitted to the quality department

ANALYSIS–

Parameters	% of Errors in Wards	% of Errors in Rooms	% of Errors in ICUs
No/ Wrong dose	1.25	5	2.5
No/Wrong frequency	3.75	7.5	5
No/Wrong concentration	1.25	5	2.5
No/Wrong rate of administration	2.5	2.5	7.5
Non-approved abbreviation used	5	10	12.5
Dose omission	1.25	2.5	2.5
Incomplete documentation by Nurse	10	7.5	10

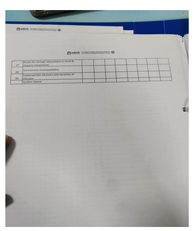
CONCLUSION–

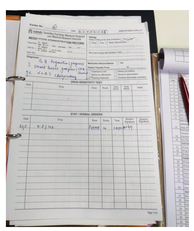
The checklist of Medication safety audit had 39 parameters.

Seen in the table above are the parameters which found deficiencies.

The analysis of the audit was forwarded to the quality department.

Training of nurses in all IPD wards was conducted.



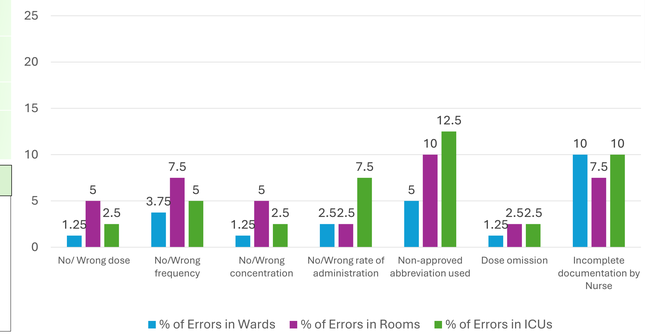


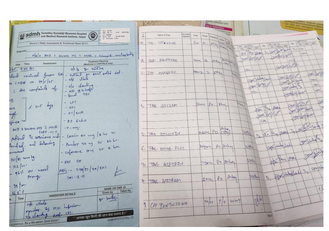
MEDICATION RECORD AUDIT(WARDS)IN%–

MEDICATION RECORD AUDIT(ROOMS)IN%–

MEDICATION RECORD AUDIT(ICUs)IN%–

COMPARISON–





CHALLENGES FACED–

1. During shift changes, communication gaps sometimes led to inconsistencies in documentation or lack of accountability for missing entries.
2. Some nursing or support staff were newly recruited or untrained in proper documentation, leading to errors or incomplete records.
3. Use of non-standard or unclear abbreviations in patient records made it difficult to interpret clinical notes accurately.

MAJOR LEARNING DURING INTERNSHIP–

1. Learned about the importance of medication audits and their role in patient safety.
2. Understood how adherence to the Five Rights of medication administration (right patient, drug, dose, route, and time) plays a central role in preventing errors.
3. Understood that regular training sessions are essential to keep staff updated on drug protocols and safety measures.
4. I got familiar with NABH documentation practices and bedside auditing.
5. Improved skills in observation, analysis and team coordination.

SUGGESTION FOR IMPROVEMENT–

1. Display standard drug abbreviations to avoid misinterpretation.
2. Ensure all medication details are properly written and complete.
3. Cross-verify dose and timing before giving medicines.
4. Conduct training sessions on medication safety and error prevention.

DIFFERENCE BETWEEN THEORETICAL KNOWLEDGE AND PRACTICAL EXPOSURE–

Theoretical Understanding at IIHMR University:	Practical Exposure at SIP Organization (SDMH):
1. Learned about hospital through lectures and Focused on ideal hospital practices and policies.	1. Gained hands-on experience by working in real hospital settings and observed actual gaps in documentation, SOP adherence, and patient care.
2. Exposure to concept like EMR.	2. Limited use of EMR, much of the documentation and auditing was still manual.
3. Learned structured formats and complete documentation standards.	3. Applied quality checklists and audit tools in real-time and Saw practical issues like missing entries and non-approved abbreviations.
4. Learned different departments in hospital and infrastructure.	4. Experienced how different departments function in practice.