ASSESSING THE QUALITY OF MEDICAL RECORDS AT ETERNAL HOSPITAL THROUGH CLINICAL OPEN FILE AUDIT

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

by

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Under the Supervision and Guidance of

Dr. Piyusha Majumdar

2025

ETERNAL HOSPITAL *Sanganer*

Completion Certification

CERTIFICATE

This is to certify that Saiyada Nausheen Ali in partial fulfillment of the requirements for the award of the degree of MBA Hospital and Health Management from the IIHMR University, Jaipur has successfully completed her internship in Medical Administration at ETERNAL HOSPITAL SANGANER during Mar 10 - June 09, 2025.

Eternal Hospital Sanganer (A Unit of Eternal Care Foundation)

Place:

Date:

Preceptor/Head of the Organization

Eternal Hospital, Sanganer

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that dissertation titled **"Assessing the Quality of Medical Records at Eternal Hospital through Open File Audit"** is a record of the research work undertaken by Saiyada Nausheen Ali in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide
IIHMR University, Jaipur

12th Jun 2025

School Dean
IIHMR University, Jaipur

12th Jun 2025

DECLARATION BY STUDENT

I hereby declare that this dissertation titled **Assessing the Quality of Medical Records at Eternal Hospital through Open File Audit** is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature)

Saiyada Nausheen Ali

9th June 2025

ACKNOWLEDGMENT

With heartfelt gratitude, I would like to thank everyone who supported and encouraged me during my internship journey at Eternal Hospital, Sanganer, Jaipur.

First and foremost, I am deeply thankful to Dr. Priyanka Maan, Head Medical Administrator, for her unwavering guidance and mentorship. Her expertise, leadership, and commitment to excellence in healthcare have been truly inspiring. It has been a privilege to learn under her supervision, and her encouragement significantly enriched my internship experience.

My sincere thanks also go to Dr. Sandeep Sharma, Deputy Medical Administrator, for giving me the opportunity to be a part of such a respected institution. His trust and openness created a learning environment where I felt valued and motivated.

I would also like to express my deep appreciation to Dr. P.R. Sodani, President of IIHMR University, for enabling this internship opportunity. I'm truly grateful to my academic guide, Dr Piyusha Majumdar, whose constant encouragement, thoughtful feedback, and kind words guided me every step of the way. Her support gave me the confidence to keep improving and learning.

This internship has been a memorable and transformative experience. I leave it with not just new knowledge and skills, but also a deeper passion for healthcare and a renewed sense of purpose. I will always carry these learnings with me as I move forward on my professional journey.

ABSTRACT

Title: Assessing the Quality of Medical Records at Eternal Hospital through Open File Audit.

Author Name: Saiyada Nausheen Ali

Keywords:
Open File Audit,inpatient documentation, compliance, NABH, patient safety, quality improvement

Background:
Accurate and complete documentation is a cornerstone of effective inpatient care, serving not only as a clinical record but also as a vital tool for communication, legal defence and quality assurance. In a hospital setting, where multidisciplinary teams manage complex cases, well-maintained records ensure continuity, safety, and accountability in patient care. However, documentation is often deprioritized due to time constraints, staff workload, and lack of training—leading to gaps that can compromise both patient outcomes and institutional accreditation standards such as NABH. Recognizing and addressing these documentation deficiencies is essential for building a culture of safety and quality within healthcare institutions.

Objective:

- To assess the completeness, accuracy, and timeliness of medical records in Eternal Hospital.
- To determine the level of compliance of documentation practices with institutional and national standards.
- To identify specific documentation gaps and deficiencies through open file audit method.
- To recommend strategies for continuous improvement in medical record management.

Methodology:
This observational cross-sectional study was conducted through a manual audit of 100 inpatient records at a tertiary care hospital. A structured NABH-aligned checklist was used to evaluate compliance across multiple documentation forms. Data were analysed both quantitatively (compliance percentages, department-wise scores) and qualitatively (common gap patterns and documentation deficiencies). Non-compliant entries were documented, and compliance scores were calculated using standardized formulas excluding 'Not Applicable' entries.

Results/Findings:
Compliance levels varied significantly across forms. Progress Notes exhibited the lowest compliance (10%), while forms such as the Anaesthesia Record and Bundle of Care Checklist scored above 90%. Five critical forms—Progress Notes, Consent Forms, Doctor's Initial Assessment, Daily Nursing Assessment, and Treatment Sheet—contributed to 44% of total non-compliance. Key gaps included missing consultant

signatures, incomplete vital signs, medication errors, and undocumented consent elements.

Conclusions:
The audit revealed considerable yet addressable gaps in inpatient documentation. A focused intervention targeting the most non-compliant forms could significantly enhance documentation quality, patient safety, and accreditation preparedness. The study emphasizes the need for sustained audits, staff sensitization, and system-level reforms to embed a culture of accurate documentation in clinical practice.

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CHAPTER 1 INTRODUCTION

1.1 Background of the Study

In the dynamic and complex environment of healthcare delivery, medical records function as the silent but central thread that connects every clinical action and decision. These records serve as more than just an administrative formality — they are vital instruments that capture the essence of patient care. Every consultation, procedure, diagnostic test, medication, or treatment pathway leaves a trace within the medical record, forming an unbroken narrative of a patient's journey through the healthcare system.

The quality of these records directly influences patient outcomes, care coordination, medico-legal protection, hospital reimbursement, and institutional reputation. In an era where healthcare is rapidly evolving toward patient-centric models, accurate and timely documentation has become both a necessity and an expectation. Clinical documentation facilitates continuity of care, especially in tertiary care hospitals where a single patient may interact with multiple departments, consultants, and caregivers. Proper documentation ensures that every provider, regardless of the shift or specialty, has access to the same critical information.

Despite these recognized benefits, several healthcare institutions — even those equipped with modern infrastructure and digital tools — continue to face persistent issues in maintaining high-quality documentation. These challenges include incomplete patient histories, undocumented allergies, missing treatment plans, absence of follow-up advice, unsigned consent forms, illegible prescriptions, and delayed discharge summaries. Such errors or omissions are not trivial; they may lead to adverse patient events, diagnostic delays, unnecessary tests, and even medico-legal litigations.

In this light, documentation is not simply a record-keeping function — it is an intrinsic component of clinical governance and quality assurance. Hospitals striving for excellence must recognize the need for ongoing evaluation and improvement of documentation practices. This study, therefore, seeks to examine the quality of medical records at EHCC Hospital, Jaipur, using an **open file audit approach** — a proactive, real-time audit technique that uncovers documentation lapses with the intent to drive systemic improvements.

1.2 Understanding the Concept of Open File Audit

An **open file audit** refers to the process of systematically reviewing patient medical records **during hospitalization**, rather than after discharge. It is a **live, concurrent audit** that provides a dynamic view of documentation practices as they occur. Unlike retrospective reviews, which assess past records, open file audits allow auditors to evaluate ongoing entries in real time, making it easier to catch missing fields, incorrect documentation, or inconsistencies **before** discharge.

The core philosophy of open file auditing is **proactive identification and immediate correction**. It not only supports compliance monitoring but also facilitates direct feedback to clinical teams, ensuring timely rectification and reinforcement of proper

documentation behavior. This real-time approach makes the audit more effective in improving ongoing practices, rather than merely highlighting past errors.

Why is Open File Audit Important?

- It provides live feedback and enables on-the-spot corrections.
- Reduces the risk of discharges with incomplete or incorrect documentation.
- Improves real-time compliance with institutional and NABH standards.
- Supports hospitals in preparing for external audits or re-accreditation.
- Builds a culture of accountability by reinforcing best practices while care is being delivered.

Examples of Open File Audit Benefits:

- If a consent form is incomplete, the auditor can immediately inform the team to obtain it before surgery.
- If a patient's medication reconciliation form is missing, it can be updated during the admission rather than being overlooked until discharge.

1.3 Difference Between Open File and Closed File Audit

Table 1.1

ASPECT	OPEN FILE AUDIT	CLOSED FILE AUDIT
Timing	During patient's hospital stay	After patient is discharged
Nature	Concurrent(real time)	Retrospective
Focus	Prevention & Improvement	Post-hoc Evaluation
Corrective Action	Immediate correction possible	Delayed action, no chance for real time fixes
Impact on care	Direct impact on ongoing care & compliance	No effect on current patient episode
Common Use	Quality assurance during accreditation process	General quality reviews, post discharge auditing
Documentation Gaps	Can be corrected immediately	Only documented for training & future purposes

While both types of audits have value, open file audits are superior in settings where continuous improvement, real-time compliance, and audit preparedness are critical goals. On the other hand, closed file audits are useful for long-term data analysis, research, and feedback loops.

1.4 Rationale for the Study

EHCC Hospital is a growing tertiary care center that prioritizes clinical excellence, patient safety, and continuous quality improvement. As the hospital gears up for NABH re-accreditation, it becomes necessary to ensure that all documentation processes are not only in place but also adhered to consistently.

While the hospital conducts occasional closed file audits, the real-time nature of an open file audit provides the added advantage of identifying and rectifying issues during the patient's stay. This aligns better with the expectations of accreditation bodies like NABH, which emphasize real-time adherence to protocols and documentation standards.

By assessing documentation quality through open file auditing, the hospital can identify real-world gaps in practice, train staff accordingly, and introduce system-wide interventions that raise the overall standard of clinical record-keeping.

1.5 Statement of the Problem

Although healthcare providers are trained in documentation practices, real-world challenges such as workload, time constraints, lack of awareness, absence of feedback, and insufficient monitoring mechanisms often contribute to suboptimal documentation. Despite policies being in place, adherence to them is inconsistent. As a result, critical forms are left incomplete, consent forms lack signatures, progress notes are missing entries, and discharge summaries are delayed or inaccurate.

At EHCC Hospital, like many other tertiary institutions, there is an observable disconnect between policy and practice when it comes to documentation compliance. Though many audits are performed in response to incidents or complaints, proactive quality assurance measures such as open file audits are seldom institutionalized. This lack of routine, proactive auditing leads to missed opportunities for real-time improvement and team accountability.

The consequences of poor documentation go far beyond administrative inefficiency. They directly impact patient care by increasing the likelihood of medication errors, incomplete histories leading to repeated investigations, and inadequate legal defense in the event of malpractice claims. Therefore, understanding the current state of documentation in real time is not just beneficial but necessary.

1.6 Research Question

How effectively do current medical records in a tertiary care hospital meet established clinical documentation standards, and what critical gaps in completeness, accuracy, and timeliness are revealed through an open file audit?

1.7 Objectives of the Study

- To assess the completeness, accuracy, and timeliness of medical records in Eternal Hospital.
- To determine the level of compliance of documentation practices with institutional and national standards.
- To identify specific documentation gaps and deficiencies through open file audit method.
- To recommend strategies for continuous improvement in medical record management.

1.8 Significance of the Study

This study holds significance at both institutional and academic levels. For EHCC Hospital, it offers a practical tool for internal assessment, supporting preparation for accreditation and providing a framework for ongoing quality assurance. The findings will not only highlight problem areas but also guide interventions such as documentation training, form redesign, process digitization, or real-time validation protocols.

For hospital administrators, the data generated from this study can inform key decisions on resource allocation — such as investing in electronic health records, appointing documentation officers, or modifying staff-to-patient ratios to facilitate better record-keeping.

For frontline healthcare workers, the study can foster awareness and understanding of documentation gaps, thus helping them recognize its value beyond administrative formality. Ultimately, improved documentation translates into enhanced patient care, legal preparedness, and organizational efficiency.

In the broader academic landscape, this research contributes to the growing body of evidence advocating for the adoption of proactive quality improvement tools in clinical settings, especially in middle-income countries like India.

1.9 Scope of the Study

The study will cover four major areas of inpatient care:

1. 4th Floor – Private Ward
2. 5th Floor – Private Ward
3. MICU – Medical Intensive Care Unit
4. CTVS ICU – Cardiothoracic Vascular Surgery ICU

The study will be conducted over a three-month period, from 10th March to 9th June 2025. It includes all eligible IPD patient records that meet the inclusion criteria of minimum 48-hour hospitalization. Records of patients who expired during hospitalization, were transferred out, or left against medical advice will be excluded to ensure consistency in documentation expectations.

1.10 Limitations of the Study

While every effort has been made to ensure the robustness of methodology, the study is subject to certain limitations. First, it focuses only on selected inpatient areas and does not account for outpatient or emergency department documentation. Second, the audit is confined to paper-based records and may not reflect challenges in digital documentation. Third, the qualitative perceptions of healthcare staff toward documentation practices are not captured in this phase, although they are equally important for behavioral change.

Additionally, since the audit is observational and does not include pre- and post-intervention comparisons, its ability to measure the impact of any future corrective actions will be limited to descriptive analysis. However, it lays the groundwork for follow-up studies that could incorporate improvement cycles or training outcomes.

CHAPTER 2 LITERATURE REVIEW

Table 2.1

Authors (Year)	Study Location	Sample Size	Sampling Technique	Salient Features
Awad et al. (2024)	Managil Teaching Hospital Gezira State, Sudan	108 inpatient records (54 per audit cycle)	Systematic simple random sampling	Identified documentation gaps in inpatient records and proposed corrective measures.
Joshi & Thomas (2020)	Teaching Hospital, Pune, India	150 inpatient healthcare records	Random selection	Highlighted non-compliance in nursing assessments and medication documentation.
Miraj (2019)	Multispecialty Hospital, India	325 inpatient medical records	Random sampling with statistical power analysis	Demonstrated improved compliance to NABH guidelines through active audits.
Singh et al. (2019)	545-bedded Multispecialty Hospital, India	320 case sheets (40 from each of 8 departments)	Systematic random sampling	Reinforced the need for systematic, department-wide documentation audits.
Bhatia et al. (2015)	India	1,460 records (first audit), 1,402 (second audit)	Random sampling	Showed that regular internal audits improved compliance and accountability.
Alemu et al. (2024)	Wallaga University Referral Hospital, Ethiopia	385 inpatient records across 7 PDSA cycles	Not explicitly specified	Used PDSA cycles to raise documentation completeness from 53% to 82%.
Haskins et al. (2020)	Victoria, Australia (7 Hospitals)	1349 EMR Records (629 nursing + 720 medical)	Random Sampling using random	Structured monitoring improved EMR documentation

			number generator	quality and clinician engagement.

CHAPTER 3 METHODOLOGY

3.1 Study Design

This study followed a descriptive cross-sectional audit design aimed at evaluating the completeness and compliance of inpatient documentation through an open file audit. The purpose was to assess the quality and accuracy of patient records by using a standardized checklist across different inpatient departments.

3.2 Study Setting

The audit was conducted at a 100-bedded tertiary care hospital located in Jaipur. The hospital caters to a wide range of medical, surgical, and critical care patients and follows NABH accreditation standards. The selected audit areas included general inpatient wards (4th and 5th floors), MICU (Medical Intensive Care Unit), and CTVS ICU (Cardiothoracic and Vascular Surgery ICU).

3.3 Study Population

The study population consisted of inpatient records of patients admitted across various departments during the audit period. Inclusion criteria involved files that had been opened and maintained during the patient's admission period, while files that were incomplete due to premature discharge (e.g., LAMA, DAMA, or mortality within 24 hours) were excluded to maintain uniformity.

3.4 Sampling Technique

A **simple random sampling method** was used to select patient files for the audit. A total of **200 patient files** were reviewed, out of which a **sample of 100 files** was selected for detailed evaluation. This method ensured that each file had an equal chance of being included, minimizing selection bias and promoting representativeness across departments.

3.5 Data Collection Tool

The primary tool used for data collection was a structured **IPD File Audit Checklist**, which had been developed and approved by the hospital's quality department. The checklist comprised of more than 30 critical forms and documents, each associated with specific fields and expected signatories. It covered various domains such as admission and discharge records, anaesthesia and surgical documentation, nursing assessments, consent forms, and interdepartmental communication forms.

This checklist categorized each documentation field as:

- Compliant (1) – if the entry was correctly filled and signed
- Non-Compliant (0) – if the entry was either incomplete, incorrect, or missing
- Not Applicable (NA) – if the field was not relevant to the patient's case

Table 3.1

Form Name	To Be Filled By	Mandatory/Important Fields
Admission Form	Admission Clerk, Medical Officer	Risk type/clinical condition; Name of Surgery/Procedure; Signature of Doctor, Emp.ID, date & time
Triage Doctor Assessment	Casualty Medical Officer	Triage Priority; Allergies; Chief Complaints; Pain assessment; Physical Examination; Systemic Examination; Medicine Reconciliation; Communicable Disease if Any; Nutrition Orders; Investigation; Referral; Outcome; Condition at Transfer; Signatures
Doctor Initial Assessment	Medical Officer/Physician Assistant	Chief complaints; Drug Allergy; Present/Past/Family History; Medicine Reconciliation; Disposition of HBM; Height & Weight; Pain Assessment; Physical & Systemic Examination; Diagnosis; Investigation; Plan of Care; Discharge Planning; Diet Orders; Consultant Counter Signature
Progress Note	Medical Officer	Consultant note every 24 hrs; Vitals; Patient Condition
Pre-Operative Anaesthesia Assessment	Anaesthetist	Name of Surgery; Diagnosis; Allergy; Diabetes status; Medication orders; Investigations; Anaesthesia Plan; Post-Anaesthesia Care; Date, Time & Signature
Anaesthesia Record	Anaesthetist	Time of Pre-Induction; Assessment Fields; Anaesthesia Technique; Vitals Monitoring; Airway Management; Anaesthesia Start/Stop Time; Surgery Time; Ventilator Settings; Post Care Notes

Surgical Safety Checklist	Surgeon, Anaesthetist, Circulatory Nurse	Sign-In, Time-Out, Sign-Out times; Criteria Completion; Signatures
Post Anaesthesia Monitoring	Anaesthetist, Nurse	Vitals every 15 min; Aldrete Score; Vitals before shifting; Signature
OT Notes	Surgeon, Anaesthetist, Circulatory Nurse	Surgery Date/Time; Type; Name; Diagnosis; Blood Loss; Post-op Instructions; Medications; Specimen Sent; Signatures
Consent Forms	Doctor Performing Procedure or Team	Full Procedure Name; Doctor/Patient/Relative Signatures; Consent Date/Time; Risks, Benefits, Alternatives
ICU Admission Criteria	ICU Team	Admission justification; Discharge criteria
Cath Lab Admission & Post Discharge Criteria	Cardiology Department / Ward Doctor	Admission Criteria: Documented indication for procedure, assessment parameters fulfilled, justification of admission. Post Discharge Criteria: Vitals stable, bleeding controlled, patient alert and oriented, post-procedure investigations complete, final notes signed.
Triage Nursing Assessment	ER Nursing Staff	Triage Priority; Mode of Arrival; Allergies; Nutrition Screening; Mental Status; Pain Score; Vitals
Nursing Admission Assessment	Nursing Staff	Orientation; Allergy; Height/Weight; Nutrition; ADL, Functional, Psychological, Fall & Pressure Risk; Pain; Special Needs; Signatures; Discharge Handover
Daily Nursing Assessment	Nursing Staff	Vitals; Fall Risk; Pain; MEWS; I/O; Shift Notes; Counter Signatures
Nursing Log for Cath Procedure	Nursing Staff	Diagnosis; Time Out; Procedure Start Time; Monitoring; Sheath Removal; Nurse ID
Growth & Development Chart	Doctors	Filled form; Verified by Doctor

In-House Transfer Form	Doctors and Nurse	Part A; Reason & Diagnosis; Condition; Vitals; Signatures
Transfer Form to Diagnostics	Doctors and Nurse	From/To; Diagnosis & Allergy; Reason; Assessment; Pre/Post Vitals; Signatures
Consultant Referral Form	Doctors	Provisional Diagnosis; Reason for Referral; TAT
Home Medication Declaration Form	Doctors and Patient/Relative	Form Completed; Signatures with Date & Time
Authorization for Home Diet	Doctors and Patient/Relative	Authorization with Signatures & Time
Patient & Family Education	Nursing, Doctors, Dietician	PFE Assessment; Forms Filled & Signed
Sedation Record	Doctors and Nurse	Consent; Pre/Post/Intra Assessment; Monitoring; Aldrete Score
Procedure Notes	Doctors and Nurse	Time-Out/Sign-Out; Procedure Notes; Consultant Signature
Cath Lab Procedure Notes	Doctors	Time of Cath; Procedure Summary; Findings
Discharge Summary	Consultant, Nurse	Admission/Discharge Times; Diagnosis; ICD Code; Summary; Condition; Follow-Up; Patient Education; Signatures
Department of Critical Care Relative Communication Record	Critical Care Department	Notes of communication with relatives regarding patient condition, prognosis, and plan of care
Handover Form to OT/Cath Lab	Doctors and Nurse	Diagnosis; Name of Procedure; Vitals at the time of shifting; Pre-medication; Pre-procedure verification; Parameters; Handover in all three areas
Cath Lab Procedure Notes	Doctors	Procedure notes documented; Signature of consultant; Findings and interpretation
Bundle of Care Checklist	Nursing/Clinical Team	Checklist for protocol adherence in ICU including infection control, sedation, ventilation, etc.
Nutrition Assessment	Dietician	Nutrition assessment within 24 hrs;

		Reassessment notes; Plan of care
Physiotherapy Assessment	Physiotherapist	Initial assessment; Therapy plan; Reassessment and progress notes

3.6 Data Collection Procedure

The data collection process was carried out in a systematic, manual, and observational manner. The audit was personally conducted by the researcher as part of the dissertation work under the guidance of the hospital's Quality Department.

Every day, the researcher physically visited different inpatient units—4th Floor IPD, 5th Floor IPD, MICU, and CTVS ICU—and conducted on-ground audits of patient files. The selection of files was done based on a random sampling list prepared in advance, ensuring unbiased representation from each area. Upon reaching the ward, the staff nurses or floor in-charges were informed about the purpose of the audit. With appropriate permission, patient files were accessed from the nurse’s station or central filing area.

Each selected file was thoroughly reviewed on the spot using the pre-approved IPD File Audit Checklist. This checklist contained specific fields for every critical form, including clinical assessments, consent forms, nursing documentation, surgical records, transfer forms, discharge summaries, and interdepartmental communication records. The auditor checked each form for:

- Completeness (i.e., whether all fields were filled),
- Correctness (i.e., proper medical/clinical entries made), and
- Authenticity (i.e., presence of signatures, dates, and designations).

To ensure the credibility and transparency of the audit process:

- The checklist was filled immediately in the presence of the file, without retrospective entries.
- No original document was altered, and all records were returned in their original state after review.
- Queries, if any, were clarified with nursing staff or the quality team without disrupting ongoing patient care.

The study primarily employed a quantitative research approach, structured around objective data collection and statistical analysis. As the goal of the study was to assess the compliance level of documentation within patient records, the methodology was designed to measure, quantify, and analyse the extent of adherence to standard documentation protocols.

Quantitative Assessment

The backbone of this study was a quantitative assessment based on predefined checklist indicators. Each form and field within the patient file was assessed using a binary scoring method, where:

- '1' indicated compliance (i.e., the field was correctly and completely filled),
- '0' indicated non-compliance (i.e., the field was either missing or incomplete),
- 'NA' was recorded for fields that were not applicable to the specific patient's case and were excluded from scoring.

This structured scoring allowed for numerical comparison of compliance rates:

- Across different patient files,
- Among individual forms and documentation components, and
- Between different departments or units (e.g., 4th Floor, 5th Floor, MICU, CTVS ICU).

The collected scores were analysed using Microsoft Excel, where compliance percentages were calculated for each file, each form, and each area. Descriptive statistics such as averages, minimums, maximums, and compliance trends were derived to highlight both gaps and strengths in record-keeping practices.

Qualitative Observations (Embedded Informal Notes)

During the audit, real-time observations and notes were also recorded. Any issues such as missing documents, unsigned records, or incomplete assessments were noted separately. Although the study was predominantly quantitative, informal qualitative observations were also noted during the file audits. These included patterns such as:

- Frequently missed fields,
- Illegible handwriting or inconsistent formats,
- Gaps in responsibility (e.g., forms not signed by designated staff),
- Observed differences in documentation practices across floors or shifts.

While these insights were not formally coded or analysed through qualitative software, they were documented in field notes and later used to supplement the interpretation of quantitative findings in the discussion chapter. These real-world observations added depth to the numerical analysis by shedding light on potential reasons behind non-compliance, such as workload, training gaps, or systemic oversights.

The manual nature of the audit helped to gain an in-depth understanding of how documentation varies between units and shifts, and allowed identification of patterns such as frequently missed forms, units with consistently high compliance, and common errors in documentation practices.

3.7 Data Analysis Plan

The data was entered and analysed using Microsoft Excel. Each compliant (1), non-compliant (0), and NA entry was recorded per form per patient.

The data collected through the IPD File Audit Checklist was systematically analysed to assess the quality and completeness of documentation across multiple dimensions—individual patient files, specific forms, clinical areas, and specialty departments. The objective was to identify trends, strengths, and gaps in documentation that could impact patient safety, care continuity, and compliance with accreditation standards.

Microsoft Excel was used as the primary tool for data entry, score computation, and visualization. The analysis was structured around the following components:

3.7.1 File-Wise Compliance Score
File Compliance Score (%) = (Total Number of Compliant Fields / (Compliant + Non-Compliant Fields)) × 100

3.7.2 Form-Wise Compliance Score
Form Compliance Score (%) = (Number of Files with Fully Compliant Forms / Total Number of Applicable Files) × 100

3.7.3 Area-Wise (Floor-Based) Compliance Score
Area Compliance Score (%) = (Sum of File Compliance Scores in that Area / Number of Files Audited in that Area)

3.7.4 Department-Wise (Specialty-Based) Compliance Score
Average Compliance Score (Department) = Sum of File Compliance Scores for all patients in the department / Total number of patient files in that department

Departments included in the analysis:
- Pulmonology
- Urology
- Cardiology
- CTVS
- Nephrology
- General Medicine
- Neurology
- Critical Care
- Gastroenterology

3.8 Operational Definitions

To ensure clarity, consistency, and precision in interpretation, the following operational definitions were established for key terms and variables used in this study:

1. Audit

In this study, an audit is defined as a systematic, structured evaluation of patient case records to assess compliance with institutional documentation standards, clinical guidelines, and regulatory frameworks such as NABH (National Accreditation Board for Hospitals and Healthcare Providers). The audit was conducted through an observational approach using a validated checklist.

2. Open File Audit

An open file audit refers to the review of patient records during their ongoing hospitalization—that is, while the patient is still admitted. This type of audit enables real-time identification of documentation gaps and facilitates prompt feedback and rectification, thereby directly contributing to ongoing quality improvement in care delivery.

3. Closed File Audit

A closed file audit is conducted after the patient has been discharged, when the file is considered finalized and archived. It provides a retrospective review of documentation but lacks the scope for real-time correction. Unlike open file audits, it does not allow for process interventions during active care.

4. Compliance

For the purpose of this study, compliance refers to the extent to which each documentation field or form in the patient record is:

- Accurately completed as per institutional standards,
- Legibly written, and
- Authenticated with proper date, signature, and designation of the healthcare provider.

A form or field was marked as compliant if it fulfilled all the above criteria.

5. Non-Compliance

A field was marked as non-compliant if it exhibited one or more of the following issues:

- Was left blank or incomplete,
- Contained errors or illegible entries,
- Lacked required signatures, dates, or provider identification,
- Was filled by unauthorized personnel, or
- Did not meet institutional or NABH documentation standards.

6. Not Applicable (NA)

The notation Not Applicable (NA) was used when a particular field or form was not relevant to the clinical course of the patient. For example, surgical forms were considered NA for patients who had not undergone any operative procedures. NA fields were excluded from scoring to maintain accuracy in compliance calculation.

7. Compliance Score

The compliance score is a quantifiable measure of adherence to documentation standards.

8. Forms

In the context of this study, forms refer to the structured documents included in the patient's medical file, designed to capture clinical, nursing, procedural, and

administrative data. These include, but are not limited to, the Admission Form, Initial Medical and Nursing Assessments, Consent Forms, Surgical Safety Checklist, Handover Forms, and Transfer and Discharge Summaries.

9. Inpatient Department (IPD)

The Inpatient Department (IPD) refers to hospital units where patients are admitted for continuous monitoring, diagnosis, and treatment. This study involved audits conducted in four IPD settings: 4th Floor, 5th Floor, MICU, and CTVS ICU of a tertiary care hospital.

10. Checklist

The IPD File Audit Checklist is a comprehensive, itemized tool approved by the hospital's Quality Department. It includes form-wise and field-wise indicators aligned with NABH documentation requirements. The checklist served as the primary data collection instrument and allowed standardized, objective assessment of each file during the audit process.

3.9 Ethical Considerations

This study was conducted with strict adherence to ethical principles and institutional standards to ensure integrity, confidentiality, and respect for all involved stakeholders. As the nature of the study was retrospective and observational, involving record-based audits without direct patient interaction, ethical risks were minimal. Nonetheless, the following ethical measures were implemented to uphold the highest standards of academic and professional responsibility:

a. Approval and Institutional Permission

Prior to initiating the audit, formal permission was obtained from the hospital's Quality Department and the Medical Records Division. The checklist used for data collection was reviewed and approved by the internal quality team, ensuring that the audit parameters aligned with institutional policies and NABH guidelines.

b. Confidentiality and Anonymity

At no stage during the study were patient names, registration numbers, or any identifiable information recorded. All data extracted from patient files was anonymized and coded before analysis. This ensured that personal health information remained strictly confidential and was not traceable to any individual.

c. Data Security

All collected data were stored securely in a password-protected electronic format accessible only to the researcher and the academic supervisor. No hard copies of patient records were retained. Data was used exclusively for academic purposes and was destroyed upon completion of the analysis and evaluation.

d. Non-interference with Clinical Workflow

The audit was conducted in a manner that did not interfere with routine clinical operations or patient care. Files were reviewed only when they were not actively being used by the clinical team, and they were returned immediately to their place after completion of the audit.

e. Voluntary Institutional Participation

The study was part of an internship-based dissertation and did not involve any experimental intervention or data collection from patients or staff. Participation by the institution in facilitating the audit was voluntary and guided by a mutual academic objective.

f. No Manipulation or Fabrication

All data recorded and analysed in this study were based on actual observations. No information was fabricated, modified, or manipulated to influence results. The study maintained a zero-tolerance policy towards academic dishonesty and aligned fully with the plagiarism and ethics policy of IIHMR University.

g. Transparency and Accountability

Throughout the audit process, the researcher maintained transparent communication with the hospital's quality team, periodically updating them about the progress and findings. Any ambiguity in interpretation of documentation was discussed with the quality department to avoid misreporting.

CHAPTER 4: RESULTS

This chapter presents a comprehensive analysis of the documentation audit findings, derived from a systematic evaluation of inpatient records using a standardized audit checklist. The objective was to critically assess the compliance level of essential clinical and administrative forms, determine variability across departments and care areas, and identify patterns of non-compliance that may impact patient safety, operational efficiency, and regulatory adherence.

The data collected through this audit has been carefully organized and analysed using quantitative methods. Compliance scores were calculated for individual forms, patient records, and departments to derive actionable insights. These findings have been visually represented through a series of bar graphs, classification charts, and contribution-based analyses to enhance clarity and support data-driven decision-making.

Beyond the numerical trends, this chapter brings to light key areas of concern that consistently contribute to documentation deficiencies—particularly forms such as progress notes, doctor's initial assessment, and consent forms. By isolating high-impact gaps, the analysis paves the way for focused quality improvement efforts that are both targeted and sustainable.

Furthermore, the chapter emphasizes the importance of inter-departmental comparisons, which reveal how documentation standards vary across specialties, and offers a critical lens to understand where interventions are most urgently needed. Together, these results form a crucial foundation for the discussion and recommendations in the following chapter, enabling the translation of data into meaningful organizational improvements.

4.1 Form-Wise Compliance Classification

This chart categorizes forms into three compliance zones: High, Moderate, and Low. It acts as a diagnostic tool to assess which parts of the patient record are consistently well-maintained and which are most often neglected.

Forms with high compliance, such as Nutrition Assessment and Physiotherapy Assessment, often have simpler formats and are completed by staff who are solely responsible for that domain. Their structured nature and limited subjectivity make them easier to complete correctly and uniformly.

In contrast, Progress Notes, Consent Forms, and Doctor's Initial Assessment fall into the low compliance category. These are often detailed forms requiring multi-step documentation, critical clinical reasoning, and coordination between departments. For instance, consent forms involve patient counselling, signature capture, and witness authentication—steps that may be missed due to time constraints or workflow disruptions.

This classification underscores the need to prioritize the improvement of low-performing forms, not just because they're non-compliant but because they directly impact patient care, legal safety, and accreditation outcomes.

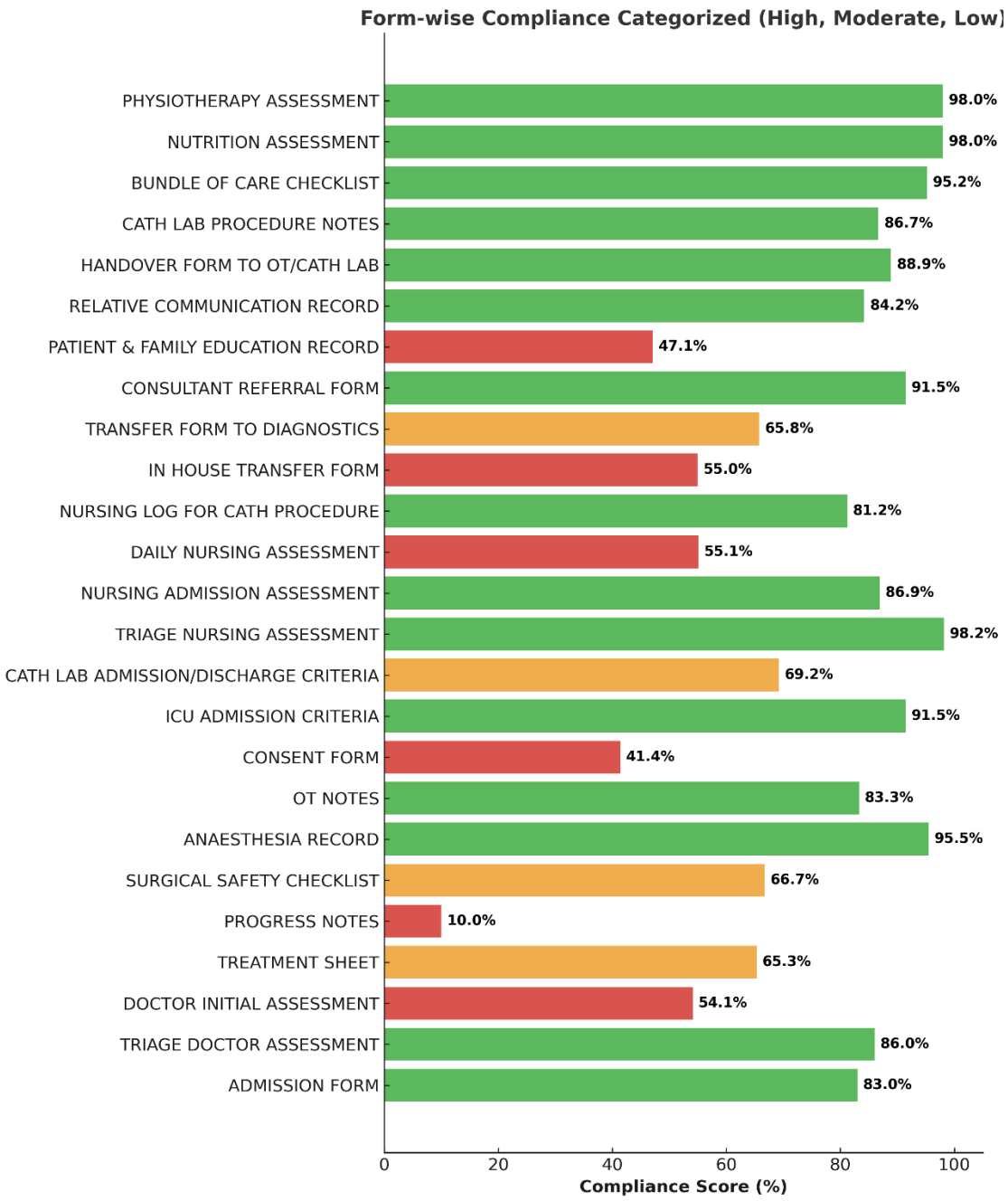


Figure 4.1

4.2 Department-Wise Compliance Scores

This visual representation dissects average file compliance scores across different medical specialties. Each department's performance offers insights into the strengths and weaknesses of documentation culture within the hospital.

Departments like CTVS (82.9%) and Obs & Gynae (77.5%) emerged as the most compliant. These departments typically manage more structured or elective cases, where documentation protocols are well-defined and followed with discipline. Additionally, smaller patient volumes and greater familiarity with case types may contribute to more complete documentation.

In contrast, departments such as Paediatrics (59.1%), Nephrology, and Orthopaedics showed relatively poor compliance. The reasons may include frequent emergencies, high patient turnover, or a lack of emphasis on documentation during busy clinical hours. Paediatrics, for example, often deals with complex medication orders and consent processes involving guardians, increasing the risk of missed or incomplete entries.

This department-wise analysis brings to light critical improvement areas. It points to the necessity of department-specific interventions, such as training programs, documentation audits, or accountability systems that can cater to the unique challenges faced by different clinical teams.

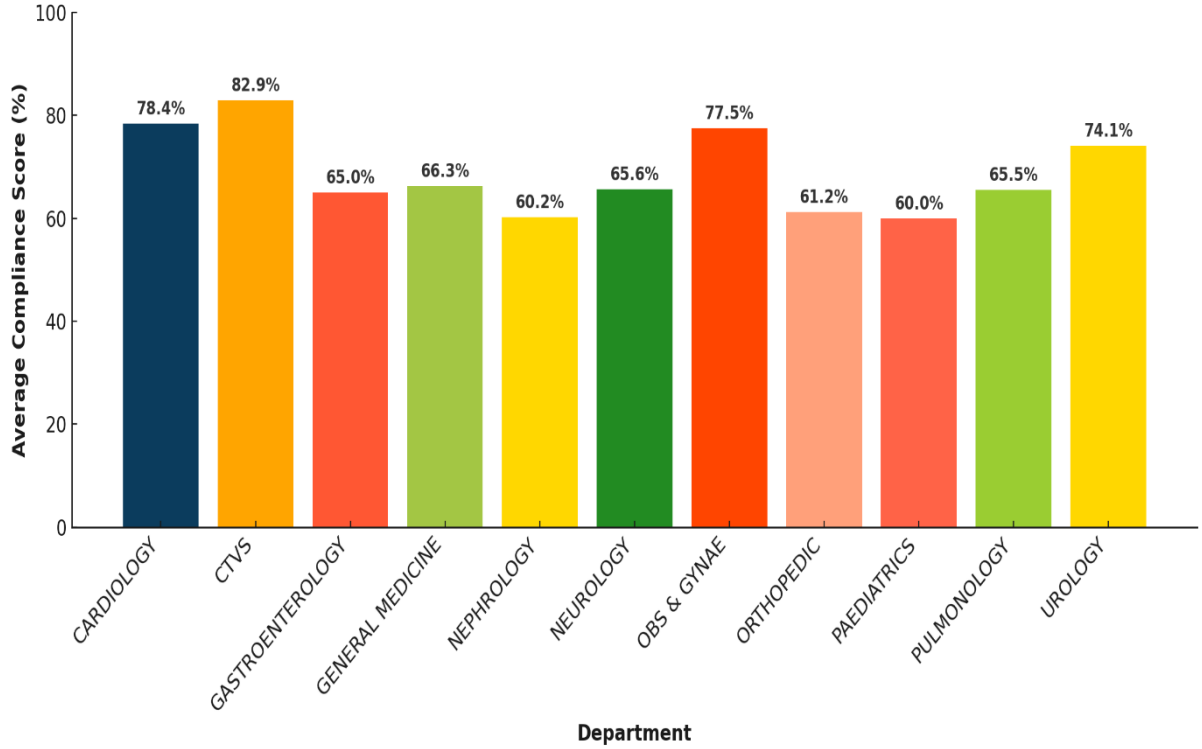


Figure 4.2

4.3 Area-Wise Compliance Scores – 4th Floor, 5th Floor, MICU, and CTVS ICU

This chart provides a comparative overview of documentation compliance across various inpatient care areas. The results reveal a noticeable pattern in how thoroughly patient records are maintained in each location. Among the audited areas, CTVS ICU and MICU demonstrated relatively higher compliance scores. These are both critical care units, where documentation is often more rigorous due to the complexity and acuity of patient care. The heightened vigilance in these areas likely contributes to better compliance, as clinical decisions in intensive care depend heavily on real-time and accurate documentation.

On the other hand, general wards such as the 4th Floor and 5th Floor IPD displayed a broader range and, at times, lower compliance percentages. This variability may stem from several systemic and operational factors. For example, staff in general wards often juggle a higher volume of routine admissions and discharges, leading to potential lapses in documentation. The rotational staffing pattern and limited monitoring might further reduce the consistency of entries.

These findings suggest that while documentation practices are relatively strong in ICU settings, additional support, supervision, and standardization efforts are needed in general wards to raise the overall compliance benchmark of the hospital.

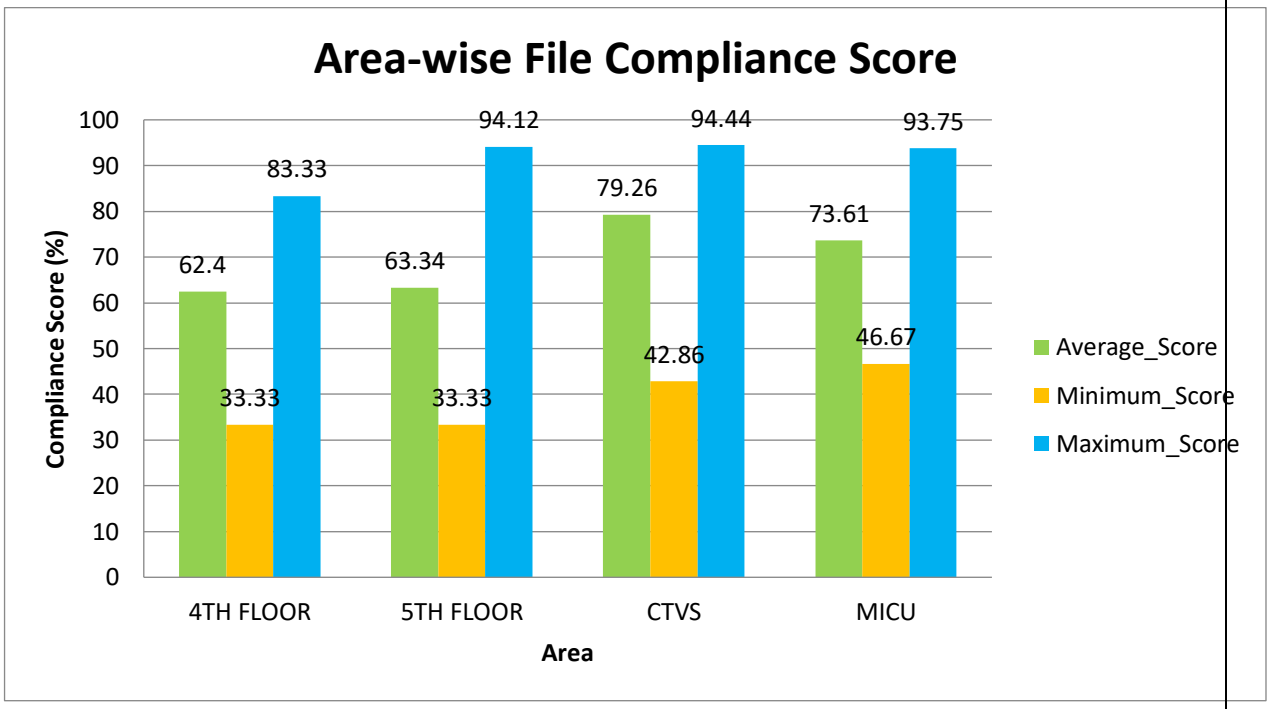


Figure 4.3

4.4 Contribution of Key Forms to Total Non-Compliance

During the audit of inpatient records, a total of 44 documentation forms were reviewed across multiple clinical areas. Upon analysing the non-compliance distribution, it was observed that five specific forms—Treatment Sheet, Progress Notes, Doctor's Initial Assessment, Consent Forms, and Daily Nursing Assessment—together accounted for approximately 44% of the total documentation-related non-compliance identified during the study.

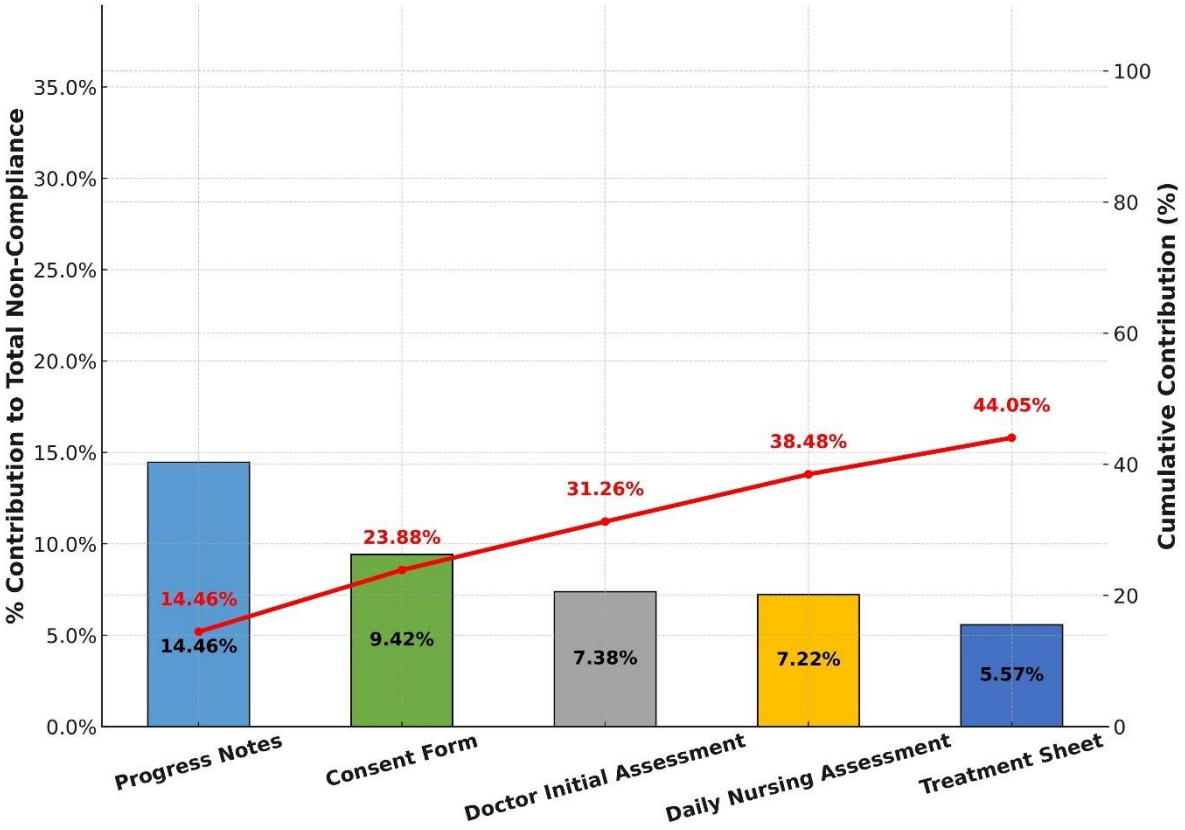
These forms were not selected in advance, but rather emerged organically from the data as the top contributors to documentation gaps. Their high share of non-compliance is especially significant given their essential role in patient care processes, including medical evaluation, daily treatment updates, clinical decision-making, and legal consent.

This data-driven insight suggests that documentation deficiencies are not uniformly spread across all forms, but instead are concentrated in a small number of clinically important areas. This naturally points toward the need for targeted interventions in these specific formats. By improving the completeness, accuracy, and standardization of these forms—through focused staff training, revised protocols, and regular compliance audits—the hospital can potentially address nearly half of its total documentation non-compliance.

Such an approach is not only practical but also strategically aligned with patient safety objectives and regulatory standards, making it an effective starting point for documentation quality improvement initiatives

Figure 4.4

This insight holds powerful implications: focusing on these five forms—through structured formats, checklists, periodic audits, and staff sensitization—can address nearly half of the documentation issues. From a hospital operations and quality



improvement standpoint, this is a highly efficient strategy, both in terms of resource allocation and clinical impact.

CHAPTER 5: DISCUSSION

Documentation serves as the backbone of safe, effective, and accountable patient care. In a healthcare setting, every form filled, note written, and signature added contributes not just to clinical continuity, but also to legal defensibility and accreditation standards like NABH. The purpose of this chapter is to interpret and critically evaluate the findings derived from the file audit, presenting both quantitative results and qualitative insights that emerged during the process. By identifying form-specific gaps, highlighting recurring compliance challenges, and contextualizing these issues within the broader framework of hospital operations, this discussion aims to provide a meaningful understanding of how documentation practices reflect organizational discipline, team coordination, and patient-centred care. The section also outlines the strengths and limitations of the study, helping readers assess the robustness of findings and offering direction for future improvement efforts.

5.1 Documentation Gap Analysis: A Form-Wise Evaluation

A critical component of this open file audit involved not only evaluating the overall compliance score of documentation but also identifying form-specific deficiencies that contributed to non-compliance. This qualitative analysis highlights the recurring issues across each form, revealing patterns that require attention for improving clinical governance and NABH accreditation readiness.

The findings demonstrate that even in forms with relatively high compliance scores, minor but critical fields were often left incomplete. On the other hand, forms with moderate or low compliance showed multiple lapses, particularly in areas such as signatures, clinical reasoning, medication details, and interdepartmental handovers. The following section presents a detailed narrative of the gap areas observed in individual forms:

The Admission Form, with a compliance score of 83%, revealed that while basic demographic details were well captured, crucial clinical indicators such as the risk type and reason for admission or procedure were often missing. These omissions affect the quality of triage, initial care planning, and medico-legal accountability.

In the Triage Doctor Assessment form (85.96%), gaps included missing medical reconciliation, triage categorization, and vital parameters at the time of patient transfer. Furthermore, names and signatures of both transferring and receiving doctors were not consistently documented—an essential step for ensuring clinical accountability during handovers.

The Doctor Initial Assessment form had a relatively low compliance score of 54.08%. Major issues included absence of consultant signatures within the required 24-hour window, incomplete vital signs, and pain assessments. Medical reconciliation was frequently overlooked. Given that this form serves as the clinical foundation for all future interventions, these gaps can severely affect treatment planning and legal documentation.

The Treatment Sheet (65.31%) also displayed considerable documentation lapses. Common gaps included non-use of capital letters for medication names, absence of generic names, and omitted antimicrobial indications. Key parameters such as frequency, route, and start time of medications were often unfilled. In some cases, unapproved abbreviations were used, which may contribute to medication errors.

Alarmingly, Progress Notes recorded the lowest compliance at just 10%. Most files lacked date, time, doctor's name, signature, or legible narrative. Critical updates on patient condition or treatment response were either incomplete or entirely absent. These notes are pivotal for continuity of care and interdisciplinary communication. Their poor completion reflects a systemic gap in clinical engagement with documentation.

The Surgical Safety Checklist (66.67%) revealed that key checkpoints under Sign In, Time Out, and Sign Out—such as post-operative precautions, antibiotic prophylaxis, and site preparation verification—were often left unmarked. This form is essential for preventing wrong-site surgery and ensuring intraoperative safety, making these omissions highly concerning.

The Anaesthesia Record scored well (95.45%) but had occasional gaps in recording the time of shifting, anaesthetist's signature, and documentation of post-operative complications. In high-risk procedures, this can impact immediate post-operative care.

Similarly, OT Notes (83.33%) had unfilled fields for date of operation, type of surgery, pre- and post-operative diagnosis, and estimated blood loss. These omissions affect the traceability of surgical procedures and are crucial during quality reviews and audits.

In the Consent Forms, only 41.41% compliance was observed. Issues ranged from missing witness signatures and guardian consent reasons to unmarked high-risk consent and incomplete physical condition assessment. This severely compromises the ethical and legal sanctity of the consent process, especially for surgical and invasive procedures.

In specialty-specific forms like the ICU Admission Criteria (91.53%) and Cath Lab Admission/Discharge Form (69.23%), there were gaps in documenting discharge eligibility, diagnosis parameters, and doctors' verification with date/time, which are important for monitoring patient transitions in and out of critical care.

The Daily Nursing Assessment (55.1%) lacked shift handover notes, countersignatures by the shift in-charge, and documentation of background conditions. This form plays a key role in 24/7 patient monitoring, and its incompleteness could jeopardize timely interventions.

For the Nursing Log for Cath Procedures (81.25%), the most frequent lapse was partially filled intra-procedure monitoring details. In the In-House Transfer Form (55%), patient condition, staff names, and handover timestamps were inadequately documented, risking miscommunication during departmental shifts.

The Transfer to Diagnostics Form (65.85%) often missed procedure names, vital signs before shifting, and confirmation of handover. These fields are essential when moving patients for imaging, endoscopy, or Cath lab procedures.

The Consultant Referral Form (91.49%) was well maintained in most cases, but lacked referral priority, reason for referral, and timing details, especially when multiple departments were involved.

The Patient & Family Education Record (47.06%) was found to be poorly maintained. Documentation by the nurse, doctor, or dietician was frequently missing, representing missed opportunities for patient empowerment and participatory care.

In the Relative Communication Record (84.21%), gaps such as severity of illness updates, team signatures, and attendant acknowledgment were often observed—critical for maintaining transparency and preparing families for clinical escalation.

Handover to OT/Cath Lab Forms (88.89%) had minor lapses, mostly in mentioning the procedure name or date. Finally, the Bundle of Care Checklist (95.24%) showed high compliance but still had missing signatures and employee IDs of the in-charge, which affects accountability.

5.2 Strengths of the Study

This study demonstrates several noteworthy strengths that enhance its credibility and practical relevance:

- **Structured and Real-Time Data Collection:** The audit was conducted manually and in real-time, allowing the researcher to observe the actual state of documentation at the point of care. This approach minimized the risk of retrospective bias and enhanced the accuracy of compliance scoring.
- **Holistic and Comprehensive Audit Tool:** A well-defined, hospital-approved checklist was used to assess a wide spectrum of forms—from clinical and nursing documentation to surgical and consent forms—making the evaluation comprehensive in nature.
- **Department-Wise and Form-Wise Analysis:** By calculating both form-wise and department-wise compliance scores, the study offers multidimensional insights into documentation performance, helping pinpoint specific units and formats requiring intervention.
- **Balanced Methodology:** While predominantly quantitative, the study also incorporated qualitative observations such as illegible handwriting, signature lapses, and workflow issues, which enriched the interpretation of numerical trends.
- **Clinical Relevance:** The study focused on forms that are critical to patient safety, medico-legal accountability, and NABH compliance, making the findings practically actionable for hospital administrators and quality managers.

5.3 Limitations of the Study

Despite its strengths, the study has certain limitations that should be acknowledged:

- **Limited Time Frame:** The data collection was restricted to a specific audit period, which may not reflect variations in documentation quality across different months or staffing patterns.
- **Manual Audit Bias:** Since the audit was performed manually, there is a possibility of observer bias or subjective judgment, particularly when classifying borderline compliance cases.
- **Single-Centre Study:** The audit was confined to one tertiary care hospital, which may limit the generalizability of findings to other healthcare settings with different documentation practices or resource availability.
- **Exclusion of Electronic Health Records (EHR):** The focus was solely on paper-based files. Any improvements or deficiencies in digital documentation were outside the scope of this study, potentially omitting key trends in institutions transitioning to EHR systems.
- **Non-Interventional Design:** The study was observational in nature and did not involve implementation of any corrective measures. Hence, while it identifies gaps, it does not evaluate the effectiveness of proposed solutions.

CHAPTER 6: CONCLUSION

6.1 Summary of the Study

This study was conducted with the objective of assessing the quality and completeness of inpatient documentation through an open file audit approach. A total of 100 patient files were randomly selected and audited using a structured checklist approved by the hospital's Quality Department. The audit was conducted across different units including the 4th and 5th floor IPDs, MICU, and CTVS ICU. The checklist evaluated documentation compliance across various clinical and administrative forms.

The study utilized a primarily quantitative approach supported by observational qualitative insights. Compliance scores were calculated form-wise, file-wise, and department-wise. Tools such as Pareto analysis, bar charts, and department compliance dashboards were employed to highlight the extent and pattern of non-compliance. Gap areas were identified in critical documents such as the Doctor's Initial Assessment, Treatment Sheets, Progress Notes, Consent Forms, and Daily Nursing Assessments.

Key findings revealed that while some forms like Anaesthesia Record and ICU Admission Criteria showed high compliance (>90%), others—especially those related to daily care and clinical assessments—exhibited significant lapses. Major gaps included missing signatures, incomplete vitals, absent medication details, and improper use of abbreviations. Additionally, a few forms such as Progress Notes and Consent Forms alone contributed to nearly half of the total documentation-related non-compliance.

6.2 Conclusion

The findings of this study underline a critical challenge in inpatient documentation—while most forms are in use, a large number are not being filled completely or correctly. This compromises not only patient safety and continuity of care but also medico-legal accountability and accreditation readiness (NABH).

The audit identified specific forms and departments where documentation gaps are recurring and significant. These deficiencies often stem from inconsistent practices, lack of training, time constraints, and limited awareness about the importance of detailed record-keeping. Thus, focused improvement in just a few high-impact forms can significantly enhance the hospital's overall compliance.

Overall, the study reinforces that documentation is not merely an administrative requirement but a vital component of quality clinical care.

6.3 Recommendations

1.Dedicated Documentation Time Block at End of Shift

To strengthen the quality of clinical records, it is recommended that each nursing and junior doctor shift include a dedicated 10–15-minute window exclusively for documentation. This time block will be reserved at the end of every shift to allow staff to complete and review their entries — such as vital signs, medication records,

treatment notes, and required signatures — without the distraction of ongoing patient care or the rush of shift handover. The Nursing In-Charge or senior JR will announce a formal "documentation wrap-up" before shift closure, ensuring that this process becomes a routine expectation. This strategy requires no additional manpower or paperwork — it simply restructures the shift timeline to prioritize documentation before duty sign-off. By institutionalizing this brief yet focused buffer, we can significantly reduce omissions, retrospective entries, and documentation errors — all while directly supporting NABH compliance for timely, legible, and authenticated medical records.

2.Shift-End Documentation Review by Nursing In-Charge with Accountability Sign-Off

To ensure documentation is not just completed, but cross-checked for quality, it is proposed that the Nursing In-Charge or unit coordinator conduct a structured documentation review before each shift handover. Approximately 20 minutes before the end of a shift, they will make rounds to verify that all mandatory fields are filled — including assessment forms, medication charts, nursing notes, and progress entries. Any missing or incomplete documentation will be flagged and corrected in real-time, before the next team takes over. To reinforce accountability, a checkbox titled "Documentation completed & cross-checked: Yes/No" will be included in the shift handover log, to be signed by both the outgoing staff and the In-Charge. This approach introduces no additional forms or steps — it integrates quality review into existing workflows. Most importantly, it creates a culture where documentation compliance is owned by teams at the frontline, not left for back-end correction after discharge.

3.Link Documentation Compliance to Performance Evaluation

Despite repeated sensitization efforts and informal reminders, certain staff members—including Junior Residents and nursing personnel continue to exhibit recurring documentation gaps. To address repeated documentation lapses and foster long-term accountability, it is recommended that documentation compliance be formally integrated into staff performance evaluation processes.

Implementation Strategy:

- Audit-Based Tracking:
  Use data from routine file audits conducted by the Quality or MRD teams to identify staff who consistently default on documentation standards. Patterns of non-compliance should be tracked form-wise and individual-wise over 2–3 audit cycles.
- Verbal Counselling as First Response:
  Initial lapses can be addressed through direct verbal feedback and counselling by Nursing In-Charges or Unit Heads, with documentation gaps explained constructively.
- Escalation to Appraisal Systems:
  In cases where the same individuals continue to default despite repeated reminders, their names should be formally shared with department heads. These patterns must be reflected in their performance appraisals or mid-term evaluations as part of quality-related KPIs.

This approach promotes behavioural change through accountability and sends a clear institutional message that documentation quality is not optional but a professional responsibility.

4.**On-Spot File Audit System and WhatsApp-Based Feedback Loop for Documentation** Compliance

To enhance real-time documentation accuracy and accountability across departments, it is recommended to initiate a two-pronged approach: a Spot File Audit System complemented by a WhatsApp-based Quality Feedback mechanism.

Under the Spot Audit initiative, the Quality Department will conduct informal daily reviews of 2–3 randomly selected patient files per clinical unit. These reviews will focus on identifying common documentation gaps — such as missing consultant signatures, incomplete treatment sheets, unrecorded vital signs, and use of unapproved abbreviations. The key objective is not punitive action, but to provide immediate feedback and promote corrective behaviour at the source.

To enable swift and transparent communication, a dedicated WhatsApp group titled *Quality Documentation Updates* will be created. The group should include key stakeholders such as representatives from Quality, MRD, Nursing In-Charges, and Junior Residents. This platform will serve as a dynamic tool to:

- Share snapshots of non-compliant documentation,
- Deliver real-time guidance on how to correct the observed errors and prevent recurrence.
- Foster daily learning, with one update each day highlighting a common documentation lapse and a practical solution.

This method ensures that audit observations do not remain confined to internal reporting, but are transformed into learning opportunities accessible to all relevant staff. It builds awareness, encourages peer accountability, and reduces repetitive errors — all without introducing additional paperwork or formal reporting burden.

By integrating this immediate feedback model into the daily workflow, the hospital can create a culture of continuous documentation vigilance, improve readiness for NABH audits, and promote high-quality patient care records in a sustainable and cost-effective manner.

5.Incorporating Documentation Training into Staff Induction

As part of strengthening documentation quality across the hospital, it is recommended that a dedicated Documentation Training Module be made an integral component of the induction program for all newly joined staff, including nurses, junior doctors, and paramedics.

This session should cover NABH-aligned documentation standards, emphasizing the importance of accurate, timely, and complete entries in clinical and administrative records. The training must also highlight common documentation errors, such as missing signatures, incomplete forms, or use of unapproved abbreviations—explaining their potential clinical, legal, and accreditation-related consequences.

By sensitizing staff right at the point of onboarding, we create early awareness, set clear expectations, and build a culture of accountability from day one. This not only improves individual compliance but also contributes to the organization's readiness for internal and external audits, including NABH inspections.

To reinforce learning, the training can include case scenarios, real examples of non-compliance, and short assessments. This approach ensures that documentation excellence becomes a shared responsibility across all cadres from the very beginning of their tenure.

6.Monthly Compliance Monitoring & Trend Analysis

To strengthen documentation practices and ensure continuous improvement, a focused monthly monitoring system should be implemented. The Quality Team will generate form-wise and area-wise compliance dashboards every month, highlighting key documentation gaps and trends over time. These dashboards will help track progress, identify recurring issues, and provide a visual snapshot of department-wise performance.

By regularly reviewing these dashboards, Nursing In-Charges and Department Heads can take timely corrective actions, such as targeted reinforcement, on-the-spot guidance, or team-level sensitization in low-performing areas. Sharing monthly trends fosters accountability and enables departments to monitor improvements or deterioration in compliance.

This structured, data-driven approach keeps documentation quality under active review and integrates well into monthly operational meetings—ensuring sustained focus without adding paperwork or extra manpower.

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