

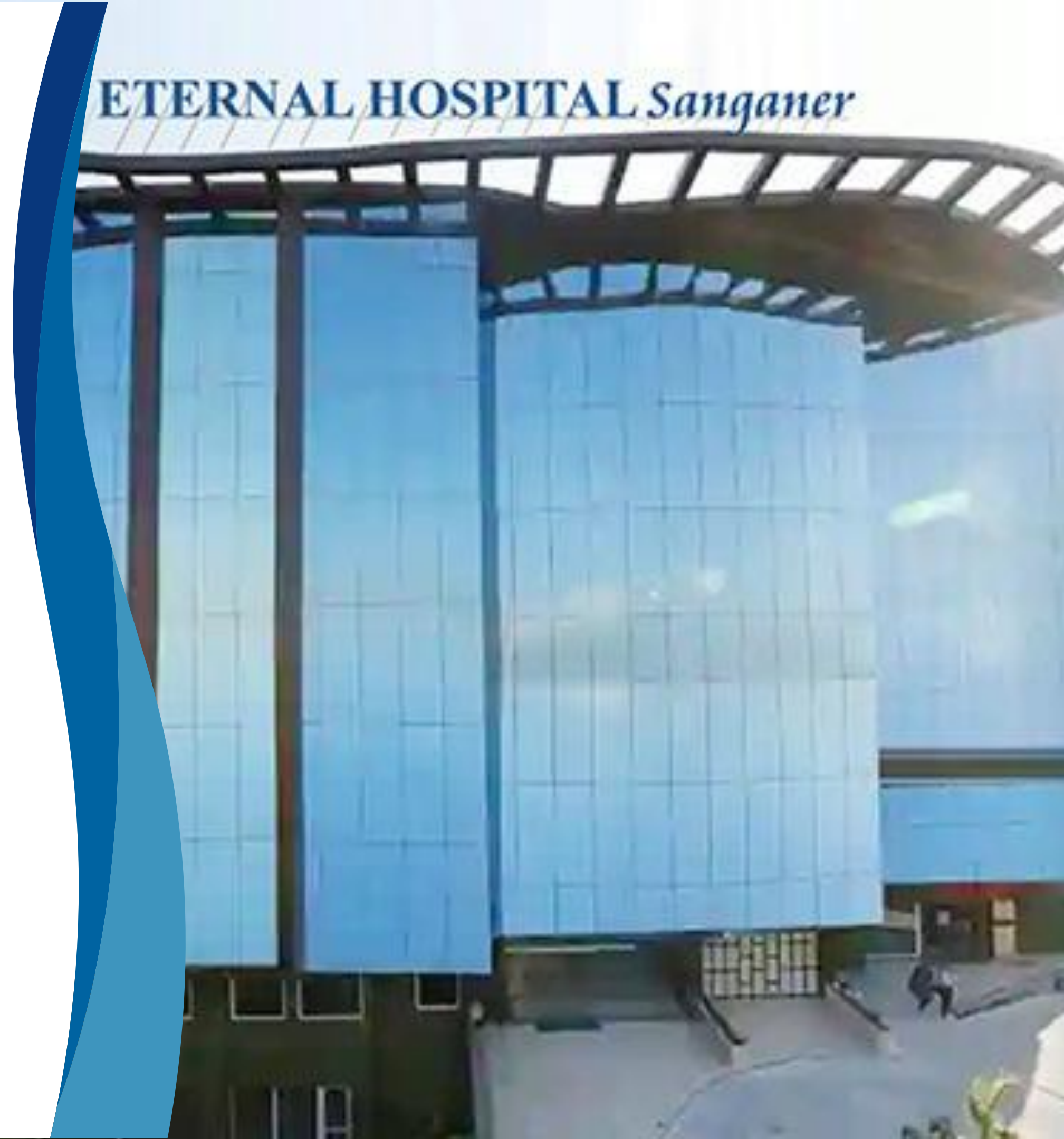
ASSESSING THE QUALITY OF MEDICAL RECORDS THROUGH OPEN FILE AUDIT



PRESENTED BY

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OVERVIEW

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. Accurate documentation is a core requirement under NABH standards. This audit provides evidence-based insights that can improve compliance and prepare effectively for upcoming re-accreditation.

OBJECTIVES

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



LITERATURE REVIEW



Maintaining high-quality documentation in inpatient records is crucial for ensuring continuity of care, meeting regulatory standards, and supporting hospital accreditation processes. Several studies have explored interventions and audits aimed at improving the quality and completeness of inpatient medical records. A clinical audit examining inpatient medical record documentation revealed notable gaps and deviations from established standards. The audit highlighted the significance of systematic evaluations to detect defects and proposed corrective measures to enhance documentation practices (1). Similarly, an audit conducted at a teaching hospital in Pune assessed 150 inpatient healthcare records using a comprehensive 52-item tool. It identified major non-compliance issues, particularly concerning nursing assessments and medication administration documentation, emphasizing the value of regular audits in addressing documentation shortcomings (2).

Focusing on a structured approach, a prospective observational study by Miraj evaluated the effectiveness of active clinical audits in a multispecialty hospital setting. The research demonstrated that adherence to National Accreditation Board of Hospitals (NABH) guidelines improved through regular audits, though deficiencies in outcome documentation and discharge summaries persisted. The study stressed the importance of ongoing staff education and regular review processes (3). In a similar vein, a retrospective descriptive study conducted in a 545-bedded multispecialty hospital in India assessed documentation compliance across various departments. Singh et al. found that numerous departments failed to meet established documentation policies, thereby reinforcing the critical need for systematic and department-wide auditing to ensure comprehensive record-keeping and patient care continuity (4).

The role of internal auditing was further explored in a comparative analysis study, which demonstrated that regular internal audits significantly improved the quality of medical records over time. This research illustrated that internal assessments not only enhanced compliance but also cultivated a culture of accountability among healthcare providers (5).

A quality improvement project carried out at Wallaga University Referral Hospital aimed to raise medical record completeness from 53% to 80% over an eight-month period. Utilizing the Plan-Do-Study-Act (PDSA) cycles, the intervention focused on staff orientation, ensuring the availability of essential materials, and empowering individual hospital departments. The project showed substantial improvement, affirming the effectiveness of structured quality improvement initiatives (6).

In the context of electronic medical record (EMR) systems, a large-scale quality improvement program was developed post-EMR implementation to monitor clinician adoption, documentation quality, and workflow compliance. The study underscored that enhancing documentation practices through structured monitoring programs directly supports high-quality patient care and improves clinician engagement with electronic systems (7).

Collectively, these studies provide compelling evidence that active and internal audits, structured quality improvement initiatives, and systematic monitoring significantly contribute to improving the quality and completeness of inpatient medical records. Regular auditing practices, staff training, departmental empowerment, and the adoption of digital systems are key strategies for sustaining documentation excellence in hospital settings.



METHODOLOGY

STUDY DESIGN

Descriptive Cross Sectional Study

STUDY POPULATION

Inclusion Criteria:

Medical records of IPD patients admitted between in following areas

1. 4th Floor (Deluxe & Semi Deluxe Private Wards)
2. 5th Floor (Deluxe & Semi Deluxe Private Wards)
3. MICU
4. CTVS-ICU

Exclusion Criteria:

1. Patients who left against medical advice (LAMA).
2. Patients transferred to other healthcare facilities.
3. Patients who expired during their hospital stay.

SAMPLE SIZE & SAMLING 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.

DATA COLLECTION TOOL

- The primary tool used for data collection was a structured IPD File Audit Checklist, which had been approved by the hospital's quality department.
- This checklist categorized each documentation field as:
 1. Compliant (1) – if the entry was correctly filled and signed
 2. Non-Compliant (0) – if the entry was either incomplete, incorrect, or missing
 3. Not Applicable (NA) – if the field was not relevant to the patient's case





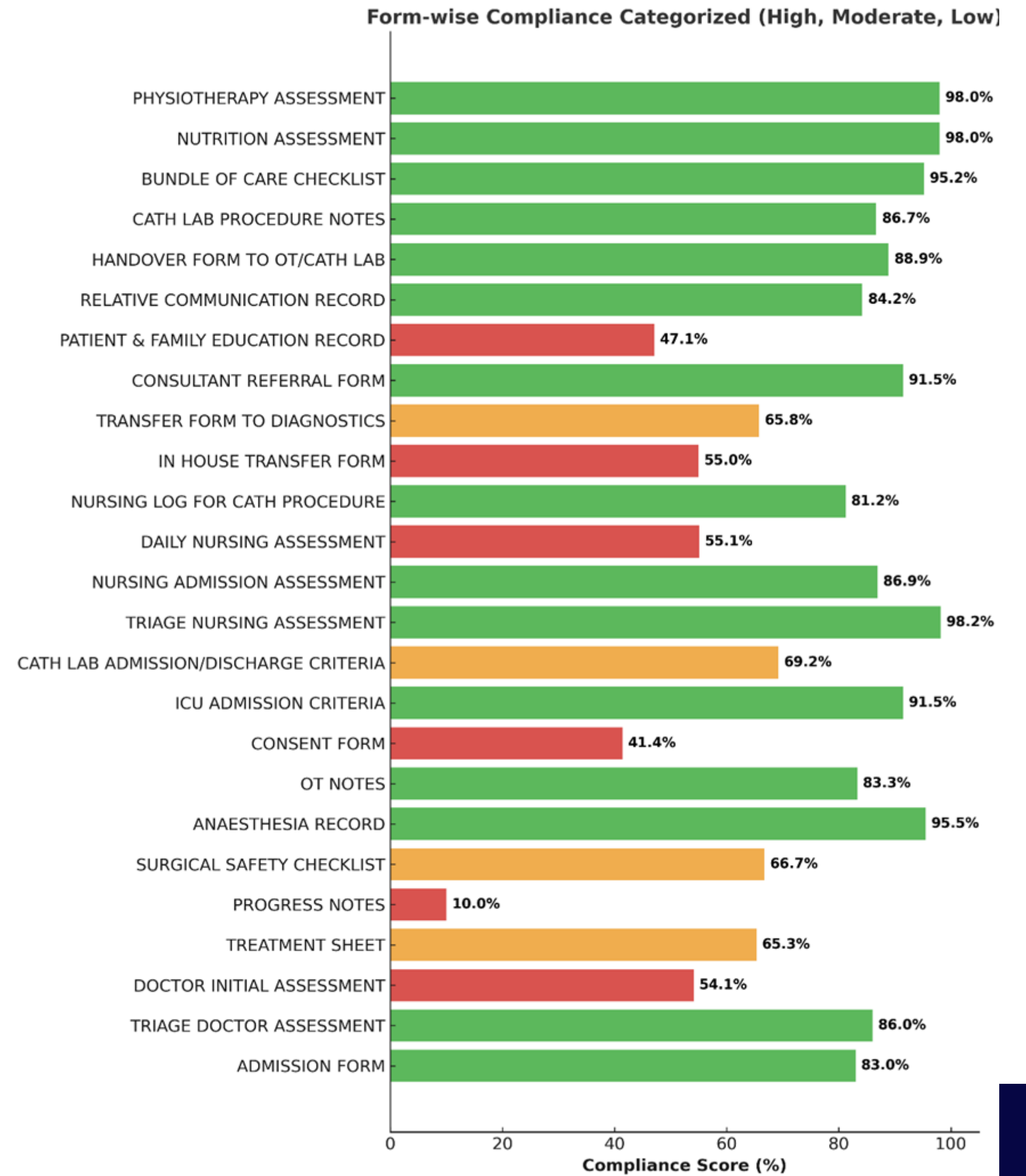
Form Name	To Be Filled By	Mandatory/Important Fields
Admission Form	Admission Clerk, Medical Officer	Risk type/clinical condition; Name
Triage Doctor Assessment	Casualty Medical Officer	Triage Priority; Allergies; Chief
Doctor Initial Assessment	Medical Officer/Physician	Chief complaints; Drug Allergy;
Progress Note	Medical Officer	Consultant note every 24 hrs;
Pre-Operative Anaesthesia Assessment	Anaesthetist	Name of Surgery; Diagnosis;
Anaesthesia Record	Anaesthetist	Time of Pre-Induction;
Surgical Safety Checklist	Surgeon, Anaesthetist,	Sign-In, Time-Out, Sign-Out times;
Post Anaesthesia Monitoring	Anaesthetist, Nurse	Vitals every 15 min; Aldrete
OT Notes	Surgeon, Anaesthetist,	Surgery Date/Time; Type;
Consent Forms	Doctor Performing	Full Procedure Name;

Form Name	To Be Filled By	Mandatory/Important Fields
Home Medication Declaration Form	Doctors and Patient/Relative	Form Completed; Signatures with
Authorization for Home Diet	Doctors and Patient/Relative	Authorization with Signatures &
Patient & Family Education	Nursing, Doctors, Dietician	PFE Assessment; Forms Filled &
Sedation Record	Doctors and Nurse	Consent; Pre/Post/Intra
Procedure Notes	Doctors and Nurse	Time-Out/Sign-Out; Procedure
Cath Lab Procedure Notes	Doctors	Time of Cath; Procedure
Discharge Summary	Consultant, Nurse	Admission/Discharge Times;
Dept. of Critical Care Relative Communication Record	Critical Care Department	Notes of communication
Handover Form to OT/Cath Lab	Doctors and Nurse	Diagnosis; Name of Procedure;
Cath Lab Procedure Notes	Doctors	Procedure notes documented;

Form Name	To Be Filled By	Mandatory/Important Fields
ICU Admission Criteria	ICU Team	Admission justification;
Cath Lab Admission & Post Discharge Criteria	Cardiology Dept / Ward Doctor	Admission Criteria;
Triage Nursing Assessment	ER Nursing Staff	Triage Priority; Mode of Arrival;
Nursing Admission Assessment	Nursing Staff	Orientation; Allergy;
Daily Nursing Assessment	Nursing Staff	Vitals; Fall Risk; Pain; MEWS; I/O;
Nursing Log for Cath Procedure	Nursing Staff	Diagnosis; Time Out; Procedure
Growth & Development Chart	Doctors	Filled form; Verified by
In-House Transfer Form	Doctors and Nurse	Part A; Reason & Diagnosis;
Transfer Form to Diagnostics	Doctors and Nurse	From/To; Diagnosis &
Consultant Referral Form	Doctors	Provisional Diagnosis; Reason

Form Name	To Be Filled By	Mandatory/Important Fields
Bundle of Care Checklist	Nursing/Clinical Team	Checklist for protocol adherence in ICU including infection control, sedation, ...
Nutrition Assessment	Dietician	Nutrition assessment within 24 hrs; Reassessment notes; Plan of care
Physiotherapy Assessment	Physiotherapist	Initial assessment; Therapy plan; Reassessment and progress notes

FINDINGS

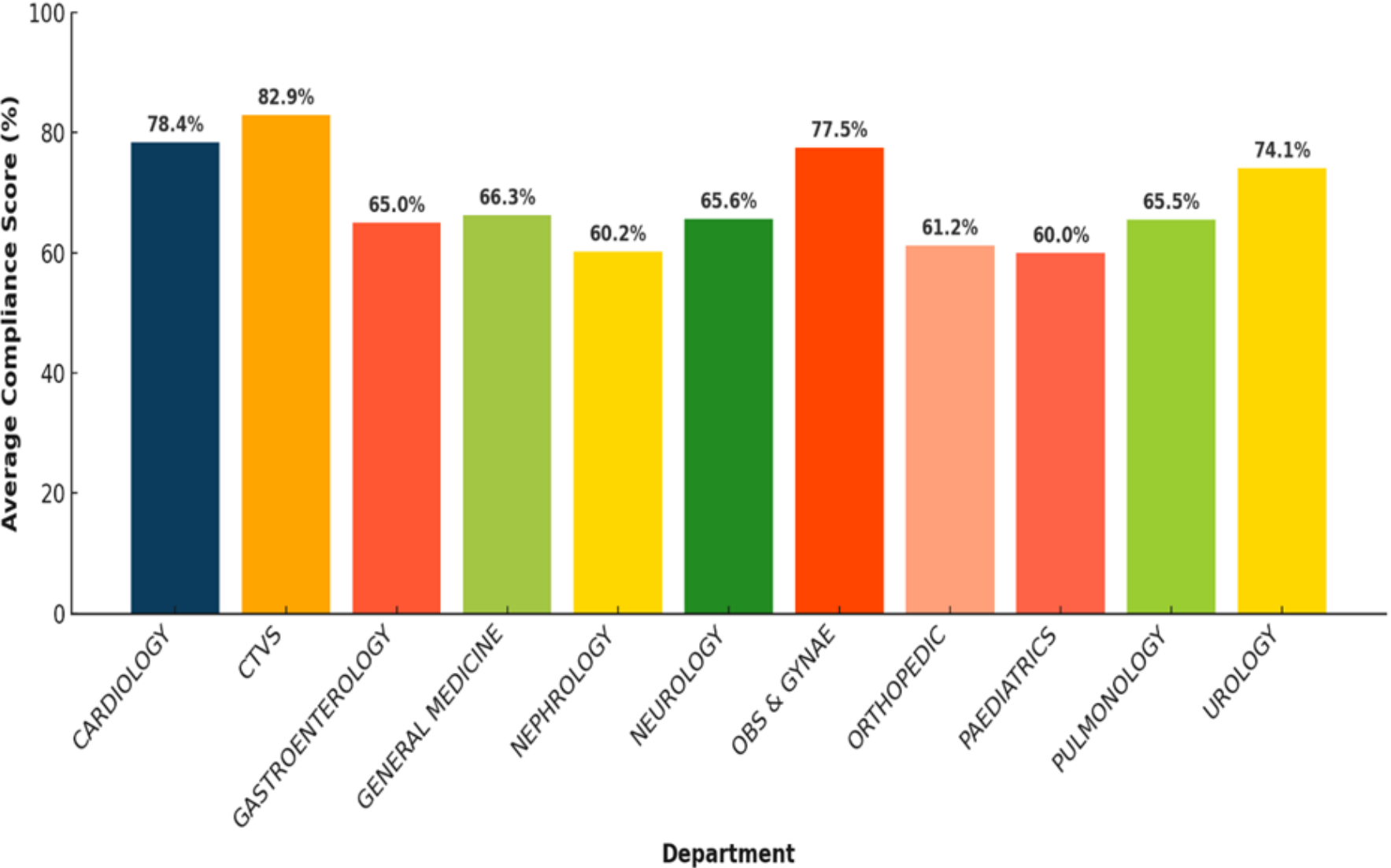
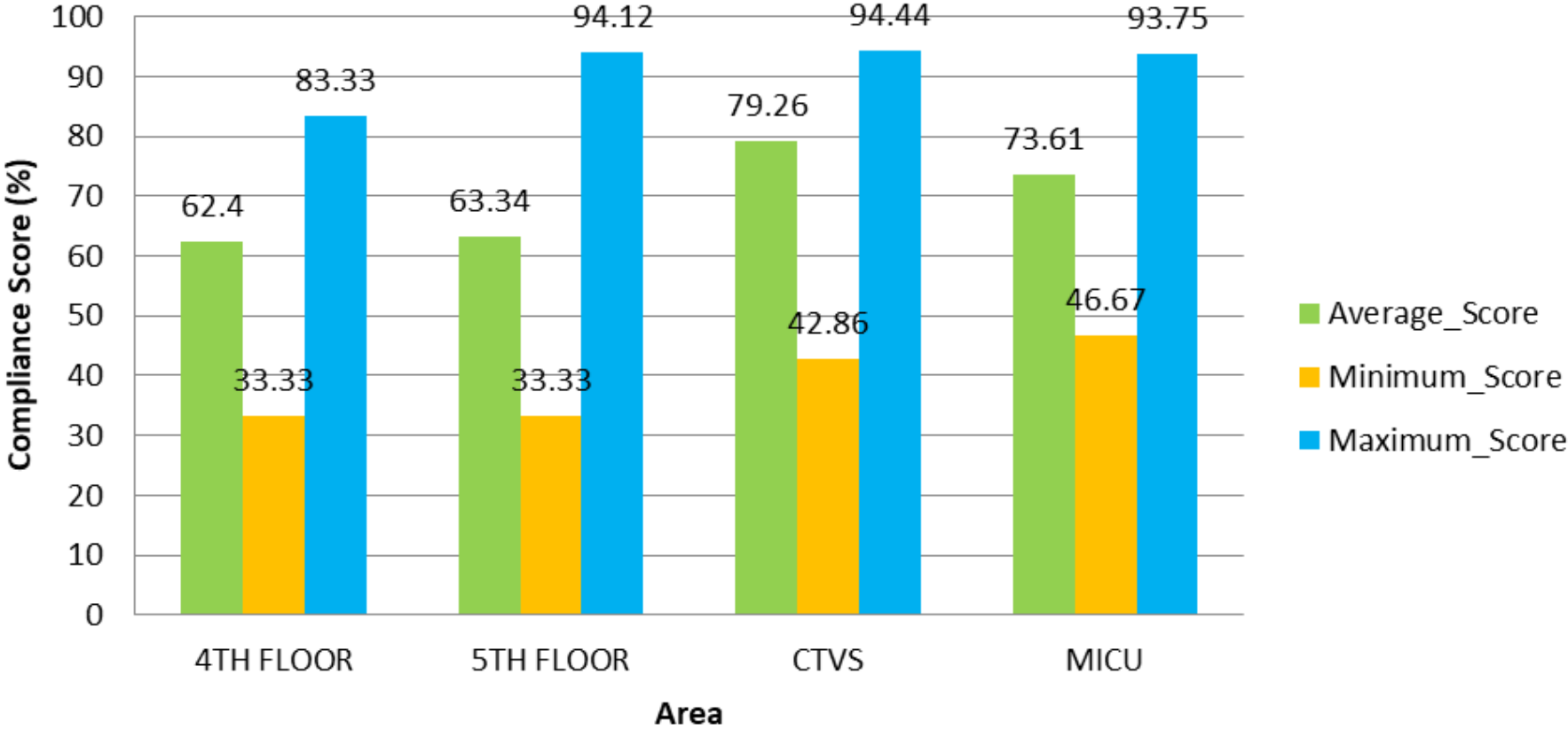


GAPS IDENTIFIED IN FORMS

Form Name	Compliance %	Major Documentation Gaps
Admission Form	83.00%	Risk type and reason for admission missing
Triage Doctor Assessment	85.96%	Medical reconciliation, triage level, doctor handover signature missing
Doctor Initial Assessment	54.08%	Consultant sign not within 24h, vital signs and pain assessment incomplete, Medical reconciliation
Treatment Sheet	65.31%	Generic Name , route/time unfilled, unapproved abbreviations, Antimicrobial Indication, Allergies unfilled
Progress Notes	10.00%	Date/time/doctor's name/signature missing, Name of medications are not in capital
Surgical Safety Checklist	66.67%	Unmarked Sign In/Out/Time Out items: site prep, antibiotics, precautions
Anaesthesia Record	95.45%	Shift time, anesthetist signature, post-op complications not documented
OT Notes	83.33%	Surgery date, Type of surgery, Postoperative diagnosis, Start/End time, Blood loss status unfilled
Consent Forms	41.41%	Witness sign missing, high-risk consent unmarked, CT Questionnaire unfilled , Procedure risks/benefits unfilled in informed consent , patient's phy condition at time of consent not marked
ICU Admission/Discharge Criteria	91.53%	Discharge criteria unfilled, diagnosis, doctor sign/time/date missing
Cath Lab Admission/Discharge	69.23%	Incomplete discharge diagnosis, doctor verification missing
Daily Nursing Assessment	55.10%	Shift handover notes, counter-sign by in-charge, background condition missing
Nursing Log (Cath)	81.25%	Intra-procedure monitoring details partially filled
In-House Transfer	55.00%	Part A unfilled, Patient condition not marked, Transferring /Receiving Doctors details, Time, Vitals unfilled
Transfer to Diagnostics	65.85%	Vital signs before shifting, procedure name, handover not confirmed
Consultant Referral	91.49%	Referral reason/priority/timing not documented
Patient & Family Education	47.06%	No nurse/doctor/dietician documentation
Relative Communication	84.21%	Severity update, team sign, acknowledgment by relative missing
Handover to OT/Cath	88.89%	Procedure name or date not mentioned
Bundle of Care Checklist	95.24%	Missing in-charge signature and employee ID

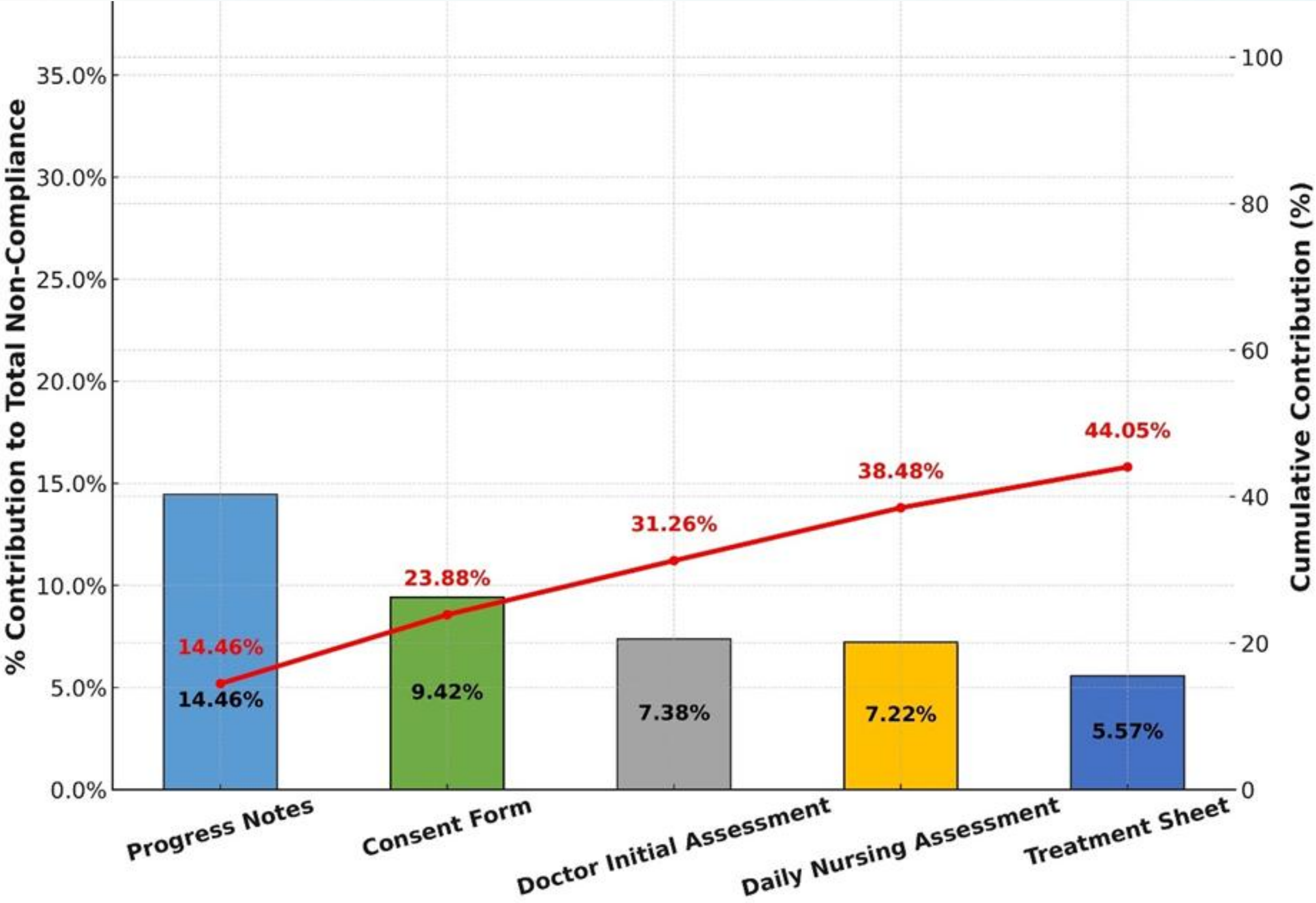


Area-wise File Compliance Score



CONTRIBUTION OF KEY FORMS TO TOTAL NON-COMPLIANCE

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. By improving the completeness, accuracy, and standardization of these forms hospital can potentially address nearly half of its total documentation non-compliance.





CONCLUSION

- The open file audit at Eternal Hospital uncovered significant documentation gaps, particularly in forms like Progress Notes, Consent Forms, Doctor's Initial Assessment, and Daily Nursing Assessments & Treatment Sheet — together accounting for nearly 44% of total non-compliance.
- Surgical Safety Checklist showed notable inconsistencies, with missing entries under 'Sign-In', 'Time-Out', and 'Sign-Out' sections — compromising intraoperative safety and procedural accountability.
- OT Notes frequently lacked essential surgical details such as type of surgery, date of surgery, blood loss status, and post-op diagnosis, impacting traceability and medico-legal documentation.
- These lapses stem from lack of sensitization, and inconsistent compliance monitoring across departments.
- Documentation is not just an administrative task—it is a cornerstone of clinical quality, safety, and institutional credibility. Systematic audits and accountability-based reforms are essential to foster a culture of excellence in medical record-keeping.

RECOMMENDATIONS

1. Dedicated Documentation Time Block at End of Shift

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

3. Link Documentation Compliance to Performance Evaluation

Despite repeated sensitization efforts and informal reminders, certain staff members continue to exhibit recurring documentation gaps. To address repeated documentation lapses it is recommended that documentation compliance be formally integrated into staff performance evaluation processes.

Implementation Strategy:

Audit-Based Tracking:

Patterns of non-compliance should be tracked over 2–3 audit cycles.

Verbal Counselling as First Response: Initial lapses can be addressed through direct verbal feedback with documentation gaps explained constructively.

Escalation to Appraisal Systems

In cases where the same individuals continue to default despite repeated reminders, These patterns must be reflected in their performance appraisals or mid-term evaluations as part of quality-related KPIs.



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

Conduct 2–3 random file checks per unit daily by the Quality team. Share documentation gaps and corrective actions via a dedicated WhatsApp group (including Quality, MRD, Nursing, and JRs).

5. Incorporating Documentation Training into Staff Induction

Introduce a structured module on documentation standards during staff onboarding. Cover NABH expectations, common errors, medico-legal risks, and case-based learning.

6. Monthly Compliance Monitoring & Trend Analysis

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.



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