Synopsis for Dissertation Submitted to

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In

Hospital & Health Management

by

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1.TITLE – Assessing the Quality of Medical Records at Eternal Hospital Through Open File Audit

2.INTRODUCTION

Medical records are the backbone of high-quality patient care, serving not only as a critical communication tool among healthcare providers but also as a fundamental component in clinical decision-making and health research. Despite significant advances in health information technology, many hospitals continue to grapple with incomplete, inaccurate, or delayed documentation. Such shortcomings not only compromise patient safety but also hinder timely treatment and degrade the overall quality of care.

Recognizing these challenges, this study aims to rigorously assess the quality of medical records within a tertiary care setting using an active audit approach. An active audit is a systematic and proactive review process designed to identify documentation deficiencies and prompt corrective actions. By thoroughly examining current record-keeping practices, the study will highlight critical gaps and generate actionable recommendations that foster both clinical and administrative excellence. This comprehensive approach is expected to drive meaningful improvements in record quality, ultimately supporting better clinical decisions and elevating the standard of care.

3.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 audit?

4.OBJECTIVES:

- 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.

5.MATERIALS AND METHODS

- STUDY DESIGN - A cross-sectional observational study will be utilized.
- SETTING - The study will be conducted in Eternal hospital, a tertiary care hospital known for its diverse clinical services and comprehensive record-keeping systems.
- STUDY POPULATION -

- Inclusion Criteria:
  Medical records of IPD patients admitted between [10th March 2025] and [9th June] 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.

- DURATION OF STUDY - The study will be conducted over a three-month period from [10th March 2025] to [9th June 2025].
- SAMPLE SIZE - Based on preliminary estimates approximately 300 patient records will be randomly selected for the audit.
- SAMPLING TECHNIQUE - Simple random sampling will be employed to ensure unbiased selection of medical records from the target departments.
- DATA COLLECTION PROCEDURE - Medical records meeting the inclusion criteria will be retrieved. Each selected record will be systematically reviewed against the checklist. Findings (e.g., missing data, inaccuracies, delays) will be recorded directly on the checklist, along with any additional observations for further analysis. Collected data will be entered into a secure electronic database in real-time or shortly after the audit process.
- OPERATIONAL DEFINITION -
  ▪ Active Audit: A proactive, systematic evaluation of medical records by trained professionals to assess and ensure adherence to documentation standards.
  ▪ Medical Records Quality: A composite measure that includes the completeness, accuracy, and timeliness of patient information documented in the records.
  ▪ Compliance**:** The extent to which the documentation adheres to institutional and regulatory standards.
  ▪ Deficiency: Any deviation from standard documentation practices, including missing or inaccurate information.

6.DATA ANALYSIS PLAN - Data will be analysed using MS Excel or SPSS software.

7.ETHICAL CONSIDERATIONS:

Prior to commencing the study, ethical clearance will be obtained from the concerned authorities of hospital.

All patient identifiers will be removed from the data to ensure confidentiality.

8.IMPLICATIONS OF RESEARCH:

The findings of this study are anticipated to provide critical insights into the current state of medical record documentation. Identifying deficiencies through an active audit will facilitate targeted interventions that can improve the overall quality of patient records. Enhanced documentation not only supports improved clinical decision-making and patient care but also strengthens medico-legal compliance and institutional accountability. Findings will influence policy and training programs aimed at enhancing documentation practices, which may have broader implications for healthcare quality improvement

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