

ISSN 1840-4855  
e-ISSN 2233-0046

Original scientific article  
<http://dx.doi.org/10.70102/afts.2026.1835.437>

## A STUDY ON THE COMPLETENESS OF PATIENT MEDICAL DOCUMENTATION BY PHYSICIANS IN MULTISPECIALTY HOSPITALS

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Received: January 14, 2026; Revised: February 26, 2026; Accepted: April 16, 2026; Published: May 29, 2026

### SUMMARY

In multi-specialty hospitals, maintaining comprehensive and accurate medical records is a mechanical necessity for high-quality care, regulatory compliance, and medicolegal protection. While physicians are the primary authors of these clinical records, a focus on care execution over documentation often leads to critical gaps in recording patient progress and treatment notes. This study investigates physician documentation completeness in three vulnerable areas: initial patient assessment, surgical consent, and discharge planning within a medium-resource multispecialty teaching hospital. Employing a quantitative descriptive design and a concurrent survey method, the study utilized convenience sampling to audit inpatient records. A total of N = 364 records were analyzed for initial patient assessment, N = 142 for surgical consent, and N = 248 for discharge documentation. Data were processed using descriptive statistics to identify compliance gaps. Significant documentation non-compliance was observed across all surveyed domains. The completion rate for initial patient assessments was 57.14%, leaving a 42.86% gap in essential admission data. Within surgical consent documentation, though administrative details were high (98.6%), critical clinical elements were severely lacking: 60.6% of records omitted specific procedure details, 54.2% lacked physician signatures, and 66.6% lacked surgeon identifiers. Furthermore, discharge documentation showed that 72.6% of records lacked advice given during rounds, and 49.2% failed to record the consultant's final discharge instructions. The findings confirm that incomplete documentation remains a major threat to patient safety and institutional accountability. The high rates of missing surgical procedure details and physician identifiers compromise traceability and legal safeguards. Institutional reforms, including the implementation of standardized templates and the integration of medical documentation into professional curricula, are recommended to bridge these systemic gaps.

Key words: *medical records, physicians documentation practice, documentation completeness, patient initial assessment, surgical consent.*

## INTRODUCTION

### Medical Record Documentation

The standardized medical record documentation practices are crucial to improve clinical decision-making, enhance patient safety, and strengthen the hospital's compliance with the quality of patient care. Medical documentation supports the medical team for effective healthcare delivery. The medical professionals, like physicians, nurses, and paramedical staff, were ensuring the accuracy, completeness, and timeliness while recording the medical documentation [1][2]. Physicians were the primary authors of clinical records related to patient medical histories, diagnostic findings, treatment plans, and progress notes. The medical records not only facilitate continuity of care but also serve as legal documents, support billing and reimbursement processes, and contribute to public health data and research [13].

A medical record is a document containing a patient's health information, created and managed by the hospital's healthcare professionals and overseen by hospital authorities. The hospital owns the medical record of the patient [8]. The patients are entitled to receive a copy of the same at any time. Electronic health records (EHRs) have become part of clinical practice in the era of digital transformation, which requires physicians to learn new documentation processes [23]. Although EHRs have the advantage of providing access to data in an efficient manner and enhancing coordination, also present problems of time burden and data entry burnout [12]. In spite of these difficulties, documentation of high quality is mandatory for patient safety, interdisciplinary communications, and the effectiveness of the healthcare system. The role of the physician in documentation is constantly growing in the context of the changing healthcare system that needs to consider not only clinical accuracy but also ethical accountability, data management, and technological competence. This role is important to understand to enhance documentation practices and maximize patient outcomes.

The patient's medical record includes various types of forms and documents that support the diagnosis, treatment, and continuity of care. Such as an initial assessment including patient history, physical exam findings, and preliminary diagnosis. Progress notes on the patient's condition, treatment response, and care plan. Consultants' opinions and findings from specialists consulted during the patient's care. Operative reports account for surgical procedures, including pre- and post-operative diagnoses. Discharge Summary, the patient's hospital stays, treatments provided, and follow-up instructions. Physician orders for medications, tests, procedures, and other aspects of care. Diagnostic Test Results of lab tests, imaging, and other diagnostic procedures. And documentation of prescribed drugs, dosages, and administration schedules. The existing research has emphasized the importance of documentation for patient safety, continuity of care, and medicolegal protection. The electronic health records successfully integrate information systems into clinical workflows.

There is a scarcity of research studies in the medium-sized hospital where poor documentation practices are prevalent. The focused research with core clinical documentation may support the standardized documentation practices for safer, reliable patient care in a multispecialty hospital in the southern part of Tamil Nadu, India.

The workflow pattern depicted in figure 1 was adopted to prepare the data collection environment of the study. It starts with the creation of a structured checklist of observation, which was carefully revised by the specialists of the hospital and administrative personnel to correspond to the current format of medical records. The next step in the workflow after this validation is the physical validation and data extraction of the inpatient wards and operating theaters, and the final step is the systematic input of these records into computer formats, which will be first processed.

The current research was conducted in a NABH-accredited multispecialty teaching hospital to control the missing data (courtesy – hospital records). The medical records of the inpatient department, except the emergency department, were taken for the study, as the emergency department was not able to give details on the focused area of the study. The study investigates the completion of medical record

documentation by the physician in three major areas of treatment and assessment with the two medical facilities of Madurai district located in South Tamil Nadu.

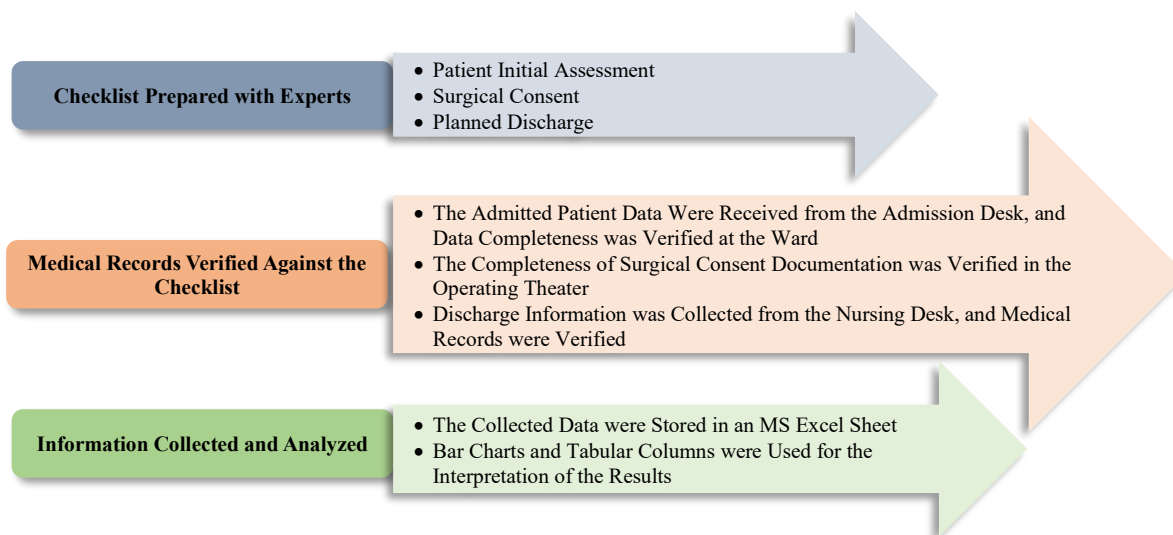


Figure 1. Workflow of data collection and audit readiness bottom of form

### Objectives of the Study

This study aims to evaluate the completeness of medical records in a multi-specialty teaching hospital and identify gaps that affect patient care and compliance.

- Assessing the completion of patient history, provisional diagnosis, and date/time in the initial assessment of the patient within 24 hours of admission.
- Assessing the completion of patient identification, diagnosis/surgical procedure, and signature of the patient/ family in the Surgery consent.
- Assessing the completion of recording of discharge advice immediately at the time of patient discharge.

### Research Questions

1. Whether the physicians complete the initial assessment form within 24 hours for all patients admitted to the hospital?
2. Whether the surgical consent was taken from the patient or authorized signatory properly by the medical personnel?
3. Whether the physicians record the discharge plan and advice in the medical record?
4. What is the percentage of incomplete clinical documentation related to the above 3 factors in the particular period in the particular department or hospital?

Section 1 consists of the introduction, objectives of the study, research questions, and organization of the paper. Section 2 consists of the review of literature, Section 3 presents the research methodology, including workflow architecture for the audit process, study design, data collection tools, and data analysis. Section 4 explains the results of the study of documentation completeness across initial assessment, surgical consent, and discharge records. Section 5 presents the findings, including the documentation gaps and their implications for hospital management. Section 6 also ends with recommendations, limitations, and future research directions. The references to the study are indicated in Section 7.

## REVIEW OF LITERATURE

Safe and effective care of the patient is founded on the medical record documentation. The clinical documentation can assist the medical personnel in tracking the diagnosis, health development, interventions, and outcomes of the patient in an accurate and timely manner. The medical record documentation assists medical practitioners in reducing preventable mistakes and ensuring continuity of care for patients. The 21st Century Cures Act has also increased the significance of documentation by making electronic health records available in real time to the patient. This change mandates clinicians to embrace the best practices as to what must be recorded and when recording should take place, which reinforces patient involvement and clinical decision-making processes [9][10].

Poor documentation is a continuum despite its critical role. Research has indicated that incomplete, inaccurate, or inadequately quality records impede patient management and continuity of care and cause more medicolegal risks [4]. Inadequate documentation may result in the wrong interpretation of patient records and the tainting of an institution's reputation. On the other hand, adequate documentation is regarded as the best defense against negligence claims as it gives a logical report of patient care and protects the patients and the providers [7].

Medicolegal aspects of the medical record refer to the significance of the medical record in terms of clinical and legal protection. To defend the physicians against litigation, it is essential to put on record all the pertinent information of patients to hold them accountable and transparent [7].

Electronic health records (EHR) have brought about new possibilities and dilemmas in documentation practices. The EHR supports data sharing and transparency simultaneously, which results in the creation of the so-called workarounds, as systems do not align with clinical workflows. These practices undermine accuracy and completeness, and thus, there is a need to have more information technology systems, which enhance the documentation requirements of clinicians.

The transfer of patients in and out of treatment areas has led to a lack of medical record documentation and completion. This kind of practice may result in the loss of critical clinical information. Research suggests that standardized checklists and improved electronic record-sharing systems can enhance the transmission of essential data, thereby support continuity of care and reduce duplication of work [5].

The reason for incomplete records is that the doctors and surgeons believed that the medical or surgical care required for patients is vital, but documentation of the data concerning care is not considered a part of the treatment process by them. This is a misconception because the time spent registering and completing the patients' medical records is considered part of the care process. As per the findings of another study, active interventions such as audit/feedback, reminders, or templates and/or multiple interventions may improve physician documentation [6].

The National accreditation board for hospitals and health care providers framed a list of standards to be followed with Key Performance Index (KPI) to ensure patient safety. MCI.1 – Medical records are maintained for every patient [10][14]. Hospitals must maintain complete and accurate medical records for each patient. MCI.2 – The content of medical records is standardized - Standardized structure across all records, including consultant documentation. MCI.3 – The medical record contains information to identify the patient, support diagnosis, justify treatment, and document outcomes. Ensures each record reflects a full picture of care delivered. MCI.4 – The medical record is legible and authenticated. Signatures, names, designations, dates, and times must be present and legible. MCI.5 – Medical records are audited periodically. Regular audits should be done to check for completeness, accuracy, and legibility.

Medical records are essential for patient care, legal documentation, and maintaining healthcare quality. Nevertheless, incomplete documentation is a recurrent problem that is usually a result of the absence of standardized documentation, missing or obscure patient data, human mistakes, lost records, poor record-keeping, illegible handwriting, and incomplete forms by physicians and nurses. Medical records are vital in the care of patients, hospital administration, and legal requirements. The Indonesian research has found that there are several factors that determine the completeness of the medical records. Other

studies note that the 5M framework: Man, Money, Material, Machine, and Method, is a very important element to consider when determining the quality of documentation [3]. Nevertheless, different research has reduced it to the scope of Man, Method, and Material and laid stress on human resource capacity, procedural consistency, and resource availability [11]. A randomized study was carried out in Prof. Dr. Margono Soekarjo Purwokerto Regional Hospital, a third-level teaching hospital, to determine the effects of internal audit on the quality of medical records. The research proposes that a properly designed information system can greatly improve the management and monitoring of the completeness of medical records. The audit program has resulted in significant changes in documentation, such as patient medical history, daily clinical progress notes, and discharge summaries. The total score of the hospital increased by 59.5% to 77.3%, which shows the relevance of the organized audit interventions. In another tertiary care hospital's general surgery department, an audit revealed that 7 out of 53 standards achieved 100% compliance, while over 75% compliance was observed in 30 standards. Nonetheless, significant deficiencies were noted in daily entries by physicians, timing of documentation, and completeness of initial assessments and progress notes. A pilot study at a tertiary care center assessed the accuracy of documentation and coding in medical records. It found that only 60% of audited records met the benchmark for good quality documentation and coding. A positive correlation was observed between accurate documentation and correct coding, reinforcing the importance of comprehensive record-keeping for reliable coding outcomes. The systematic review in accordance with PRISMA guidelines conducted by Diane and co., found that the need for active interventions to improve the physicians' documentations continuously [6]. Documentation quality in hospitals is often rated as good but faces persistent challenges such as staff shortages and poor teamwork [15]. Completeness of medical records is legally critical; missing signatures or discharge notes can compromise accountability [14][16]. Clinical audits demonstrate that structured checklists and re-audits significantly improve compliance [17]. Knowledge and perception of doctors directly influence record quality, with perception showing stronger positive effects than knowledge alone [18]. Training interventions for interns markedly improve medico-legal documentation practices, highlighting the need for standardized curricula [19]. Incomplete records in Indonesia stem from human, material, and policy factors, requiring systemic reforms and budget prioritization [3]. Orientation and awareness programs in Sudan improved documentation from "poor" to "excellent" within one audit cycle [20]. Pre-intern doctors in Sri Lanka perceive documentation as essential but admit gaps in competency, stressing the need for refresher training before internships [21]. Organizational culture and knowledge strongly drive compliance, while motivation alone has little measurable effect [22]. Overall, sustained improvement in documentation requires a blend of training, supportive supervision, structured tools, and cultural reinforcement across healthcare systems.

## RESEARCH METHODOLOGY

An observation checklist was formulated as a structured observation checklist in order to assess the adequacy of physician documentation in inpatient medical records. The checklist questions were based on the forms of medical records used in the hospital, the guidelines of the internal medical audit committee, and the documentation standards of accreditation. The hospital administrative personnel who participated in the medical audit process reviewed the checklist to make sure that it was clear and applicable to the clinical documentation practices. Minor changes were incorporated to integrate the checklist and the hospital documentation forms. The completed checklist was then adopted as the main data collection tool of the research.

The checklist was mainly aimed at three major areas of documentation, including initial assessment of the patient within 24 hours of admission, completeness of the surgical consent form, and the consultation, planned discharge advice documentation.

Every item in the checklist contained certain variables that comprised patient identification details, diagnosis or procedure details, date and time of entries, physician name and signature, and patient or next-of-kin consent signature.

## Workflow Architecture of the Medical Record Audit Process

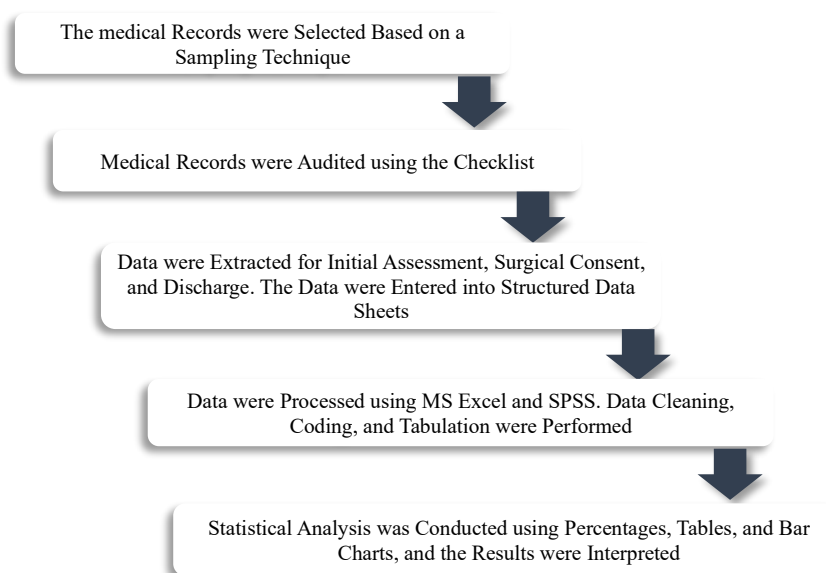


Figure 2. Workflow architecture of the medical record audit and analysis process

The figure 2 above shows the workflow architecture that will be used in the present study to audit the physician documentation practices. The medical records of inpatients were chosen by convenience sampling during the study period. A checklist prepared on three key documentation elements was used to analyze these records. The information that was obtained in the records was imported into data sheets and later processed in Microsoft Excel/SPSS to clean, code, and tabulate. The completeness of physician documentation was interpreted by percentages and graphical representations to reveal the areas of non-compliance with documentation standards.

### Study Design

The study followed a quantitative descriptive research design, a concurrent cross-sectional survey method employed to evaluate the completeness of physician documentation in inpatient medical records. The study focused on identifying gaps in clinical documentation practices within a multispecialty teaching hospital located in Madurai District, Tamil Nadu, India. The analysis was conducted using hospital inpatient medical records during the study period of October 2024 to November 2024.

### Study Setting

The research was conducted in a private multispecialty teaching hospital accredited by national healthcare quality standards. The hospital maintains standardized medical record formats and conducts periodic medical record audits through its internal medical audit committee to ensure compliance with documentation standards.

### Sample Size and Sampling Method

The total number of admissions during the study period was  $N = 1868$ . Likewise, the total surgeries were  $N = 305$ . Moreover, the discharge during the period was  $N = 1859$ .

The number of admissions, surgeries, and discharges of the hospital under study for the year 2023-2024 were 11,208, 963, and 11,117, respectively (courtesy – hospital records). The average admission for the 2 months is calculated as 1868. As the study was planned for a period of 2 months, the formula used to calculate the sample size. By using the formulae in equation (1):

$$n = \frac{N}{(1 + Ne^2)} \quad (1)$$

Where:  $n$  = sample size,  $N$  = population size and  $e$  = acceptable margin of error  $n = \frac{1868}{(1+(1868*0.05*0.05))}$   
sample size = 329. The medical records taken for the study were based on convenience sampling, specialty-wise, from the various wards of the hospital, without affecting the patient care and documentation work of the hospital. The total sample collected was 375. After trimming the data, a sample of 364 was taken for the data analysis of the initial assessment record.  $N = 364$  records for initial patient assessment documentation

The case sheets for completion of surgical consent data were calculated based on the number of surgeries performed at the hospital. The hospital's average monthly surgeries, including major and minor surgeries, was 305. Applying the formulae in equation (1), the calculated Sample size = 173. The medical records from the operating theater were observed after the completion of the surgery. So, the case sheets available for consent study completion after data trimming are 142.  $N = 142$  records for surgical consent documentation

To study the discharge entry completion, the patient record related to the discharged patient's case sheet was taken for the study. So, based on convenience sampling, only 248 case records were taken to study the pre-discharge documentation by the researcher during the study period.  $N = 248$  records for discharge documentation

Medical records were selected using convenience sampling across different hospital wards and specialties, ensuring that the audit did not interfere with ongoing clinical activities.

### Data Collection

Both Primary and secondary data were used for this study. The secondary data was collected for the literature review using Google Scholar, and citations were collected using the Mendeley software. The medical audit committee report of the hospital, hospital forms, and the patient medical records were used for secondary data. The primary data was collected using the data sheets by the researcher with a team of administrative trainees. The source of primary data is the private multispecialty hospital located in the Madurai district, Tamil Nadu, India.

### Data Collection Tools

The checklist was prepared and used to verify the documentation practices of the physicians of the hospital in the three main areas, as explained. Identify the level of completeness of the elements (e.g., date/time, diagnosis, progress notes). Quantify the level of completeness (e.g., % of files with or without signatures or treatment plans) related to consent documentation, the doctor's initial assessment form with the consultant's signature, and the checklist for planned discharge within 24 hours by the consultant. The format of the data sheets below was used as a data collection tool. The checklist included variables related to documentation completeness such as Patient identification details (name, age, sex, inpatient number), Diagnosis and clinical history, Date and time of physician entries, Documentation of procedures or treatment plans, Physician authentication (name and signature), Patient or next-of-kin consent signatures, Documentation of discharge advice and planned discharge. The checklist served as the primary instrument for extracting relevant data from inpatient medical records.

### Audit Procedure

The audit was conducted through a systematic review of inpatient medical records by the researcher with the assistance of hospital administrative trainees. Prior to the audit, the trainees were oriented on the use of the checklist and the identification of required documentation elements. The information that was extracted was captured in structured data sheets that were to be used in the study.

**Data Quality Control**

In order to attain reliability and accuracy of the data gathered, the researcher checked the filled data sheets periodically. Any irregularities that were discovered during the auditing process were compared to the original medical records. Following data collection, the set of data was filtered based on incomplete data entries and inconsistencies, and it was ultimately ready to be analyzed.

**Data Analysis**

The data collected was tabulated and analyzed with Microsoft Excel. Statistical methods (descriptive statistics) were used to assess the physician documentation completeness. Three documentation areas were analyzed:

Primary Patient evaluation (N = 364): The audit explored the availability of the following elements, such as Patient identification details, Date and time of physician assessment, Presenting complaints and clinical history, Provisional diagnosis, Physician name and signature.

Surgical Consent Documentation (N = 142): The variables are the patient identification information, diagnosis, and proposed procedure documentation, Physician name, signature, date, and time, Patient or next-of-kin signature and date, and clinical disclosure evidence.

Planned Discharge Documentation (N = 248): The discharge documentation audit focused on Documentation of discharge advice during consultant rounds, Planned discharge written by the consultant, Date and time stamps, Physician signature, and authentication

The results were summarized using frequency counts, percentage analysis, tables, and graphical representations to identify gaps in physician documentation practices.

**RESULTS**

The collected data was represented in an Excel sheet. The data was analyzed using MS Excel and SPSS. The Percentage analysis, tables, and bar diagram are used to represent the results.

**Initial Patient Assessment**

The table 1 below explains the hospital ward-wise completeness of the medical records for the initial assessment.

Table 1. Initial assessment completion analysis hospital ward-wise

<b>Initial Patient Assessment</b>					
<b>Ward</b>	<b>Completed</b>	<b>Percentage %</b>	<b>Not Completed</b>	<b>Percentage %</b>	<b>Total</b>
Hospital A 1 <sup>st</sup> Floor	17	60.71%	11	39.28%	38
Hospital A 2 <sup>nd</sup> Floor	11	55.00%	9	45.00%	20
Hospital A 3 <sup>rd</sup> Floor	17	44.74%	21	55.26%	38
Hospital A Ground Floor	8	53.33%	7	46.67%	15
Hospital A ICU	34	73.91%	12	26.09%	46
Hospital A General Ward	26	63.41%	15	36.59%	41
Hospital B 2 <sup>nd</sup> Floor	15	53.57%	13	46.43%	28
Hospital B General ward	29	51.79%	27	48.21%	56
Hospital B ICU	9	56.25%	7	43.75%	16
Hospital B First Floor	27	64.29%	15	35.71%	42
Hospital B Special ward	15	44.12%	19	55.88%	34
Total	208	57.14%	156	42.85%	364

The table 1 inferred that by observing the hospital medical records out of 364 records, Hospital A, Intensive care unit, has the highest completeness 73.91% followed by Hospital B, first floor, In-patient

department, with 64.29 %. But on the other hand, the highest incompleteness is with Hospital B, special ward 55.88% followed by Hospital A, 3<sup>rd</sup> floor, 55.26%.

### Surgery Consent Documentation

The observations related to surgical consent documentation, such as patient identification, clinical disclosure, physician accountability, and legal authorization, are represented in the table -surgery consent documentation.

Table 2. Surgery consent documentation

<b>Surgery Consent Documentation</b>				
<b>Consent Component</b>	<b>Present</b>	<b>Present (%)</b>	<b>Absent</b>	<b>Absent (%)</b>
Patient Details (Name/Age/Sex/I.P. No/Ward)	140	98.6%	2	1.4%
Diagnosis/Procedure	56	39.4%	86	60.6%
Doctor’s Name/Signature/Date/Time	65	45.8%	77	54.2%
Patient or Next of Kin Signature/Date/Time	116	81.7%	26	18.3%

The table 2 inferred that the documentation of patient details, comprising name, age, sex, inpatient number, and ward, 98.6% of consent forms containing this information. This denotes the performance of administrative protocols by the staff /physicians towards patient safety practices and medico-legal requirements. The diagnosis and procedure details were found to be complete in 39.4% of records, while 60.6% were incomplete. The attending doctor's name, signature, date, and time were present in just 45.8% of records, whereas 54.2% of the records were found lacking. Consent forms were signed and dated by the patient or the patient's next of kin in 81.7% of records, indicating relatively strong compliance. However, the remaining 18.3% represent a significant lapse in legal authorization.

Table 3. Specialty-wise surgical procedure documentation

<b>Patient Surgical procedure details</b>					
<b>Specialty</b>	<b>Total Records</b>	<b>Complete</b>	<b>Incomplete</b>	<b>Completion %</b>	<b>Incompletion %</b>
Orthopedics	24	11	13	45.8%	54.2%
Urology	11	6	5	54.5%	45.5%
Nephrology	7	1	6	14.3%	85.7%
General Surgery	29	15	14	51.7%	48.3%
ENT	8	1	7	12.5%	87.5%
Neurology	4	2	2	50.0%	50.0%
Neuro surgery	3	1	2	33.3%	66.7%
Gastro surgery	18	6	12	33.3%	66.7%
Pediatric surgery	7	2	5	28.6%	71.4%
Oncology surgery	12	5	7	41.7%	58.3%
Vascular surgery	10	3	7	30.0%	70.0%
OBG	9	3	6	33.3%	66.7%
<b>Total</b>	<b>142</b>	<b>56</b>	<b>86</b>	<b>39.4%</b>	<b>60.6%</b>

The table 3 inferred that surgical procedure documentation was completed by the physicians in the surgical consent form with Urology (54.5%), General Surgery (51.7%), Neurology (50%), Orthopedics (45.8%), and Oncology surgery (41.7%). The Obstetrics and Gynecology (33.3%), Gastro surgery (33.3%), Vascular surgery (30%), Pediatric surgery (28.6%), Nephrology (14.3%), ENT (12.5%), are keeping very low completion metrics. Overall, only 39.4% of records were complete, which indicates the documentation compliance is low across specialties.

### Planned Discharge Documentation

The table 4 denotes the percentage of planned discharge by the hospital consultants. The discharge advised during the rounds is lower than the planned discharge documented by the consultant. 72 .6% of the discharges were not recorded in the medical record by the physician. Planned discharge written by

the consultant. Completion rates are below 50%, exhibiting significant gaps in discharge workflow consistency.

Table 4. Planned discharge analysis

Planned Discharge Documentation				
Category	Complete	Incomplete	Completion %	Incompletion %
Discharge advised during rounds	68	180	27.4%	72.6%
Planned discharge written by the consultant	126	122	50.8%	49.2%

## DISCUSSIONS

The researcher conducted the study in the multi-specialty private hospitals located in the same geography, and the study focuses on only three selective areas of hospital documentation. The previous studies underscored that medical record documentation is not just a clerical task but a clinical, legal, and technological cornerstone of healthcare delivery. The study results highlighted that the compliance as per NABH, standard MCI.2, content of medical records is standardized and found to satisfy standard MCI.3, of patient identity documentation has some deviation. The study reveals the gap in documentation practices of the physicians, with the non-completion of 42.85% with the initial assessment, with the highest incompleteness of Hospital B, special ward 55.88% followed by Hospital A, 3<sup>rd</sup> floor, 55.26%. So, the hospital management frames policies and maintains vigilance for completing the initial assessment on time without delay to support patient care. Related to the surgical consent, the majority of forms (98.6%) contain the patient identification. The gaps were observed in the inclusion of physician details (54.2%), lack of procedure information (60.6%), absence of patient or family signature in (17%) surgical consent, and absence of surgeon details in (66.6%) surgical consent. The 72.6% medical records lacked discharge advice during rounds, and 49.2% not record the discharge advice given by the consultant. This is affecting patient safety and hospital efficiency due to missing information related to patient care and patient communication.

The initial assessment of the patients supports the medical team with the right path of the treatment protocol for the patient, so the gap affects clinical decision-making and overall healthcare quality. The patient consent form is a legal document signed by the patients, indicating relatively strong compliance. However, the management has to avoid a potential risk to informed consent integrity, as patients and patient attenders may not be fully aware of the nature of their surgical intervention.

As per the study, the reason for incomplete records is that the doctors and surgeons believed that the medical or surgical care required for patients is vital, but documentation of the data concerning care is not considered a part of the treatment process by them. "This is a misconception because the time spent to register and complete the patients' medical records is considered as part of the care process," and Tsani et al. (2021) disclosed that the hospital's overall score rose from 59.5% to 77.3%, demonstrating the effectiveness of structured audit interventions. This proves that frequent audits have to be conducted by the organization to ensure the quality of medical records. These study findings support and reiterate the suggestions of Lorenzetti et. al., 2018 to confirm that active interventions such as audit/feedback, reminders, or templates may improve physician documentation.

## CONCLUSIONS

Incomplete medical documentation represents a significant clinical and ethical challenge that transcends simple administrative oversight, directly impacting patient safety, treatment outcomes, and hospital efficiency. This study, conducted within a multispecialty teaching hospital, confirms a substantial disparity between standardized quality benchmarks and actual physician documentation practices. The research revealed critical statistical gaps in documentation completeness across three primary clinical domains. In surgical consent forms, although administrative identification was high at 98.6%, there were severe deficiencies in clinical and legal accountability: 60.6% of records lacked specific procedure information, 54.2% lacked attending physician identifiers, and 66.6% failed to include surgeon details. Furthermore, 17% of surgical consents lacked essential patient or family signatures, presenting a major medicolegal risk. In the discharge workflow, 72.6% of records lacked documentation of advice given during rounds, and 49.2% failed to record the consultant's final discharge instructions. These missing

data points compromise the traceability of care and hinder effective post-operative reviews and quality assurance processes. The findings emphasize that documentation is not a peripheral task but a core component of the care process. To bridge these gaps, institutional reforms are necessary to mandate physician sign-off as a non-negotiable requirement. Management must implement systemized workflows that allow clinicians sufficient time for record-keeping and adopt standardized, user-friendly digital templates to reduce entry fatigue. Future research should focus on a longitudinal workload analysis to determine the correlation between physician burnout and documentation accuracy. Additionally, investigating the impact of real-time electronic health record (EHR) alerts and the integration of medical documentation as a formal course in healthcare professional education would provide valuable insights into sustaining long-term compliance and improving patient care quality.

### Structured Disclosures

**Funding:** The research does not require any funding, basically. The data sheets, the time the researcher spent collecting and analyzing the data. Moreover, the support given by the hospital management to access the Inpatient medical records for the collection of data.

**Conflicts of Interest:** There is no financial or nonfinancial conflict of interest in this study

**Ethical Approval:** Not applicable for this study.

**Disclaimers:** The researcher conducted and prepared the report for academic purposes only and does not constitute financial investment, legal, tax, or other professional advice. The findings, inferences, and discussion were based on the author's experience as of the date of publication and are subject to change without notice. The data and results of this study, as to its completeness, reliability, or accuracy, have no representations or warranty, express or implied, made. The author or publisher shall not be liable for any direct, indirect, or consequential loss arising from the use of this material.

**Previous Presentation:** The researcher has not presented this study to any other journal or conference previously.

**Data Availability:** The researcher collected data from the secondary data, which are medical records, with the help of a checklist. The data in the checklist typed in Excel format is available to the researcher.

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