IMPROVING QUALITY OF CARE DURING PATIENT ADMISSION BY INTERN DOCTORS AT A TERTIARY HOSPITAL IN BANGLADESH THROUGH MULTIPLE AUDITS OF CLINICAL DOCUMENTATION

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Background: Complete and proper medical record documentation is essential for ensuring safe patient care, maintaining effective communication, and accountability. Inadequate documentation is a critical problem in clinical practices observed all over the world, including Bangladesh. **Methods:** Two-cycle clinical audits were conducted at a tertiary-level medical college hospital in Bangladesh to assess the quality of medical record and clinical note documentation by intern doctors during patient admission. The audit evaluated parameters against criteria based on the Royal College of Physicians' approved "Generic Medical Records Keeping Standards" and the hospital's own documentation format. Following the first audit cycle, which included 91 samples, an educational intervention was delivered to interns. Subsequently, a re-audit of 73 samples was conducted to assess improvements in documentation practices. A semi-structured online questionnaire was prepared, and intern doctors were encouraged to provide their responses regarding the information and proper training they received from the respective hospital authority. 65 responses from intern doctors were also recorded via a questionnaire and analyzed, which helped to develop realistic recommendations and significant positive change on reaudit. **Results:** The result showed marked improvement with proper history taking (26.4% 1st cycle '! 72.6% 2nd cycle), sign-symptoms noticing and documenting (71.4%,1st cycle '! 87.7%, 2nd cycle), physical examination checking and documenting (60.4%, 1st cycle '! 61.6%, 2nd cycle), recording vitals during admission (64.8%, 1st cycle '! 83.6%, 2nd cycle), follow-up checking and documentation after initial treatment (75.8%,1st cycle '! 98.6%, 2nd cycle), investigation order (70.3%, 1st cycle '! 71.2%, 2nd cycle), signature of physicians who wrote medicine orders (59.3%, 1st cycle '! 93.2%, 2nd cycle). Only 9.2% of interns received proper training from the authority on clinical note documentation during admission prior to starting the internship. 80% of interns have never encountered any medical record documentation guidelines. **Conclusion:** Upon discussion, recommendations from intern doctors included proper training in medical documentation from a uniform source before starting the internship, posting guidelines as a poster or laminated paper in the unit, and checking by seniors or the unit head during ward rounds. The positive results of the 2nd audit of this study bring hope and demonstrate that, above all, rather than punishing or humiliating interns, a fearless, inclusive discussion can bring promising, drastic positive changes in patient-centered service without any financial investment.

Keywords: Medical record documentation, Clinical audit, Intern training

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