

ORIGINAL ARTICLE

Safeguarding Patient Care: The Intersection of Documentation and Legal Aspects in Health Care

Debraj Banik¹, Ravindra S. Honnungar², Perumal P.³, Vinay S. Bannur⁴

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ABSTRACT

Introduction: Accurate, complete, and timely medical documentation is a cornerstone of safe and effective healthcare delivery. It ensures continuity of care, facilitates communication among healthcare providers, and serves as an essential medico-legal record. Inadequate or incomplete documentation can compromise patient safety, lead to diagnostic or therapeutic delays, and expose practitioners to legal liability. This study aims to assess the quality and completeness of inpatient medical records across multiple clinical departments in a tertiary care hospital and to examine the legal and ethical implications associated with documentation deficiencies.

Materials and methods: A retrospective descriptive study was conducted in a 1250-bed multispecialty teaching hospital. Medical records from nine departments like Internal Medicine, Gynaecology & Obstetrics, Forensic Medicine & Toxicology, General Surgery, ENT, Ophthalmology, Paediatrics, Dermatology, and Psychiatry were evaluated. Using systematic random sampling, 50 inpatient case sheets were selected from each department, yielding a total sample of 450 records from April 2022 to April 2023. A structured 12-domain audit tool assessing demographics, admission details, history, examination findings, investigations, diagnosis, treatment notes, procedure-related entries, daily progress, discharge summaries, signatures, and supporting documents was used to analyze documentation completeness.

AUTHOR'S AFFILIATION:

¹ Postgraduate Trainee, Department of Forensic Medicine and Toxicology, Jawaharlal Nehru Medical College, Belagavi, Karnataka, India.

² Professor and HOD, Department of Forensic Medicine and toxicology, Jawaharlal Nehru Medical College, Belagavi, Karnataka, India.

³ Assistant Professor, Department of Forensic Medicine and Toxicology, Sri Venkateswara Medical College Hospital and Research Institute, Redhills, Chennai, Tamil Nadu, India.

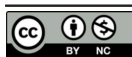
⁴ Associate Professor, Department of Forensic Medicine and Toxicology, Jawaharlal Nehru Medical College, Belagavi, Karnataka, India.

CORRESPONDING AUTHOR:

Debraj Banik, Postgraduate Trainee, Department of Forensic Medicine and Toxicology, Jawaharlal Nehru Medical College, Belagavi, Karnataka, India.

E-mail: deb411990@gmail.com

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Results: The audit revealed marked inter-departmental variation in documentation standards. Forensic Medicine & Toxicology demonstrated the highest accuracy, with only 1.1% cumulative documentation errors, reflecting stringent medico-legal protocols. The highest deficiencies were observed in Internal Medicine (18.5%) and General Surgery (11.7%), largely involving incomplete demographic entries, irregular clinical notes, missing time documentation, and inconsistent filing of supporting documents. Additional lapses were noted in operative notes, weekend entries, and signature authentication across several departments.

Conclusion: Regular audits, training in medical record-keeping and implementation of standardized documentation protocols are essential to improve the quality of medical records and reduce medico-legal risks. Strengthening documentation practices supports better patient care, enhances institutional accountability, and safeguards healthcare professionals in legal contexts.

KEYWORDS

- Medical documentation • Legal compliance • Confidentiality • Ethics
- Healthcare providers

INTRODUCTION

A patient's treatment may be planned and evaluated by healthcare professionals with the use of a medical record, which also guarantees continuity of care among different providers.¹ Medical records, which describe a patient's interactions with healthcare facilities. They are crucial for future use and clear communication between clinicians who want to better understand the patient's health and clinical care, both in a hospital setting and in the community.^{2,3} In environments with a high patient volume and complicated situations, such as the emergency department (ED), it has been discovered that the quality of the documentation is deficient. The diversity and quantity of medical personnel caring for the patient has a detrimental impact on the documentation's quality as well. When patient care is transitioning, the need for precise documentation is even more crucial since poor patient Documents might cause unneeded delays and medical errors. Furthermore, since patient records are a major source of data used to organise research and quality improvement projects, allocate resources, and apply for funding, inaccurate or incomplete documentation may have a negative impact on the quality of healthcare services that are not directly related to clinical care. Numerous factors have been proven to have a detrimental impact on quality, including the number of patients, the complexity of the cases, and

the type and quantity of healthcare experts participating in the patient's treatment.

The National Institute of Clinical Excellence (NICE) defines Clinical audits as, "A quality improvement process that seeks to improve patient care & outcomes through systematic review of care against explicit criteria and the implementation of change".⁴ Clinical audit is a quality improvement method that aims to enhance patient care and results by conducting a systematic assessment of treatment in comparison to predetermined standards or criteria and, if necessary, making appropriate adjustments to practice. Electronic medical record (EMR) systems were implemented in several Emergency departments (ED) with the goal of enhancing the accuracy and completeness of medical data while lowering emissions. Although this is a very positive development, opinions on the effectiveness of this new documentation technique are still conflicting.⁵

MATERIAL AND METHODS

The 1250-bed multi-specialty hospital where this retrospective, descriptive study was done has wards for General medicine, Gynaecology and Obstetrics, Forensic medicine and Toxicology, Surgery, ENT, Ophthalmology, Paediatrics, Dermatology, and Psychiatry. From April 2022 to April 2023, a systematic random sample of the inpatient medical records for the previous 12 months was taken.

Systematic random sampling was done by calculating a sampling interval (k) for each department and selecting every k -th case sheet after choosing a random starting point. This process continued until 50 records were obtained from each department. A total of 450 case documents from each department (50) were included in the sample. The Institutional Ethics and Research Committee provided prior approval. The Helsinki Biomedical Ethics Guidelines, which are principles and standards relevant to the ethics of human research, have been respected and adhered to throughout this study. The accuracy of the following records was assessed: the date of admission, the serial number, the demographics (age, sex, and patient number), the history, the physical examination, the results of any investigations, the diagnosis, the course of treatment, the attending physician, the specifics of the procedures, a day-by-day rundown, and the follow-up history; availability of supporting documents in the relevant part; The first, second, and third doctors listed are accessible via means of communication. Data collection was done by using a quantitative methodology. Survey and observation methods were employed. With a handful of the quality indicators serving as the baseline, a systematic checklist (audit tool) was created. A structured audit checklist containing 12 domains such as demographics, admission details, history, examination, investigations, diagnosis, treatment notes, procedures, daily progress, discharge summary, signatures, and supporting documents, was used. Each item was scored as complete, incomplete, or absent, allowing calculation of a cumulative documentation quality score for each department. Follow-up was assessed, but because it frequently takes place at a separate period from the rest of the inpatient book, it was excluded in the final primary outcome analysis. Statistical Package for Social Science software (SPSS) version 23.0, EpiData Analysis v 2.2.0.164, MedCalc 18.11 was used to analyse the data. Frequencies and percentages were used to express qualitative variables.

RESULTS

A total of 450 inpatient case records were reviewed across nine departments, with 50 records sampled from each department through systematic random sampling. The distribution of case records used for the audit is presented in Table 1.

Table 1: The frequency of cases Records categorized by Department

Departments	Case Records Frequency
Forensic Medicine & Toxicology (FMT)	50
Internal Medicine (IM)	50
Gynaecology & Obstetrics (OBG)	50
General Surgery (GS)	50
ENT	50
Ophthalmology (OPH)	50
Paediatrics (PAED)	50
Dermatology (D)	50
Psychiatry (PSY)	50
Total	450

Different departments surely maintain records to varying degrees from one another. Forensic medicine and Toxicology was regarded to be the most excellent department with cumulative document errors 1.1%, whereas the departments of internal medicine and surgery (cumulative document errors 18.5% and 11.7% respectively) were found to be deficient in Table 3. Although most departments demonstrated acceptable standards in documenting essential identifiers such as the patient's name, printed name, date, and signatures, several important inconsistencies were revealed through the audit tool analysis (Table 2).

Demographic details including age or birth date, hospital identification number, and contact information were frequently incomplete in Internal Medicine, where up to 16% cases lacked age/ID and 22% lacked contact numbers, and similar gaps were noted in Paediatrics and Dermatology. Clinical entries also showed notable variation: many records lacked comprehensive physical examination findings or contained irregular day-to-day progress notes, especially during weekends, with Internal Medicine and General Surgery each showing 16–20% missing entries. Time documentation emerged as a major deficiency across several departments, with missing entries recorded in 36% cases in Internal Medicine, 24% in Obstetrics & Gynaecology, 18% in General Surgery, and 20–22% cases in ENT and Ophthalmology, indicating inadequate chronological tracking of clinical care. In addition, patient identification and proper preservation of notes were less consistent in Internal Medicine, where 30% records lacked clear identification, and similar

but lesser deficiencies appeared in OBG and GS. Procedure-related documentation was particularly variable, with surgical departments displaying incomplete operative notes and postoperative instructions, reflected by 14–18% missing entries across GS, ENT, and OBG. While handwriting was generally legible, several departments particularly Internal Medicine, OBG, and Paediatrics had 30–70% oversized case sheets, suggesting disorganized filing and a higher likelihood of page loss. Furthermore, signature-related errors such as missing signatures, absent seals

or designations, or illegible sign-offs were more commonly seen in Internal Medicine (32%), General Surgery (28%), and ENT (24%), suggesting inconsistent adherence to authentication standards. Overall, the structured audit tool revealed marked inter-departmental variation, with Forensic Medicine & Toxicology showing consistently compliant documentation and the lowest error frequency, while Internal Medicine, General Surgery, and selected other departments displayed higher rates of incomplete, inconsistent, or missing entries.

Table 2: Clinical Audits - Cases Records categorized by Department

Audit tool Present (Yes/No)	FMT	IM	OBG	GS	ENT	OPH	Paed	Derma	Psyc
Name	50/0	45/5	47/3	50/0	50/0	49/1	47/3	49/1	50/0
Printed name	50/0	43/7	46/4	48/2	50/0	48/2	45/5	49/1	50/0
Birth date (Age) and hospital ID number	48/2	42/8	45/5	43/7	46/4	46/4	43/7	48/2	47/3
Contact number	50/0	39/11	43/7	44/6	45/5	45/5	43/7	45/5	50/0
Name of the person who filled out the entry	48/2	44/6	45/5	42/8	42/8	46/4	44/6	44/6	49/1
Number of entries overall	-	45/5	47/3	45/5	47/3	47/3	44/6	45/5	46/4
Signature	50/0	48/2	50/0	50/0	49/1	50/0	49/1	50/0	50/0
Date	50/0	47/3	49/1	47/3	49/1	50/0	48/2	50/0	50/0
Time	50/0	32/18	38/12	41/9	40/10	39/11	45/5	42/8	47/3
Patient identification	50/0	35/15	40/10	40/10	42/8	38/12	42/8	45/5	47/3
Case sheet entry for all days, including on the weekends	-	42/8	45/5	45/5	47/3	45/5	47/3	47/3	48/2
Are the entries for the current admission properly filled	-	40/10	46/4	46/4	45/5	42/8	46/4	47/3	49/1
Are the notes on the ward placed & preserved properly	50/0	39/11	41/9	43/7	46/4	45/5	48/2	48/2	48/2
Current operational notes	50/0	41/9	43/7	42/8	45/5	42/8	47/3	-	-
Legible	50/0	44/6	46/4	46/4	48/2	46/4	47/3	49/1	49/1
Postoperative instructions that are distinct and clear	-	45/5	46/4	48/2	45/5	48/2	48/2	-	-
Oversized	0/50	22/28	15/35	12/38	10/40	14/36	9/41	10/40	6/44
Signed errors	4/46	16/34	10/40	14/36	12/38	11/39	11/39	5/45	7/43

Table 3: Documentation cumulative errors categorized by Department

Departments	Cumulative documentation error %
Forensic Medicine (FMT)	1.1
Internal Medicine (IM)	18.5
Gynaecology & Obstetrics (OBG)	9.5
General Surgery (GS)	11.7
ENT	8.5
Ophthalmology (OPH)	8.6
Paediatrics (PAED)	9.6
Dermatology (D)	7.1
Psychiatry (PSY)	4.1

DISCUSSION

According to WHO's Medical Records Manual: A Guide for Developing Countries, 2006, the four main elements of an in-patient medical record are administrative data, clinical data, legal data, and financial data.⁶

Medical records are files that contain information regarding a patient's identity, examination, treatment, and other actions at a healthcare facility. A collection of information about who, what, where, and how to care for the patient while they are in the hospital is contained in the medical record. The "alfred values," which are viewed as

having administrative, legal, and financial value are what make up a medical record's worth- Research value, educational value, and documentation value. Medical records can serve as legal documents, specifically as crucial evidence as an expert witness; however, it depends on the judge's judgement.

The judge has a major role in determining the importance and place of the medical record throughout the trial. In order to lower morbidity and avoid death, medical records are also crucial for assessing the quality of healthcare provided and the performance of healthcare personnel. "Medical records may be used as evidence in legal proceedings, in the administration of medical and dental discipline and in the upholding of medical and dental ethics."

For evidence in medico-legal situations, an in-depth medical record is essential. Medical records must have adequate information to identify the patient and substantiate the diagnosis or reason for the visit and health care institution to explain the therapy and the outcomes of that treatment.

This issue will be solved by the greater and maybe exclusive use of electronic records, but in the interim, physicians are responsible for writing clearly. The ability to discover information will be directly impacted by note size.

Oversized notes will be difficult to manage, may have pages fall out, and people will be hesitant to file them. The existing paper-based clinical notes' excessive quantities and storage issues will also be resolved by electronic records. Although electronic records seem perfect, there are other issues to be resolved. These include expenses (both up-front and ongoing) for a financially strapped health service, personnel training, and managing system disturbances.^{7,8}

Based on the findings of this study, we are able to provide a number of potential solutions and conduct an interesting and enlightening analysis of the moral and legal problems associated with patient care documentation.

A research carried out at Felegehiwot Referral Hospital by Feleke *et al.* supports the findings of the majority of survey respondents (52.8%) who stated that when medical documentation was insufficient, pharmaceutical errors were

administered. These results are higher than the South African ones from Cape Town.^{9,10}

This may arise from care givers inadequate understanding of the importance of medical records.¹¹ Additionally, this study attempted to pinpoint several self-reported obstacles to health workers' medical record-keeping practices. The participants listed many possible barriers to documentation, including insufficient staff, insufficient time, unfamiliarity with standard documentation sheets, and insufficient ability. According to the research from Nigeria¹², a key obstacle to medical recording among health professionals is a lack of time and insufficient documentation sheets. Strong evidence against the doctor in situations of negligence stemming from improper documentation. The patient has the right to take action by bringing a civil lawsuit if they have been harmed by the doctor's certificate being filled out with false, inaccurate, or misleading information. A doctor's ability to demonstrate his competence and refute allegations of negligence is supported by adequate documentation.

In order to decrease medical negligence cases and to secure proper documentation, the results of this study suggest the following measures:

Consent Importance

- Defence from legal action of Medical Negligence Cases.
- Patients' claims that they understood the nature of the operation for which they gave consent.
- It was inappropriate to do the procedure without receiving informed consent.

OPD card and supporting documents must be completed as follows:

- Full name is written legibly (ideally computerized or with clear writing in capital letters).
- Age, gender, and mother's, father's, and husband's names.
- Address and phone numbers in complete manner.

Surgery Records:

- The most frequent reason for negligence lawsuits is surgical complications.
- The properly documented surgical

records include complications and treatment.

- Summary of the discharge: findings from the investigation, complications, preventive measures, and recommended treatments.
- Clear explanations should be mentioned throughout the follow up visits.
- Warning indications that necessitate prompt treatment to be mentioned in the discharge note.
- Additionally, the paramedical team must be trained in advance to triage such patients and get them to a senior physician/surgeon as soon as possible.

Referral notes

- Keep another duplicate of the referral note with the patient's and witness' signature in case it is referred to someone outside of the healthcare facility.
- This supports claims that the patient's condition was referred shortly after they became worse.
- The referral's date and time.
- Explanations for referral.
- Decisions made in accordance with a doctor's referral should be mentioned.

Discharged in Against Medical Advice-AMA:

- Advice on the necessary course of action and its potential consequences (in the patient's or their relatives' language).
- The patient's opposition to the therapy.
- The doctor, the patient, or a witness should all sign the document in the discharge summary.

Each patient's records should include the following:

- The reason of the hospital visit.
- Important past history.
- Examination findings.
- Results of laboratory tests.
- Assessment, diagnosis, and treatment strategy.
- Important findings, both positive as well as negative.

Prescription:

- Capitalized generic medicine names, dosage instructions, and frequency.

- Don't include the pharmacy or medical shop name on prescription letters.
- Side effects of the pharmaceuticals being taken as directed Doctor's signature and seal.

Recommendations for legal documentation:

- The court will only believe your documents - "If something wasn't documented, it wasn't performed".
- Errors should not be removed with a rubber, whitener or scribbling.
- Immediately correct all mistakes.
- Spell correctly.
- Write down the details in objective language.
- Completely document, avoid ambiguous statements.
- Be precise with the date and time and note any omissions and the subsequent actions.
- Never leave out any space.
- Write clearly and in pen - Including phone consultations, keep a record of everything you do, in accordance with the regulations.
- There's no erasable pencils should be used.
- Use only recognized abbreviations!
- Sign at the right place.
- Never use a whitener - A single line should be drawn through the mistake. Add a message outlining the change. Put the Date and sign over the modification.
- Keep a record of all medical certifications that were issued, including the patient's signature and at least mention two particular kind of identification mark.
- Medical records should be computerized to facilitate speedy retrieval.

Preservation of Medical Records:

- National Medical Council regulations for OPD/IPD hard copy: 3 years
- Medico-legal case/IPD: 10 years or till the disposal case
- Electronic medical record that will be kept endlessly.
- Pre-Conception and Pre-Natal Diagnostic Techniques Act (PC-PNDT Act) Rules, 1996: 2 years

- Consumer Protection Act, 1986: 2 years
- Medical Termination of Pregnancy Rules, 2002: 5 years
- If a patient requests a copy of their medical records, they must be provided within 5 days.

CONCLUSIONS

We advise that in order to maintain proper medical record keeping, periodical audits are necessary attributable to the on-going rotation of trainee doctors. To some extent, the requisite high standards will be kept by the formal education of medical students and clinicians as well as the reinforcement of these behaviours at chances like hospital inductions. Medical documentation represents the worth and morality of the healthcare system in addition to being a professional and ethical obligation. It offers a record of the patient's care, diagnosis, treatment, and results that may be utilised for legal protection, research, communication, and quality improvement. Along with ensuring correct and prompt payment for the services, it also helps to demonstrate the medical need, the professional competence, and the functional objectives of the service. For medical documentation to meet the requirements and recommendations for health records, it must be clear, succinct, and pertinent. Healthcare personnel may increase the standard of care for their patients and lower the chance of mistakes, disputes, and liabilities by correctly documenting the duties they perform.

Institutional Review Board Statement

A prior approval was obtained from the Institutional Ethics and Research Committee. (Ref- MDC/DOME/343).

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Conflict of Interest:

The authors declare that they have no conflicts of interest. Moreover, they declare that no competing interests exist.

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