SHORT REPORT

Assessment of Compliance with Bed Head Ticket Documentation Standards in a Tertiary Hospital in Sri Lanka: A Document Audit

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Abstract

In Sri Lanka, the Bed Head Ticket (BHT) serves as the primary medical record for in-patient care, and inaccurate documentation within it can pose significant risks to patient safety. This audit aimed to assess compliance with BHT maintenance guidelines among healthcare professionals in two wards at a tertiary hospital in Sri Lanka. A 25-item audit tool, based on Ministry of Health guidelines, was used to review 101 randomly selected BHTs from medical and surgical wards in February 2023. Compliance was categorized as satisfactory, unsatisfactory, or not applicable, with items marked as not applicable when specific conditions rendered the standard irrelevant. Findings revealed unsatisfactory compliance in areas such as proper documentation of patient's blood group (100%), staff identification (62.4%), and consistent date/time recording (63.4%). In contrast, higher levels of satisfactory compliance were observed in prescription practices (100%) and care plan documentation (100%). Based on the identified gaps, recommendations include in-service training, introducing name stamps for staff, and promoting consistent documentation practices.

Keywords: medical records, healthcare guidelines, Sri Lanka, document audit

1 | Introduction

In Sri Lanka, the Bed Head Ticket (BHT) is the main medical record used in in-patient care and management. It contains vital information about the patient, such as admission data, medical history, clinical findings, diagnosis, care plan, investigations, and other essential details. The BHT is also a legal document that can be produced in medico-legal inquiries. Inaccurate, illegible documentation and inappropriate maintenance of BHTs can pose a significant threat to patient safety and quality (Demsash et al., 2023; Madden et al., 2018).

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The general circular issued by the Ministry of Health in 1999 served as the guideline for BHT maintenance until recently. In September 2022, a new guideline was introduced by the Ministry of Health to ensure prompt and quality patient care and to minimize medical errors (Ministry of Health Sri Lanka, 2022). Adherence to the new guidelines is expected to safeguard healthcare providers in case of litigation issues.

Despite the guidelines issued by the Ministry of Health, it was unknown how healthcare providers in Sri Lanka are complying with the new BHT maintenance guidelines. Accurate and complete documentation in the BHT is essential for ensuring continuity of care, supporting clinical decision-making, and maintaining patient safety. With the introduction of new BHT maintenance guidelines, it is crucial to assess whether healthcare professionals are adhering to the expected standards, particularly in busy clinical settings where documentation errors are common. Auditing compliance provides evidence on the effectiveness of the guidelines, identifies gaps in current practice, and highlights areas requiring further training or system improvement.

The gap between the guideline expectations and real-world practices could potentially compromise patient safety, continuity of care, and decision-making (Ricciardi & Cascini, 2021). Therefore, conducting this audit is crucial in identifying whether the new guidelines are being followed as intended and understanding the barriers that may be hindering full compliance. This will provide valuable insights into areas of further training, system improvements, or policy adjustments.

Ethical Oversight

According to guidelines on clinical audit-related ethical oversight (Kinn, 1997; University Hospital Bristol, 2009; Dixon, 2025) the audit team maintained the ethical practices related to audits on patient records. BHTs were not taken outside the premises of the medical records room. Confidentiality and privacy of patient information were ensured. Data on any identifiable details of the patient were not collected or recorded. Anonymity of the staff was ensured. Identifiers of the ward and ward staff who were involved in record-keeping were not included in the data matrix.

This audit was a quality improvement exercise. The hospital administration provided approval to conduct the audit considering the following facts: The audit did not have any intervention or interviewing patients, carers or staff members; nor did it assess the suitability of clinical procedures, decisions or outcomes and was strictly limited to examining the compliance with the BHT maintenance guideline (Sabhapathige et al., 2024).

Authorisation to conduct the audit was obtained from the hospital's Director and the audit was registered at the Medical Records Unit of the hospital. Results were presented to the hospital authority. Consent was taken from the hospital's Director for the dissemination of results.

2 | Methods

Guided Model

This audit was conducted adhering to the PDSA (Plan-Do-Study-Act) cycle. The PDSA cycle is used as a structured methodology for continuous quality improvement (CQI) to enhance healthcare practices (Christoff, 2018; Manandi et al., 2024; Taylor et al., 2014). This audit followed the PDSA cycle to systematically evaluate and improve the standardisation of Bed Head Ticket (BHT) documentation. Plan: At the Ministry level, a decision has been made to standardise BHT documentation to ensure consistency, accuracy, and adherence to best practices across healthcare institutions. Do: Producing a guideline that clearly defines BHT maintenance standards. Study: An audit was then conducted to evaluate the extent to which healthcare professionals adhered to the newly established BHT maintenance standards. Act: Based on the findings from the audit, actions were recommended to address gaps in compliance.

Audit Indicators and Standards

An audit tool was developed based on the BHT documentation guideline by the Ministry of Health, Sri Lanka in 2022 (Ministry of Health Sri Lanka, 2022). It was reviewed for clarity and content appropriateness by two Sri Lankan experts (a nursing educator and a hospital administrator). There are overall 30 standards provided in the guideline. However, five items were not suitable as audit indicators as they should be observed during the actual time to determine accuracy. Standards to be followed by physicians when planning and documenting the management of the patient were excluded as it was in the realm of clinical decision making. Hence, only 25 standards were included in the audit tool.

Audit Setting

The clinical audit was conducted in a tertiary hospital in the Western Province. Two wards, a surgical ward and a medical ward were randomly selected.

Audit Sample

Using a 95% confidence interval (z = 1.96), a margin of error of 10, and an estimated population proportion of 50%, the calculated sample size required for analysis was 88 BHTs. Due to the feasibility of auditing a higher number, it was decided to audit 10% from each ward.

Disproportionate stratified random sampling was done. From each ward,10% BHTs from the admissions during February 2023, were randomly selected and included in the sample.

Total number of admissions to the medical ward in February 2023	-	646
10% of medical ward admissions	-	65
Total number of admissions to the surgical ward in February 2023	-	356
10% of surgical ward admissions	-	36
Total number of BHTs audited	-	101

Audit Process

The audit was conducted on 08th April 2023. BHTs were selected using the Excel random number generator. Selected 101 BHTs were audited using the audit tool. Compliance was determined and recorded under three categories: satisfactory, unsatisfactory, or not applicable by a single member in the team to maintain consistency. Any ambiguities in documents were discussed with the medical records office staff and rectified. The audit was done under the supervision of a senior nursing academic as a proactive measure to resolve any issues. Data were directly fed into an Excel document and later stored in a password protected external storage device.

The percentages were calculated based on the number of applicable cases for each criterion, with the total number of cases considered as the denominator.

3 | Results

Audit results were analysed to determine the percentage of compliance among healthcare professionals on 25 BHT maintenance standards. The specific BHT maintenance standards that have not met full compliance requiring further improvements or training for healthcare professionals were identified and presented in Table 1.

The audit revealed strong satisfactory results across several key areas of BHT documentation. We observed a 100% compliance in multiple aspects, including the documentation of the principal diagnosis, maintaining continuous sheets (such as proper page numbering, intact pages, and accurate recording of name, ward number, and BHT number), and individual entries (such as writing entries in chronological order, identifying the most senior healthcare professional, recording all communications, and using blue or black ink). Furthermore, 100% compliance was achieved in ensuring that all diagrams were clear and properly labeled, abbreviations were avoided, and that actions for identified problems and care plans were comprehensively documented. Medications were consistently prescribed using their generic names, and within-hospital transfers were properly documented with details of the new consultant, date, and time. Additionally, consent for treatment and procedures was always clearly documented.

The audit revealed several significant unsatisfactory findings too. 100% non-compliance was found in documenting allergy status and blood group, sub-folder numbering, and providing separate subsections for different categories of staff. Additionally, 100% non-compliance was observed in the practice of repeating and verifying instructions received. Furthermore, 37.6% of entries were unsatisfactory for placement of name, designation, and signature at the end of each entry, while 36.6% of entries lacked proper date and time documentation at the beginning. Although only 3 (3.0%) patients had allergies, none of their BHTs documented the allergy status in red on the front page. These areas showed the alarming rates of non-compliance and require immediate corrective action.

4 | Discussion

The results of this audit indicate that while there are many satisfactory practices in maintaining BHTs, several areas require substantial improvement. This mirrors findings from several studies conducted in Sri Lanka, such as (Mallawarachchi & Mallawarachchi, 2020; Mallawarachchi, 2022; Sabhapathige et al., 2024), where similar issues with clinical documentation were identified. However, this audit adds new insights by revealing critical areas where non-compliance persists, specifically in the documentation of allergies, blood groups, and the placement of signatures. The audit also highlights discrepancies in the consistency of documenting allergies on the BHT front

page, even though this information was recorded in drug charts, suggesting an issue with documentation practices that is not just about knowledge but also about the systems in place.

Table 1. Compliance with Bed Head Ticket (BHT) Documentation Standards

No.	Description of the criteria	Satisfactory n (%)	Unsatisfactory n (%)	Not applicable n (%)
1	All cages are filled legibly and accurately	94 (93.1%)	7 (6.9%)	0 (0.0%)
2	Allergy status (if any) is mentioned in red	0 (0.0%)	3 (3.0%)	98 (97.0%)
3	The blood group is mentioned in red	0 (0.0%)	101 (100.0%)	0 (0.0%)
4	The principal diagnosis is written (if available)	101 (100.0%)	0 (0.0%)	0 (0.0%)
5	All pages are numbered at the top right-hand corner	101 (100.0%)	0 (0.0%)	0 (0.0%)
6	All pages are intact	101 (100.0%)	0 (0.0%)	0 (0.0%)
7	Sub-folders are numbered	0 (0.0%)	101 (100.0%)	0 (0.0%)
8	The patient's name, ward number, and BHT number are written at the top of each page	101 (100.0%)	0 (0.0%)	0 (0.0%)
9	Separate subsections are provided for different categories of staff	0 (0.0%)	101 (100.0%)	0 (0.0%)
10	Entries are written in chronological order	101 (100.0%)	0 (0.0%)	0 (0.0%)
11	The name, designation, and signature are clearly placed at the end of each entry	63 (62.4%)	38 (37.6%)	0 (0.0%)
12	The date and time are written at the beginning of each entry	64 (63.4%)	37 (36.6%)	0 (0.0%)
13	The most senior healthcare professional present is identified when making an entry	101 (100.0%)	0 (0.0%)	0 (0.0%)
14	All communications regarding the patient (including telephone) are recorded	65 (64.4%)	0 (0.0%)	36 (35.6%)
15	Instructions received by another are repeated back, and verified	0 (0.0%)	65 (64.0%)	0 (0.0%)
16	No undue space in between entries	96 (95.0%)	5 (5.0%)	0 (0.0%)
17	Clarity and legibility of all entries are ensured	99 (98.0%)	2 (2.0%)	0 (0.0%)
18	Blue or black ink is used for making entries, except for special entries	101 (100.0%)	0 (0.0%)	0 (0.0%)
19	All diagrams are clear and properly labeled	74 (73.3%)	0 (0.0%)	27 (26.7%)
20	Abbreviations are avoided (except for standard abbreviations)	101 (100.0%)	0 (0.0%)	0 (0.0%)
21	Action taken for an identified problem is always documented	101 (100.0%)	0 (0.0%)	0 (0.0%)
22	The care plan is documented as comprehensively as possible	101 (100.0%)	0 (0.0%)	0 (0.0%)
23	Medications are prescribed using their generic names at every possible instance	101 (100.0%)	0 (0.0%)	0 (0.0%)
24	For within-hospital transfers, the name of the new consultant, date, and time are recorded	4 (4.0%)	0 (0.0%)	97 (96.0%)
25	Consent taken for treatment and procedures is clearly documented	20 (19.8%)	0 (0.0%)	81 (80.2%)

The findings of 0% compliance for allergies and blood groups being documented in red are concerning, as these are critical for patient safety, particularly in preventing adverse drug reactions. The systemic factors contributing to this could include a lack of standardized protocols, inadequate training, or inconsistent enforcement of guidelines (Demsash et al., 2023). A previous study also pointed to a lack of training as a key contributor to poor documentation in Sri Lanka (Mallawarachchi & Mallawarachchi, 2020). Therefore, it is vital to explore whether there are gaps in training or role clarity. The lack of clarity in documentation roles and workload pressures may contribute to these lapses in documentation, as healthcare professionals may prioritize clinical tasks over documentation, particularly in high-pressure settings (Bjerkan et al., 2021). Studies have suggested systemic challenges such as staffing shortages, unclear roles, and heavy workloads might be influencing documentation practices (Shihundla et al., 2016).

One interesting observation in this audit was that allergies were documented in drug charts but not on the BHT front page. This discrepancy suggests a lack of alignment in documentation systems within the hospital, where different teams may not be aware of or follow the same standards. This could point to a broader issue with documentation culture, where certain critical data might be captured in specific forms (e.g., drug charts) but not others, potentially due to the absence of a standardised protocol for where and how specific information should be recorded. As mentioned in a previous study (Mallawarachchi & Mallawarachchi, 2020) inconsistent documentation practices among healthcare professionals often arise from such system-level discrepancies.

Furthermore, this audit also revealed a gap in the documentation of date and time for entries, with only 63.4% of cases fully complying. This gap is concerning, as the accurate recording of dates and times is essential for patient care continuity and legal purposes. It could be attributed to the busy nature of clinical practice, where such documentation details might be overlooked during patient rounds or due to time constraints. This points to the need for stronger enforcement of documentation protocols and potentially, more training on their importance.

The audit revealed several areas of satisfactory performance, particularly in the prescription of medications and the documentation of care plans/management, which were fully compliant with the standards set by the Ministry of Health, Sri Lanka. These critical components of patient care were maintained to a high standard, ensuring that patients received appropriate treatment and that their care plans were clearly documented and actionable. Despite the significant challenges posed by staff shortages and the ongoing crisis in the country, the commitment of staff members towards ensuring proper documentation deserves recognition. Their dedication to maintaining these standards, even in difficult circumstances, reflects a strong sense of professionalism and a commitment to patient safety and quality care. This adherence to standards, despite external pressures, highlights the importance of staff resilience and the essential role of clear, comprehensive documentation in the healthcare system.

This audit has several limitations, notably the inclusion of admissions from only a single month and the observation of a single hospital, which limits the generalisability of the findings. Furthermore, while the audit provides a snapshot of documentation practices, it does not explore the reasons behind non-compliance in depth, limiting the ability to identify root causes. Additionally, assessing inter-rater reliability could have enhanced the credibility of the results.

5 | Conclusions and Recommendations

While the audit results demonstrate that certain aspects of BHT documentation are being maintained at a high standard, there are significant areas that require attention, particularly in the documentation of allergies, blood groups, and signature placement. These gaps point to potential system issues, including inconsistent documentation practices, insufficient training, and the challenges posed by high workloads. The fact that critical information like allergies is documented in drug charts but not on the BHT front page underscores the need for standardisation in documentation practices across all departments.

Given the findings, several recommendations are made to address these gaps. Short-term actions should include the introduction of training programmes for staff, with a focus on the importance of consistent documentation, particularly for allergies and blood groups. Additionally, hospitals should consider introducing "name stamps/seals" to streamline the documentation process and improve compliance. System-level improvements should include the revision of the BHT templates to ensure that all required fields are clearly outlined and easy to complete. Furthermore, the introduction of dedicated documentation time during shifts could alleviate workload pressures, allowing staff to prioritize accurate record-keeping.

The audit cycle should be completed with a re-audit plan to evaluate the effectiveness of these interventions. The re-audit should focus on the percentage of BHTs that meet documentation standards, particularly regarding the areas identified as problematic, and assess the sustainability of the improvements. The SMART recommendations for the next phase should focus on measurable improvements in these areas, with a timeline for implementation and specific targets for improvement.

Overall, this audit highlights the need for a comprehensive approach to improving BHT documentation, which includes training, standardised protocols, and system-level changes to address both individual and organisational challenges. By implementing these recommendations and conducting a follow-up re-audit, it will be possible to ensure that these issues are systematically addressed, improving the quality and consistency of clinical documentation in the hospital.

Author Contributions

DMAP: Conceptualization, data collection, data analysis and manuscript drafting
SSPW: Data analysis, critical revision, supervision
Both authors have read and approved the final manuscript

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