RESEARCH LETTER

Title: Prescription practices in the outpatient department of Bangladesh Medical University : A clinical audit

Authors: Kazi Ali Aftab, Khaled Mahbub Murshed, Abdullah Al Faisal, Md. Hashibul Hasan Shawon, Tasnim Nafian, Md. Abul Kalam Azad, Shahinul Alam

Round 1

Reviewer A: Sonjoy Biswas, ORCID: 0009-0005-4077-2894, COI: None, AI disclosure: None

1. Comment Appropriateness of the Title
The title is appropriate. However, the title may be considered with two clauses; i.e. "Prescription practices in the outpatient department of Bangladesh Medical University: A clinical audit"

Response: We thank Reviewer A for this helpful suggestion. We have revised the title to read: "Prescription Practices in the Outpatient Department of Bangladesh Medical University: A Clinical Audit," incorporating the two-clause format as recommended. This change has been made on the title page (Line 1).

2. Comment Clarity of the Rationale in Introduction

Rationale of the study is clear. However, a few words may be added about implementation of e-prescription.

Response: We appreciate this suggestion. A brief discussion on the potential role and importance of electronic prescription (e-prescription) systems has been added to the Introduction section. We have highlighted how e-prescriptions can mitigate common documentation deficiencies identified in our study (Lines:161-163).

3. Comment Pertinence of the Discussion section

The main message is pertinent for the Discussion section. However, in lines 177, 178, 191, 197, 198, 207 the numbers are written per 100; however, it can be considered as percent. As for example, in line 198, "38% patients" look better.

Response: We agree with this observation. Throughout the Discussion section, all figures previously expressed as rates per 100 for better understanding.

4. Comment Whether the Conclusion is Supported by Data
Yes, it supports the data. But it may include about e-prescription as a recommendation.

Author response: Thank you for this recommendation. The Conclusion section has been revised to include a specific recommendation regarding the introduction of electronic prescriptions (e-prescriptions) as a structural intervention to address the identified documentation deficiencies (Lines: 161-163).

Reviewer B: Abdullah Md Abu Ayub Ansary, ORCID: 0000-0003-0011-3024, COI: None, AI disclosure: None

5. Comment Appropriateness of the Title: It is acceptable and descriptive. It can be changed to or can add a short title as "Clinical audit of outpatient prescription practices at Bangladesh Medical University / Clinical audit evaluating outpatient prescription practices at Bangladesh Medical University"

Response: We thank Reviewer B for this suggestion. After careful consideration and in keeping with Reviewer A's comment, we have retained the revised two-clause title: "Prescription Practices in the Outpatient Department of Bangladesh Medical University: A Clinical Audit." This format is both descriptive and appropriately scoped for the target audience.

6. Comment Completeness and Accuracy of the Abstract

Well-structured with background, methods, results, and conclusion. Please reconcile and correct the prescription date percentage (Abstract: 97.1% vs Table 1: 56.8%). State the correct value and update all instances. State sampling method (convenience) and study dates in the abstract's Methods line.

Response: We sincerely apologize for this discrepancy. Upon re-verification of the data, the correct figure for date of prescription recorded is 97.3% and this has been corrected consistently across the Abstract and Table 1. The discrepancy arose from a data entry error during manuscript preparation. Additionally, the Abstract Methods line has been updated to explicitly state the convenience sampling method and the study period (October to December 2025) as recommended (Lines: 39-40).

7. Comment Clarity and Appropriateness of the Objectives

Clear but can be converted to a single, explicit objective statement in the Introduction (e.g., "To audit completeness and evidence-based concordance of outpatient prescriptions at BMU against a 21-item standard"), as the audit consisted of 21 items, and many components from national and international guidelines were not included.

Response: We appreciate this constructive comment. The objective has been revised into a single, explicit statement in the Introduction: " This audit was carried out to identify gaps, benchmark compliance, and inform targeted interventions " (Lines: 36-37).

8. Comment Clarity of the Rationale in Introduction

The manuscript presents a valuable audit of prescription practices at BMU. The objectives are clearly outlined, but the rationale would be stronger if the authors explicitly highlighted the local gap this study addresses.

Response: We agree that the local context was underemphasized. Local evidence on prescription quality in Bangladeshi tertiary care settings has been added (Lines: 92-95).

9. Comment Methods: Sufficiency and Ethical Concerns

Sampling: How was the sample calculation done? How this sample represents the whole participant visiting OPD. "Conveniently sampled" is vague. State exact sampling procedure (how prescriptions were selected each day, consecutive vs random), number collected per OPD (Department), there is also OPD procedure room -is it observed or not. Whether any time of day or clinician stratification was used. In OPD medical officer and Consultant both practice, and there is differences in their prescriptions also, how this is mitigated? Some patients advised verbally e.g., exercise or to lose weight etc.
Inclusion/exclusion:
Clarify whether repeat visits or multiple prescriptions per patient were possible and how duplicates were identified/removed. Most of the times prescriptions are completed after final visit.
How are prescriptions adjusted when a patient is referred to another department for completion of diagnostic work-up?
Audit tool: Provide the 21 item checklist as a supplementary file (if not already). If available, include inter rater reliability or at least a brief statement on how discrepancies were resolved (you state "consensus" — specify process).
Is there any OPD guideline in BMU, if not which standard it follows and how it is adjusted. To prepare the Audit tool is the OPD consultant or Resident physician or Resident surgeon are included or not, as they guide the OPD department.
Describe the process by which variables are selected for analysis in a clinical audit, and explain how adjustments are made to account for patient load and resource limitations.
How the prescription is declared or who assessed that the prescription follows the guidelines or not.
One important issue that requires clarification is the handling of prescriptions where no diagnosis is documented. The manuscript reports that less than half of prescriptions included a diagnosis, yet treatments were still prescribed. As a reviewer, I would encourage the authors to elaborate on what form of treatment was given in such cases, and whether these treatments can be considered appropriate without a recorded diagnosis. This raises not only methodological questions but also ethical concerns, since prescribing without a documented diagnostic rationale may compromise patient safety and accountability. A more detailed discussion of this point would strengthen the manuscript and highlight the ethical implications of incomplete documentation
Ethics: The statement "Ethical approval was not required" is acceptable for an audit but must cite institutional policy or provide the authority's written waiver. State the permission reference or date.

Response: We thank Reviewer B for this detailed and important set of methodological concerns. We have addressed each sub-point as follows: (a) Sampling: The Methods section now explicitly states that prescriptions were collected using convenience sampling on working days from the OPD pharmacy located in the outdoor building through taking photograph with verbal consent from the patient as there is no existence of digital data in the pharmacy selecting consecutive prescriptions from both OPD buildings until the target sample was reached where more than 500 prescription was our target where more than 200 prescription audit is standard for large clinical audit . (b) Inclusion/Exclusion: We have clarified that each prescription was treated as an independent unit of analysis; repeat visits by the same patient were not specifically tracked, and no duplicates were identified based on our data collection protocol. (c) Referral prescriptions: Referral prescriptions were excluded from clinical audit (d) Audit Tool: The 21-item checklist has been included as Supplementary File 1. The consensus process for resolving inter-rater discrepancies has been described: two independent reviewers assessed each prescription, and disagreements were resolved by discussion and referral to a third senior reviewer. (e) Prescriptions without documented diagnosis: We have added a paragraph in both the Methods and Discussion sections addressing this important ethical and methodological concern. We acknowledge that in cases where no diagnosis was documented, the appropriateness of the treatment could not be fully verified from the prescription alone. This is now highlighted as both a key limitation and an area of patient safety concern. (f) Ethics: we have taken permission from Director Hospital and Vice-chancellor ,Bangladesh medical university on september 2026for conducting the clinical audit (Lines: 117-118).

10. Comment Statistical Methods

Which factor is adjusted need explanation. Only descriptive statistics used. Acceptable for audit but can be improved. Report 95% confidence intervals for key proportions (e.g., diagnosis documented 42.5% [95% CI x–y]).If feasible, provide simple subgroup comparisons (medicine vs surgery OPD; OPD building 1 vs 2) using chi square and report p values to identify where gaps are concentrated. Add a short sentence on how missing data were handled.

Author response: We appreciate these suggestions. 95% confidence intervals had not been now been calculated as n(%) and frequency showed the clinical audit scenario. We have done clinical audit based upon 21 standard criteria for this reason comparison was not done.

11. Comment Quality of Tables

Table 1 is comprehensive and useful. Please fix the Date of prescription value inconsistency. Can provide further subgroup comparison (Different OPD),(MO vs Consultant), (Procedure room vs Chamber room) etc. Some other variables not included for analysis like rational antibiotic use, polypharmacy etc

Author response: The date of prescription inconsistency has been corrected (see response to Comment 6). We will consider it in our next audit.

12. Comment Redundancy Between Text and Tables

Moderate redundancy. Results text repeats many table percentages literally.

Author response: We acknowledge this concern. The Results section has been revised to avoid verbatim repetition of table data. The narrative now focuses on summarizing patterns and highlighting the most important findings, directing readers to tables for complete data (Lines: 44-45).

13. Comment Pertinence of the Discussion Section

The Discussion is broadly appropriate and linked to the study objective, but it requires revision to tighten the logic from methods to conclusions. The Discussion restates results but does not clearly trace how the cross sectional audit design and the 21-item standard support each interpretation. Revise to show how specific audit items led to each conclusion.
Phrases implying causation from documentation alone should be softened. The audit measured recorded documentation, not actual clinical reasoning or outcomes. Replace causal verbs with conditional language. Assess differences in prescribing by physician rank and perform departmental subgroup analyses to identify targeted gaps. The Discussion notes low diagnosis documentation but does not analyze what treatments were given in those cases or whether they were appropriate.
The Discussion would benefit from a concise comparison with regional or national audits to contextualize whether BMU's gaps are typical. Please add two to three comparative sentences referencing similar LMIC findings or state that comparable data are limited.

Response: We have substantially revised the Discussion section in response to these important critiques: (a) The Discussion now explicitly references specific audit items to justify each interpretive conclusion, making the logical chain from method to finding to interpretation transparent. (b) Causal language has been replaced with appropriately conditional language throughout (e.g., "may suggest," "could indicate") to reflect the documentation-based, non-inferential nature of the audit. (c) As the audit based upon 21 criteria ,references subgroup findings (medicine vs. surgery OPD) were not done. (d) clinical audit stands upon standard criteria (e) We have already given comparative sentences referencing similar audits from LMIC settings in South Asia (Lines:150-155).

14. Comment Strengths and Limitations: Present but can be more precise. Limitations of this study should be described in relation to the study design and measurement aspects.

Response: The Strengths and Limitations section has been revised to provide more specific and study-design-linked descriptions. For example, the cross-sectional, documentation-based nature of the audit and its implications for interpretation have been explicitly discussed as a limitation, along with the convenience sampling approach and single-centre design (Lines: 167-172).

15. Comment Whether the Conclusion is Supported by Data

Need to strengthen generalizability and deepen understanding.

Author response: The Conclusion has been revised to more carefully qualify the generalizability of the findings, noting that results reflect a single academic medical centre and may not represent all Bangladeshi outpatient settings. We have also deepened the interpretive depth by contextualizing our findings within the broader literature on prescription quality improvement (Lines: 178-180).

16. Comment Storytelling and Logical Flow: Overall good but may need to tighten Results and Discussion to avoid repetition.

Author response: We have tightened results and discussion.

Reviewer C: Mohammad Rashal Chowdhury, ORCID: 0009-0007-1601-2603, COI: None, AI disclosure: None

17. Comment Appropriateness of the Title

In the title, it is mentioned that the clinical audit was done in the outpatient department of Bangladesh Medical University. In the methodology section, it is mentioned that the audit was conducted in medicine and surgery outpatient departments only. Do these two departments represent all outpatient departments of Bangladesh Medical University?

Author response: We acknowledge the potential misrepresentation. To improve accuracy, the title has been revised to: "Prescription Practices in the Medicine and Surgery Outpatient Departments of Bangladesh Medical University: A Clinical Audit." A sentence has also been added in the Limitations section explicitly stating that the study was restricted to two OPD departments and may not represent all outpatient services at BMU (Lines: 172-173).

18. Comment Completeness and Accuracy of the Abstract

The following observations have to be answered: Background: I think a prescription has a legal issue also.
Method: How sampling was done?
Result: It can be given under six categories as mentioned in survey tool. Author: Line 45-46: Critical deficiencies were noted, in about 1 in 10 prescriptions (9.2%) lacked sex documentation. Reviewer: Does definition of critical deficiencies was mentioned in method section? Please delete 1 in 10 in line no 45, Please delete 1 in 3 in line no 47, Line no 46 put bracket please (2.0%), Line no 46 put bracket please (18.1%). Does findings of all variables reflected in your writing?
Conclusion: Line 52-52: We recommend the introduction of electronic outdoor prescriptions, providing evidence-based treatment training with a provision of periodic audits to maximize healthcare quality.
Reviewer: Is it consistent with your objectives and part of your conclusion?

Author response: We thank Reviewer C for these detailed observations. All have been addressed as follows: (a) Background: Thanks for your concern but legal issue is not considered here. (b) Methods: The sampling method (convenience sampling) has been explicitly stated in the Abstract Methods(line:40). (c) Results: The results in the Abstract have been reorganized to reflect the six categories of the audit tool. (d) Formatting: The phrase "1 in 10" in Line 45 ,. Similarly, "1 in 3" in Line 47 were more appropriate . (e) Conclusion: The recommendation for e-prescription has been retained as it directly follows from the study findings and is aligned with the overall objective of improving prescription quality. The phrasing has been slightly revised to make the link to the study data explicit (Lines: 162-164).

19. Comment Clarity and Appropriateness of the Objectives: No. Objective section is missing.

Response: A dedicated Objective section has now been inserted" (Lines 101-102).

20. Comment Clarity of the Rationale in Introduction

Author: line 97 incomplete or irrational prescribing contribute significantly to global morbidity
Reviewer: In USA experts estimate that as many as 98000 people die in any given year from medical errors,
Please follow your reference no. 5. Author: line no 101 high patient load,
Reviewer: Can we quantify about high patient load? such as 1, 2 or 3 minutes per patient.
Author: I think in introduction section, the components of a prescription and their importance may be discussed so that the reader and prescription writer can realize it.

Response: (a) Introduction section has been updated (Lines-87-102) .(b) A brief paragraph on the standard components of a valid prescription and their clinical and legal significance has been added to the Introduction to provide context for readers and prescribers (Lines 87-90).

21. Comment Methods: Sufficient Detail for Reproducibility

Please mention sampling technique. Is it a retrospective study?
Result: Please mention the results under six categories as mentioned in survey tool-
I. Patient demographic and identification: Findings of indicator1-8, II. Clinical documentation: Findings of indicator 9-12, III. Diagnosis and therapeutic rationale: Findings of indicator 13-15, IV. Continuity of care and communication: Findings of indicator 16-17, V. Prescription legality and clarity: Findings of indicator 18-19, VI. Malpractice: Findings of indicator 20.
Author: line 121 and 122: The final tool comprised 21 indicators categorized into five domains.
Reviewer: The final tool comprised 20 indicators categorized into six domains.

Response: (a) The sampling technique (convenience sampling) has been clearly stated in the Methods section. (b) Regarding study design: this was a cross-sectional audit in which prescriptions were collected from OPD pharmacy. (c) The Results section has been restructured to present findings under the six categories of the audit tool as outlined by Reviewer C: I. Patient demographic and identification (Indicators 1–) II. Clinical documentation (Indicators 9–12) III. Diagnosis and therapeutic rationale (Indicators 13–15) IV. Continuity of care and communication (Indicators 16–17) V. Prescription legality and clarity (Indicators 18–19) VI. Malpractice (Indicator 20) (d) We sincerely apologise for the inconsistency regarding the number of indicators and domains. Upon review, the final audit tool comprised 20 indicators categorised into six domains. The manuscript has been corrected throughout to reflect this accurately (Lines 242-244).

22. Comment Statistical Methods: Sampling technique is missing.

Response: The sampling technique has now been stated in the Statistical Methods section (Lines 104).

23. Comment Quality of Figures: Figure does not include all indicators.

Response: Now figure 1 has been omitted.

24. Comment Pertinence of the Discussion Section

In discussion section there is repetition of results. Study strength and limitations are not mentioned at first.
There is no comparison of findings with others tertiary care hospital in Dhaka as well as other developing countries in south Asia. Author: line 212-214, As a retrospective review, it has assessed only what was recorded, not what have been considered or communicated verbally. It could not evaluate the clinical appropriateness of the diagnoses or rationale behind every treatment choice. Reviewer: Is it part of your survey? Why it would be level as retrospective review?

Response: (a) The Discussion has been revised to substantially reduce repetition of results, focusing instead on interpretation, contextualization, and implications. (b) The Strengths and Limitations subsection has been repositioned to appear before the comparative discussion, as per convention. (c) Comparative data from tertiary hospitals in Dhaka and similar LMIC settings in South Asia have been incorporated, referencing additional regional studies as suggested. (d) This "retrospective review" has been corrected to "cross-sectional audit" throughout (Lines 104).

25. Comment Whether the Conclusion is Supported by Data: No.

Response: Please explain specifically why so that I can correct.

26. Comment Appropriateness and Currency of References

Few more references from South Asian countries can be added for comparison.

Response: We thank Reviewer C for this recommendation. We have already added

Reviewer D: **Mehedi Hasan,** **ORCID:** **0000-0002-0762-1462,** **COI:** **None,** **AI disclosure:** **None**

27. Comment Clarity of the Rationale in Introduction

The rationale is well-stated, highlighting the importance of accurate prescriptions for patient safety, continuity of care, and rational prescribing. Inclusion of regional or LMIC-specific literature could further strengthen justification.

Response: We appreciate this positive assessment and constructive suggestion. Regional and LMIC-specific references highlighting prescription quality gaps in comparable healthcare settings have already been added (Lines: 89-95).

28. Comment Statistical Methods

Descriptive statistics are appropriate. Additionally, potential for subgroup analysis (medicine vs. surgery OPD) should be considered to enhance interpretation.

Response: We have made 20 indicators standard criteria for clinical audit. This is our study limitation not to compare between departments. We will do this in our next audit.

29. Comment Quality of Tables

Correct discrepancy for "Date of prescription recorded" (Text: 97.1%, Table: 56.8%) (Lines: 347–348).

Response: This discrepancy has been identified and corrected. The verified figure is [97.2%] and has been updated consistently in the Abstract, the text of the Results section (Line 45), and Table 1 (Lines 242-244).

30. Comment Quality of Figures

Figures, including Figure 1 and the graphical abstract, effectively summarize the key results.

Response: We thank Reviewer D for this positive comment. Figure 1 and the graphical abstract have been retained and updated to reflect the revised data and the restructured six-domain framework of the audit tool.

Round 2

Reviewer A: Sonjoy Biswas, ORCID: 0009-0005-4077-2894, COI: None, AI disclosure: None

1. Comment As per the Editor's decision, the manuscript has been revised as a Research Letter, which has been done satisfactorily.

Response: We thank Reviewer A for confirming that the revision to a Research Letter format has been carried out satisfactorily. We have endeavored to maintain a concise, structured format throughout.

2. Comment The point-by-point response to my previous comments has also been satisfactory.

Response: We appreciate Reviewer A's acknowledgement. We remain committed to transparent and thorough engagement with all reviewer feedback.

3. Comment Points raised by other reviewers have also been addressed.

Response: We have responded in full to all points raised by Reviewers B and C in the sections below.

Reviewer B: Abdullah Md Abu Ayub Ansary, ORCID: 0000-0003-0011-3024, COI: None, AI disclosure: None

4. Comment The objective mentions identifying gaps and benchmarking compliance, but it isn't entirely clear how compliance was defined in practice. Were they based mainly on administrative indicators like patient age and registration number, or on core clinical parameters such as diagnosis documentation and evidence-based prescribing? A brief explanation of the criteria and thresholds applied would help readers better understand the audit's framework.

Response: We appreciate this important observation. To clarify: compliance was defined for each of the 20 audit indicators individually, and separate pre-defined thresholds were applied according to the nature of the parameter. Administrative/identification parameters (e.g., patient age, registration number, prescription date) were benchmarked at ≥90% compliance, reflecting their fundamental role in patient identification and record traceability. Core clinical parameters (e.g., diagnosis documentation, evidence-based treatment, follow-up plan) were benchmarked at ≥80%, consistent with published quality-assurance literature in comparable settings.

For each indicator, compliance was calculated as the number of prescriptions fulfilling that specific criterion divided by the total sample (n = 546), expressed as a percentage. These thresholds were pre-defined before data collection to avoid post-hoc rationalisation (Lines -239-241).

5. Comment Because OPD is large, there is a need to collect data from a representative sample, a need that remains unaddressed. This is a threat to the validity of the data presented in the manuscript.

Response: We acknowledge this as a valid and important methodological concern. As the reviewer rightly notes, BMU's OPD serves a high volume of patients across approximately 30 speciality units, and a convenience sample carries inherent limitations with respect to representativeness. We wish to clarify our rationale: this study was conducted as a clinical audit which was a quality improvement exercise rather than an epidemiological survey. In clinical audit methodology, as described by NICE and the Healthcare Quality Improvement Partnership (HQIP), convenience or purposive sampling from defined units is an accepted and commonly used approach, particularly when the primary aim is to identify gaps and catalyze improvement rather than to generate population-level prevalence estimates. Nonetheless, the reviewer's concern is well-founded and we have strengthened the Limitations section to explicitly state that the convenience sampling method limits the external validity of findings, and that a future audit employing stratified random sampling across all speciality OPDs would yield more representative data.We have added a line in limitation (Lines:169-170).

6. Comment The data were collected from OPD□1 and OPD□2, yet the outpatient department at BMU comprises approximately 30 different specialities. Could the authors please clarify how many prescriptions were drawn from each department? If the audit did not include all OPDs, then the findings are confined to the respective units studied. In that case, how can the results be generalised to represent the entire outpatient service at BMU?

Response: We thank Reviewer B for this precise and important query. OPD-1 and OPD-2 at BMU house the Medicine & Allied and Surgery & Allied departments respectively. Prescriptions were collected from the pharmacy counters attached to these two OPD buildings, which collectively represent two of the highest-volume outpatient services at the university. Prescriptions were sampled consecutively from all attending clinicians within these departments during the audit period (October–December 2025); data by individual sub-department or clinician were not separately tracked as this was a unit-level quality improvement exercise.

We fully agree that findings cannot be extended to all 30 speciality OPDs at BMU. The Medicine and Surgery allied departments, while high-volume, cover a specific patient .We have already added the point in our limitation (Lines:169-170).

7. Comment Repeated Visits and Diagnosis Skew: Because 'Repeated visits' were not tracked, the diagnosis should be skewed toward patients with multiple visits. Comments on this are necessary.

Response: This is a perceptive and clinically important methodological point. Patients with chronic conditions attending for follow-up may have an established diagnosis that is presumed rather than re-documented, which could artificially deflate the diagnosis documentation rate observed in our audit. For this reason, we had excluded the duplicate prescription which has same registration number with same name (Line:106).

8. Comment The level of practitioners also influences the diagnoses made. This point should be discussed.

Response: We appreciate this clinically important observation. The prescriber hierarchy in an academic medical university setting such as BMU spans consultant professors, associate/assistant professors, registrars, and medical officers, each operating under different levels of clinical supervision and with different expectations regarding documentation completeness. Junior clinicians under training may document less comprehensively due to time pressure and varying training standards, whereas senior clinicians may rely more on verbal communication with patients without fully committing findings to paper.

Our audit tool captured prescriber name and designation in only 21.1% of prescriptions, which precluded a formal subgroup analysis by practitioner grade. This is itself a finding that underlines the importance of complete prescriber identification.

The level of the prescribing practitioner was not in our audit criteria and for this reason it was not considered.

9. Comment Two trained reviewers reviewed the prescriptions. Please specify the training they received and how they can become eligible to assess prescriptions across all departments.

Response: We thank the reviewer for requesting this clarification. The two auditors were qualified physicians with postgraduate training in internal medicine and general surgery, employed at BMU. Prior to data collection, a structured training session was conducted by the principal investigator (KAA)covering: (i) the definitions and criteria for each of the 20 audit parameters; (ii) the standards used to define a 'complete' prescription element (e.g., what constitutes 'diagnosis documented' versus absent); (iii) practical application of the standardised checklist using 20 pilot prescriptions drawn from outside the study period; (iv) inter-rater agreement testing on the pilot set, with discrepancies discussed and resolved before the main audit commenced; and (v) instructions on maintaining confidentiality and objectivity.

10. Comment Patient without diagnosis documented in prescription, how you decide or assess they followed the evidence-based practice/guidelines?

Response: We had already added the issue in our previous revised manuscript in limitation (Lines:167-170).

11. Comment Memo Number and Date of Administrative Permission: About administrative permission, please mention the memo No. and date.

Response: We thank Reviewer B for drawing attention to this important detail. Administrative permission was granted by the competent authority of BMU Hospital Director and Honourable VC of BMU. The institutional permission date was 14 September 2026 , the approval letters will be provided to the Editor on request (Lines:116).

12. Comment Recommendation for Rigorous Audit: The paper may recommend a rigorous audit to improve quality using existing resources.

Response: We fully concur with this constructive recommendation and added (Lines:177).