Shropshire Community Health NHS
NHS Trust

CLINICAL AUDIT REPORT

Clinical Record Keeping Audit

2012

Audit Team:

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1.0 Background

As community paediatrics is primarily about co-ordinating complex multidisciplinary care it is vital that documentation is thorough and accurate, and not open to misinterpretation.

Key reason for carrying out this audit is to comply with the requirements of the Clinical Record Keeping Policy (and related policies and procedures) in relation to auditing of patient records. It is also recognised that an audit will help to identify areas of concern as well as areas where good practice can be shared. It will also ensure that all staff involved in clinical record keeping are aware of the relevant requirements and ensure efficiency, professionalism and cost effectiveness in the clinical record keeping processes and procedures.

2.0 Aim

The aim of the audit is:

- To ensure compliance with the relevant national, regional, professional and local clinical record keeping requirements.

3.0 Objectives

The objectives of the audit are:

- To give evidence based assurance that clinical record keeping standards and best practice is being carried out within the service
- To identify any areas of concern within the clinical record keeping practices
- To ensure a consistent approach to clinical record keeping practices
- To highlight areas of good practice that can be shared with other services
- To identify areas of concern and develop a action plans to resolve these matters
- To identify gaps or areas for future training.

4.0 Standards

The standards of the audit are:

NHS Records Management Code of Practice	DH	No Exceptions
Care Quality Commission – Essential Standards for quality and safety – Regulation 20, Outcome 21	CQC	No Exceptions
Information Governance Toolkit in particular Clinical Information Assurance requirements 400, 401, 402, 404 and 406	DH	No Exceptions
NHS Litigation Authority Risk Management Standards – in particular clinical records related 1.1.8 and 1.4.2	NHSLA	No Exceptions
Clinical Record Keeping Policy	SCHT	No Exceptions

NHS Number Retrieval, Verification and Use Procedure	SCHT	No Exceptions
General Medical Council (GMC) Good Medical Practice: Guidance for doctors	GMC	No Exceptions

5.0 Sample

For the week beginning 30th July 2013 the auditor selected the first four sets of notes from every community paediatric clinic. Exclusions were Special Educational Needs or Looked After Children medicals and did not include patients that the auditor was present in clinic for.

In total, six clinics were used and 21 sets of records identified (N=21).

6.0 Data Sources and Methodology

The methodology for this audit was a prospective case note audit. Data was gathered and analysed and presented using Microsoft PowerPoint.

7.0 Results

The results of the audit are shown below (N=21)

7.1 Professional Identification:

Table one: Professional Identification:

Criteria	Number	% of Cohort
Signed	19/21	90%
Name Printed	10/21	48%
Designation of Dr	9/21	43%
Student/Spr countersigned	0/1	0%

7.2 Patient Identification:

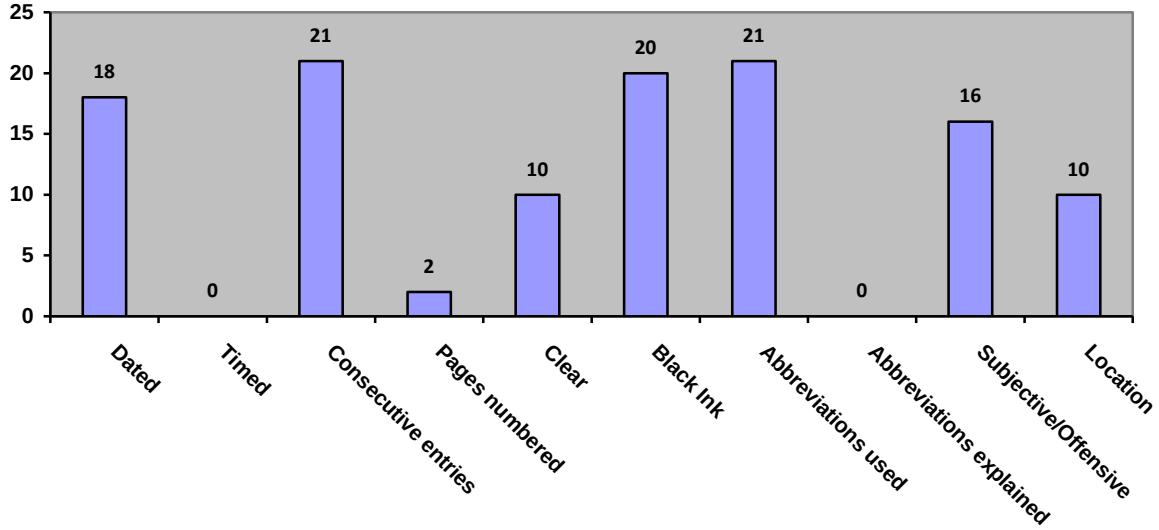
The patient's name was recorded in 20 cases (96%) but the NHS number only in nine cases (43%).

7.3 Case Note Entries:
Chart one shows the results for some of the criteria for record keeping. In addition, only eight records were found to have alterations. None of these showed that the alteration was legible and no Tippex had been used.

Chart one shows that whilst abbreviations had been used in 100% of the records, in none of them had the abbreviation been explained. Additionally, 16 records (76%) were considered to be subjective or offensive. Only sixteen recorded which other people were present at the consultation.

It was considered that only three sets of records would be understandable to the patient/parent whilst only 19 would be understandable to other doctors.

Chart one: Case note entries (N=21
All



All 21 sets of records identified problems – 20 recorded actions taken, all showed which assessments had been carried out and decisions made and all required care was completed in 100% of cases.

However, evidence of appropriate consent was not seen and record of parents being included in decisions was seen in three records (14%). Information was recorded as being shared in four cases.

8.0 Findings

The following areas are those where the main issues were seen:

- Time of consultation – 0% compliance
- Full name and designation of staff - 48% and 43% recorded respectively
- NHS number – 43% compliance
- Numbered pages – 9% compliance
- Clearly written – 49% compliance
- Abbreviations – 100% used and 0% explained.
- Subjective – 76% of cases were considered to have subjective comments.
- Legible alterations – 0% compliance
- Understandable by patient – 14% compliance
- Documentation of consent, information shared, and parental involvement in decisions (0%, 19%. 14% compliance respectively.

9.0 Action Plan

Key finding	Recommendation	Action required to implement recommendation	Person(s) responsible	Timeframe	Status
All findings	Findings fed back to community	Audit presented to community	Drs Morgan & Hulme	Q1 2013/14	Presented February

	doctors and importance of compliance reported	doctors at doctors meeting. Pointed out that we ate no better than 3 years ago.			2013
Entries not signed, name not printed and no GMC number	Management purchase as in the hospital rubber stamps with individual doctors names and GMC numbers,	Stamps for medical personnel to be acquired	Dr Hulme to discuss with J Pointon	Q1 2014/15	In progress
100% abbreviations	Approved list of medical abbreviations	Already available Send to anyone who needs to read notes	Dr Hulme to let manager know these are available and for head of admin know	Q1 2014/15	In progress
Individuals who are not complying not identified	Audit individuals And feedback on their individual practice.	Repeat audit 3 years but results personalised	Dr Hulme to discuss with manager.	2015	In progress