

Short report

Clinical audit on documentation of medical records at a teaching hospital in London, United Kingdom

T R W Waduge¹

Sri Lanka Journal of Child Health, 2007; **36**: 14-15

(Key words: clinical audit, documentation of medical records, teaching hospital, United Kingdom)

Abstract

Objective To compare current practice in paediatric units of St. George's Hospital, London, with the Clinical Negligence Scheme for Trusts (CNST) guidelines and service standards for documentation of medical records and identify desirable changes.

Method Fifty Bed Head Tickets (BHTs) from 2 paediatric medical units at St. George's Hospital, London were audited using a questionnaire. Proforma used on admission and daily records were audited.

Results In admission proforma, recording of parents' ages was 24%. In history section, birth history and developmental milestones were noted in 74% of records. In examination section, the most poorly filled parts were 'endocrine' at 6% and 'skeletal system' at 38%. Differential diagnosis and treatment plan were complete in 90% of notes. All entries by doctors and nurses were legibly written and signing and dating of entries had been done in over 80% while writing time of entry and printing of name had been done only in 40% and 38% respectively. A daily entry by a doctor was noted in 98% of BHTs. A consultant had reviewed 56% of the children who had been in-ward.

Introduction

Regular evaluation of documentation of medical records is a mandatory requirement of hospitals administered by the United Kingdom (UK) National Health Service (NHS). A clinical audit is targeted at systematically evaluating the currently practised standards of care in a unit/hospital with an 'ideal standard', and consequently aiming to improve any identified shortcomings. Careful documentation

facilitates a high standard of patient care and accountability and is essential because Case Notes / BHTs are legal documents liable to be discussed in a court of law. Similar audits can be conducted in Sri Lanka.

Method

An audit conforming to the statutory requirements was conducted in respect of records maintained by the paediatric medical units of St. George's Hospital. Fifty BHTs of children admitted between 1st August and 1st November 2005 were chosen randomly. A pre-tested questionnaire, eliciting empirical and relevant clinical and laboratory information, was used for recording data. The proforma used for clerking information regarding social history, community services, presenting problem, medical history, family history, birth history, development, immunisation record, vital signs, examination of systems, differential diagnosis, treatment plan, investigations/drugs/fluids and involvement of other professionals, was evaluated. Accuracy of such information was beyond the scope of this audit. The section of the proforma which had to be filled by nursing staff at time of admission was checked. Entries by doctors and nurses were scrutinized. Legibility of such entries, use of black ink, indication of time and date of making entries along with availability of the signature of doctor/nurse, were also addressed during the audit. Drug chart entries were audited for similar criteria. The last ≤ 10 pages of BHT were audited to check whether child's full name and BHT number had been written on top of each page. Results are given in percentage form. The expected standard in all sections was 100%

Results

In the admission proforma, recording of the parents' ages was only 24%, the rest of the information being recorded in over 60%. In the history section, presenting problem, medical history, family history, allergies, medication and immunisation details had

¹*Clinical Fellow in Paediatrics, St. George's Hospital, London.*

been completed in over 85% but birth history and developmental milestones were recorded in only 74%. In the examination section, vital signs, cardiovascular and respiratory system findings were entered in 90-92%, the most poorly filled sections being 'endocrine' at 6% and 'skeletal system' at 38%. As regards writing the name and BHT number on all pages, 84% had the name written although only 30% had BHT number on all pages. Differential diagnosis and treatment plan were complete in 90% of notes. Although the management of 17 children had required the services of other professional disciplines (e.g. dietician, physiotherapist, psychiatrist etc) it was appropriately recorded only in 12%. In audited BHTs all entries by doctors and nurses were legibly written in black ink and signing and dating of entries had been done in over 80% while writing time of entry and printing of name had been done only in 40% and 38% respectively.

In UK, entries in the drug chart have to be done by doctors. These were audited using same criteria as for entries on BHT with similar results. A daily entry by a doctor was noted in 98% of BHTs. A consultant had reviewed 56% of children who had been in-ward. Those who were not reviewed by a consultant had been in hospital for less than 3 days.

Discussion

This audit covered most aspects of record-keeping on BHTs. Proper records are necessary in providing optimal patient care and also minimising problems of litigation, which appear to be beginning in Sri Lanka too. Using a proforma for clerking at admission helps remind a busy medical officer of all the facts in the history and examination that need to be recorded.

Fulfilling all the requirements when making entries in BHT (e.g. printing name, putting date/ time) is of vital importance. Correct time-recording gives an excellent idea of progress of patient's condition and response to treatment over a period of time. Ability to identify person who made a particular entry increases accountability and responsibility. The stipulated standards for doctor's entries are basic requirements that should be practised in Sri Lanka.

At St. George's Hospital, the consultant in charge of the ward does a ward round twice during week days; a specialist registrar does the ward rounds on other days. This contrasts with the situation in Sri Lanka where the consultant in charge of a particular ward does a ward round on all week days.

Conclusion

This audit reiterates the necessity and importance of maintaining accurate records not only as clinical data bases but also in planning and division of duties in the health care services. It is strongly recommended that similar audits are carried out in respect of records and data storage so that such information would be universally applicable. The 'ideal standards' of record keeping need to be practised in Sri Lanka with the advent of increasing litigation.

Acknowledgements

I thank Dr. P Heath (Paediatric Clinical Governance Coordinator), Prof. D V Walters, staff of the clinical audit training and assistance unit, the medical officers, nursing staff and ward clerks of the paediatric medical units of St. George's Hospital, London for their invaluable help.