Audit on Record Keeping in the Acute Hospital Setting

Final report produced: 2 September 2015

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Introduction

Background to the audit

Good record keeping is an important aspect of health and social care professionals' role. During January 2008 the Safety, Quality and Standards Directorate within the Department of Health, Social Services and Public Safety, Northern Ireland (DHSSPSNI) issued generic record keeping standards. These were based on best practice guidance developed by the Health Informatics Unit within the Royal College of Physicians (RCP) in London. These standards were considered to be applicable to the content of any patient's hospital medical record regardless of the specialty or profession involved.

The record keeping standards produced by the RCP aimed to maximise patient safety and quality of care and support professional best practice. The standards were developed to complement other guidance produced by professional bodies and those relating to 'Good Management Good Records' document.

A spokesperson for the RCP at the initial launch of the generic record keeping standards during September 2007 stated "mistakes and missing information in records are common and are a major contributory factor in medical errors, poor clinical care, leading to complaints and medical negligence cases."

The need for improved communication and record keeping continue to be themes regularly highlighted in external reviews and inquiries, serious adverse incident investigations and reviews, Coroner's inquests and professional and medical negligence cases. The need for improved record keeping has also been detailed within various reports and publications produced by the Northern Ireland Ombudsman's Office.

Record keeping audits were and continue to be undertaken within individual Trusts. At the time this regional audit was undertaken such projects were generally occurring on a profession or specialty specific basis within Trusts instead of results being compared across specialties, hospital sites or Northern Ireland as a whole.

The 'Quality Standards for Health and Social Care' (March 2006) document also highlight the importance of record keeping and contain criteria regarding the recording of care given, using recognised standards to measure quality, promoting the implementation of evidence based practice and effective records management.

It was felt therefore that undertaking a regional evidence based record keeping audit in line with the aforementioned standards would provide valuable information regarding record keeping practice across Northern Ireland. An application for funding to undertake the audit was duly submitted to the Guidelines and Audit Implementation Network (GAIN) and approval was obtained to proceed in 2009.

Aim of the Audit
- To improve record keeping within acute hospitals maximising patient safety and improving quality of care

Objectives of the Audit
- To measure practice regionally against standards/guidance relating to record keeping produced by the DHSSPSNI, 2008
- To improve record keeping practice and facilitate learning
- To share information widely regarding the audit findings, sharing the learning regionally to all health and social care professions

Audit Methodology/Process

The project was co-ordinated by the Northern Health and Social Care Trust (NHSCT) and a project steering group was established chaired by the Trust's Medical Director. The main Project Team was: Dr Peter Flanagan (Medical Director, NHSCT at time of project), Mrs Carolyn Kerr (Deputy Director of Nursing, NHSCT at time of project) and Mrs Ruth McDonald (Assistant Governance Manager, NHSCT) with additional support from those individuals listed at Appendix 6.

Audit standards were agreed by the Project Steering Group based on those produced by the RCP and endorsed by the DHSSPSNI. Some standards were excluded from the audit. Some draft standards on hospital discharge developed by the RCP for inclusion in a Hospital Discharge Audit Tool were included at the time of the audit design.

Audit standards included

Standard	Description	Target (%)	Source
1	The contents of the medical record should have a standardised structure and layout. Appropriate information should be filed in the relevant sections	100%	RCP
2	Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order	100%	RCP
3	Every page in the medical record should include the patient's name and identification number – hospital/HSC number	100%	RCP

4	Every entry in the medical record should be:
	  ○ Dated
	  ○ Timed (24 hour clock)
	  ○ Legible
	  ○ Signed by the person making the entry - the name and designation of the person
		100%	RCP

	making the entry should be legibly printed against their signature ○ Deletions and alterations should be countersigned		
5	Entries to the medical record should be made as soon as possible after the event to be documented and before the relevant staff member goes off duty. If there is a delay the time of the event and the delay should be recorded	100%	RCP
6	An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than 4 days for acute medical care, the next entry should explain why	100%	RCP
7	Consent must be clearly recorded in the medical record	100%	RCP
8	Data recorded or communicated on admission and discharge should be recorded using a standardised proforma	100%	RCP
9	The discharge letter should be available within the medical record in the case of all hospital admissions	100%	RCP
	Diagnosis should be clearly recorded on the discharge letter	100%	RCP
	The discharge letter should be forwarded to the patient's GP as soon as possible	100%	Recommended practice as per published literature/ guidance

Design and piloting of the data collection forms/proformas

Various proformas were designed relating to the audit standards:

- **Proforma A** - for individual Trust use as a patient coding sheet to record information relating to all patients included in the audit (see **Appendix 3**)

- **Proforma B** - to record information regarding the layout of the patients' hospital records including whether the record was divided into identifiable sections and whether continuation sheets in use during the admission period were uniprofessional or multiprofessional (see **Appendix 4**); and

- **Proforma C** – used as the main data collection form to record information retrieved from the patients' hospital records relating to the identified and agreed audit standards (see **Appendix 5**)

Proforma C was piloted within the NHSCT and was revised following the audit workshop/training day when representatives from all Health and Social Care Trusts were present and a small sample of hospital records across the region were reviewed.

Raising awareness regarding the audit/training

A letter was sent during December 2009 to the Chief Executives, Directors of Nursing and Medical Directors in all Health and Social Care Trusts in Northern Ireland informing them regarding the planned audit and seeking their co-operation and agreement to participate in the audit. This was duly obtained.

A letter was also sent to Audit Managers within all Health and Social Care Trusts during January 2010 and informed them regarding the audit and assistance was sought in relation to the data collection. A 2 hour training session/workshop was organised and held on 9 February 2010. The purpose of the workshop being to:

- Outline the rationale for the audit, its aims and objectives, the methodology, sample size, project timescales and available funding
- Share the various data collection forms and accompanying explanatory notes
- Review a sample of records against the various data collection forms
- Answer any questions/queries; and
- Discuss the next steps/way forward

Patient sample

Sample selection criteria

- Any patients aged over 16 years
- Discharged between 1 September 2009 and 4 December 2009 from the following clinical areas:
  - Acute Medicine
  - Surgery
  - Gynaecology
  - Cardiology
- Patient length of stay should be 4 days or longer

Total number of patients to be selected

- Each Trust was to identify and select 200 patients for inclusion in the audit from the relevant hospital information systems (1,000 patients in total across the region)
- Fifty (50) patients were to be selected per specialty across 2 different hospital sites
- Each Trust could select which hospital sites to be included in the audit

Data collection

Each Trust Audit Department received the appropriate number of copies of the various proformas and return envelopes during March 2010 along with an information pack and detailed guidance notes. The expectation being that 40 Proforma B's and 1,000 Proforma C's would be completed and returned. The patient coding sheets (Proforma A's) were retained by individual Trusts.

Data collection for the audit was carried out between March and September 2010.

Data analysis

The proformas were returned to the NHSCT for data input and analysis. The data were input onto the Statistical Package for the Social Sciences (SPSS) and 'cleaned' to ensure data inputted were consistent with the content of the paper proformas. Both SPSS and PSPP (a program for statistical analysis of sampled data) were used to run the necessary analyses.

The audit findings are detailed overleaf. A list of Tables and Figures contained within the report can be found at Appendix 1 and Appendix 2 respectively.

Findings

Demographics pertaining to the audit sample and other information on the cases audited

The case notes of 1,000 patients were included in the audit. 5 Health and Social Care Trusts within Northern Ireland were involved in the audit

Table 1: Participating Trusts	Number of cases audited
Belfast Health & Social Care Trust (BHSCT)	200
Northern Health & Social Care Trust (NHSCT)	200
South Eastern Health & Social Care Trust (SEHSCT)	200
Southern Health & Social Care Trust (SHSCT)	200
Western Health & Social Care Trust (WHSCT)	200
Total	**1,000**

Table 2: Number of hospital sites where specialties were audited	Number of hospital sites audited
Surgery	9*
Acute Medicine	10
Gynaecology	10
Cardiology	10

Note: *1 Trust did not have surgical cases available on both sites and therefore audited 50 cases on a single site rather than 50 cases across 2 sites i.e. 25 per site

Table 3: Specialty patient discharged from	Number of cases
Surgery	248 (24.8%)
Acute Medicine	251 (25.1%)
Gynaecology	251 (25.1%)
Cardiology	250 (25%)
Total	**1,000 (100%)**

The intention was to audit 250 cases per specialty across Northern Ireland. The WHSCT audited 48 surgical, 51 acute medicine and 51 cardiology cases accounting for the slight variation from the anticipated number of cases audited by specialty.

Table 4: Length of stay relating to the cases audited

Average length of stay (days)	7.9
Length of stay range (days)	0 - 85

Eighty-four (84) of the 1,000 (8.4%) cases audited had a length of stay of less than 4 days with 21 of the 84 cases having a length of stay of 1 day or less.

The admission dates of patients included in the audit ranged from 1 July 2009 – 30 November 2009. Patient discharge dates were between 1 September 2009 and 4 December 2009.

Table 5: Ages of patients in the cases audited

Average age (years)	59.4 years
Age range (years)	13 – 100 years

There were 7 patients aged less than 16 years included in the audit. The patient ages were as follows: 13 years (2 cases), 14 years (2 cases) and 15 years (3 cases). These 7 cases were under the care of the following specialties: acute medicine (4 cases), surgery (2 cases) and gynaecology (1 case).

Figure 1: Uniprofessional or multiprofessional continuation sheets in use
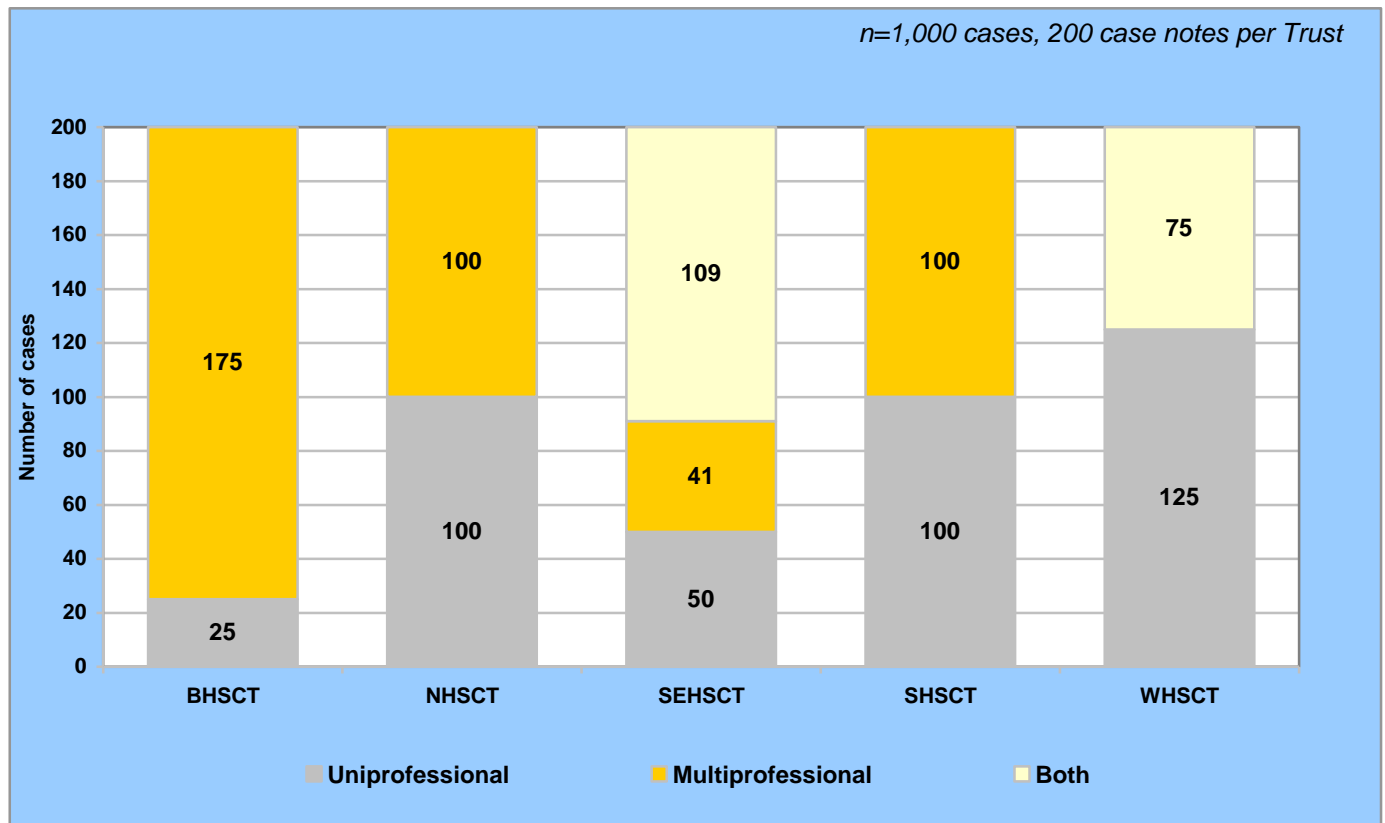

A large amount of data relevant to the audit standards were contained within and retrieved from continuation sheets. Continuation sheets are used to record patient assessment, diagnosis and management plan details as well as details relating to patient contacts, investigation results and other aspects of patient care.

Different types of continuation sheets were in use. Of the 1,000 cases audited in 400 of these cases (40%) the continuation sheets were uniprofessional in nature where information was recorded by a single professional group only (i.e. medical staff), in 416 cases (41.6%) these were multiprofessional where entries were recorded by a number of professional groups and in 184 cases (18.4%) both uniprofessional and multiprofessional continuation sheets were in use depending on the site, specialty and cases selected.

The heading/title of continuation sheets in use varied across the 5 Trusts audited. Examples of headings in use were: clinical notes, multidisciplinary progress notes, ward notes sheet with ward name detailed, continuation sheet, clinical notes with specialty detailed, and medical clinical notes with hospital name detailed. Within each Trust there was not a consistent continuation sheet in use across all sites and specialties audited.
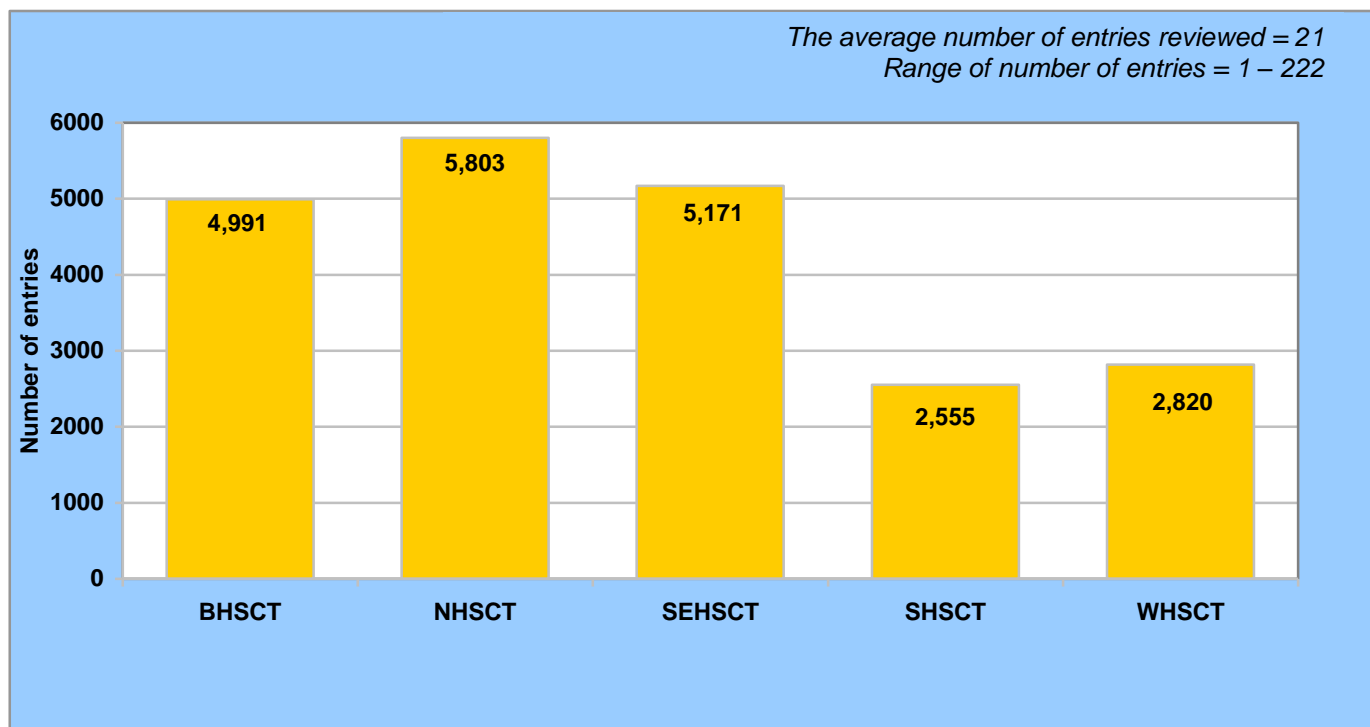
The number of continuation sheets for the hospital admission period being audited for each of the 1,000 patients varied depending on their length of stay.

Figure 2: Number of continuation sheets reviewed by Trust (n = 5,759)

The average number of continuation sheets per case audited = 15
Range of number of continuation sheets per case audited = 1 – 67
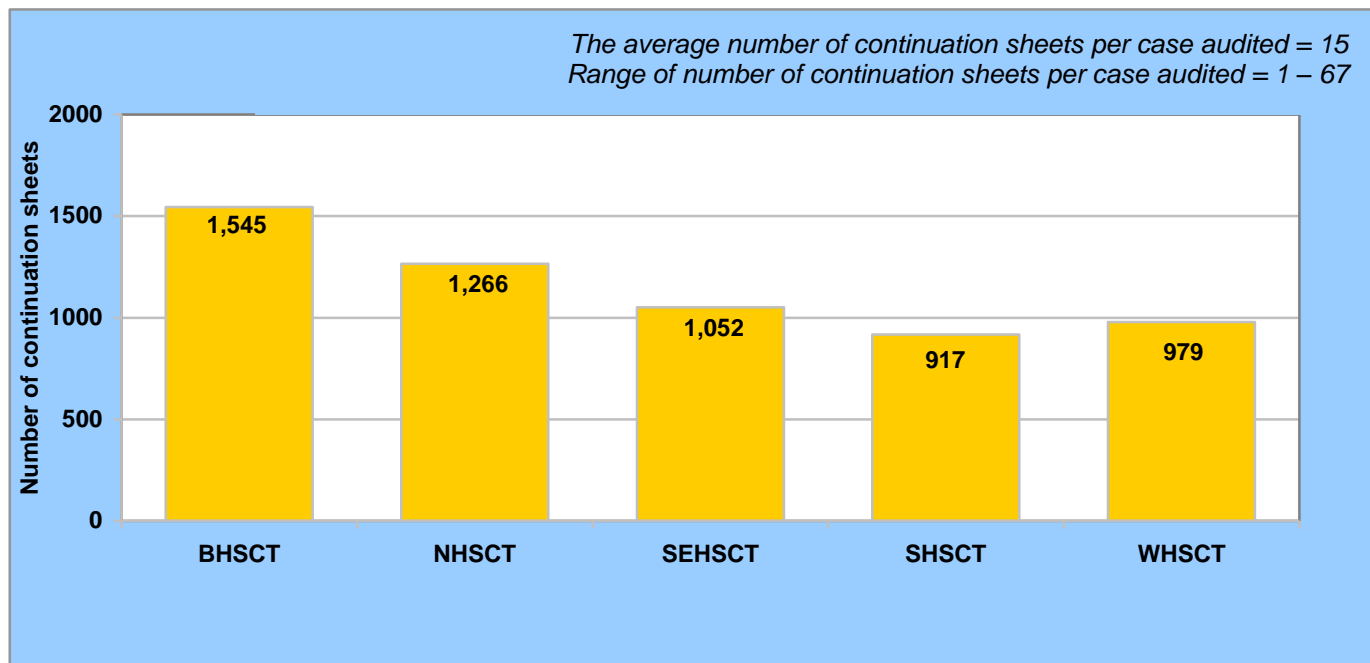
The number of entries made by clinical or social care staff on continuation sheets for the hospital admission audited varied depending on length of stay and individual patient need. Across the 5 Trusts this equated to 21,340 entries in total on 5,759 continuation sheets filed within the patients' case notes.

Figure 3: Number of entries reviewed by Trust (n = 21,340)

The average number of entries reviewed = 21
Range of number of entries = 1 – 222

Figure 4: Percentage of total entries included in the audit by professional group

Not known, 9.7%
(2,065 entries)

Other, 8.1%
(1,739 entries)

Nursing, 23.0%
(4,907 entries)

Medical, 59.2%
(12,629 entries)

n= 21,340 - number of entries reviewed
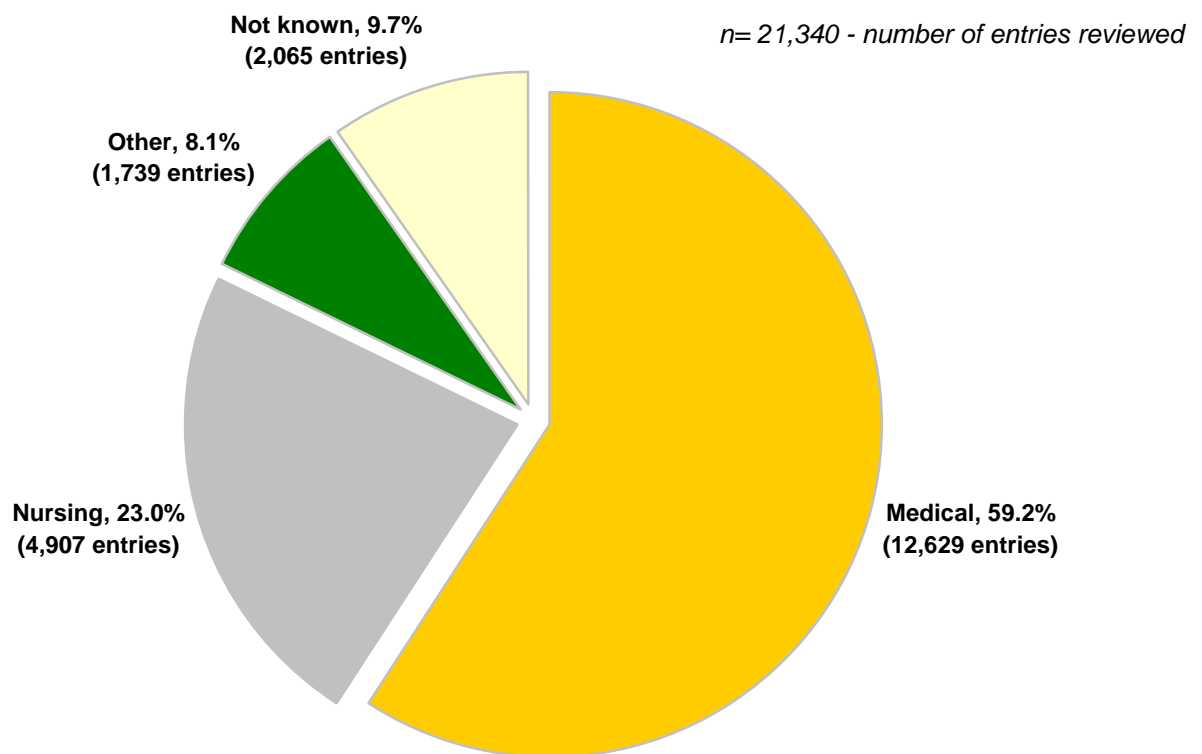
Other professional groups with entries on continuation sheets were wide ranging and included for example: Allied Health Professionals, Social Workers, Pharmacy staff, Specialist Nurses e.g. Stoma Care Nurse/Specialist Cancer Nurse/Respiratory Nurse, Cardiac Rehab, Radiology, Palliative Care, and members of the Acute Pain Service.

In some cases the professional group was not known as entries may have had a signature/name but designation was not recorded.

Standard 1

The contents of the medical record should have a standardised structure and layout. Appropriate information should be filed in the relevant sections

Figure 5: Are the patients' charts divided into sections?
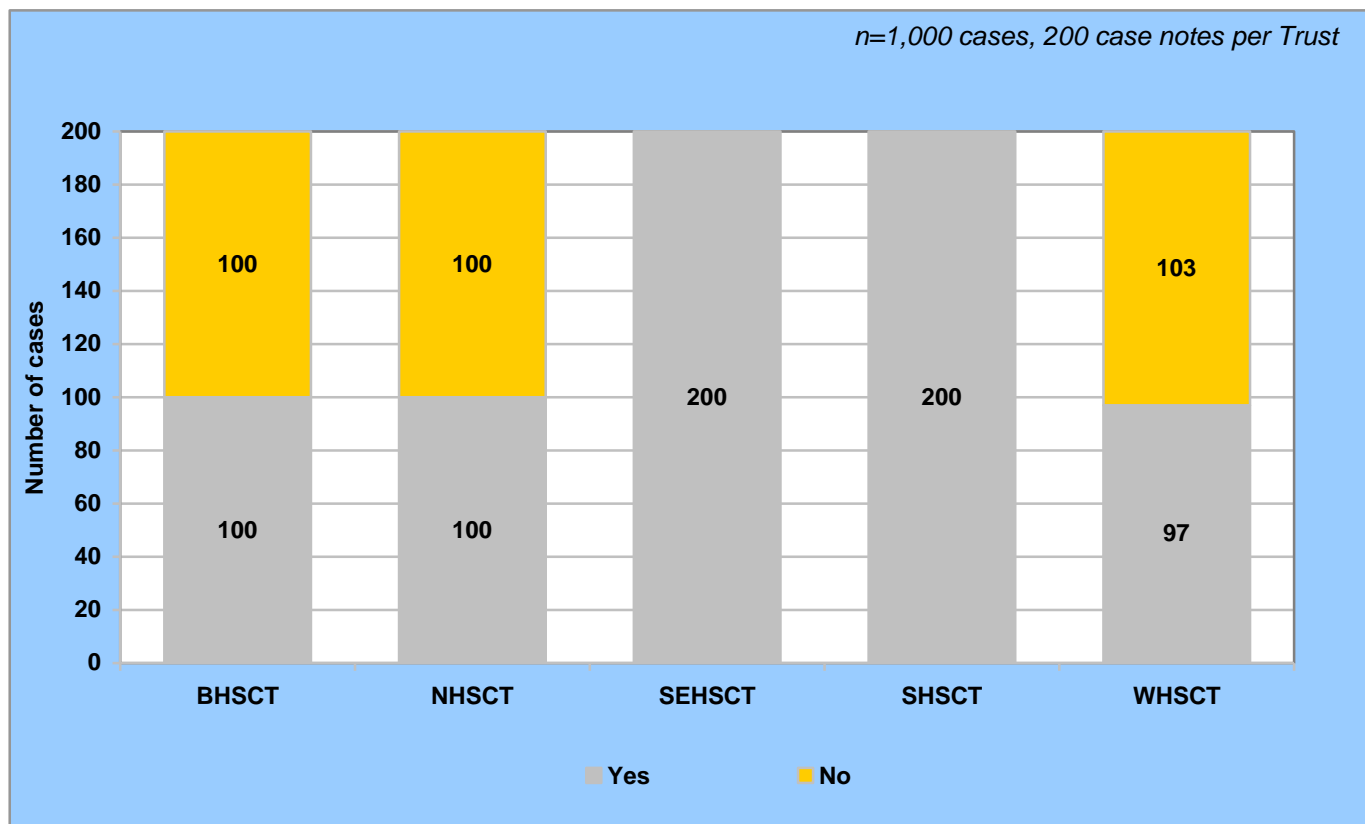
Six hundred and ninety-seven (697) of the 1,000 (69.7%) cases audited were divided into sections. Section headings varied depending on the Trust, hospital site and specialty audited. Some examples of these are detailed within Table 6 below.

Table 6: Examples of section headings in use within the case notes audited

Belfast HSCT	
Specialty	**Section headings**
Gynaecology	Discharge Summaries Inpatient Episodes Investigations Gynae Separate chart – (folder) for each admission
Northern HSCT	
Specialty	**Section headings**
Surgery	Correspondence Case records Reports Miscellaneous Nursing

Table 6: Examples of section headings in use within the case notes audited (cont'd)

South Eastern HSCT	
Specialty	**Section headings**
Acute Medicine	Inpatient Outpatient Investigations Nursing Records P.A.M.S. notes Miscellaneous Alerts Correspondence Anaesthetics & Operation Sheets Reports & Investigations
Southern HSCT	
Specialty	**Section headings**
Cardiology	Medical Clinical information Inpatient information Investigation Nursing information
Western HSCT	
Specialty	**Section headings**
Surgery	Divider for each specialty e.g. Medical, surgical and divider for Reports/Investigations

Figure 6: Percentage of cases where generally, the information in the record appeared to be filed in the relevant sections
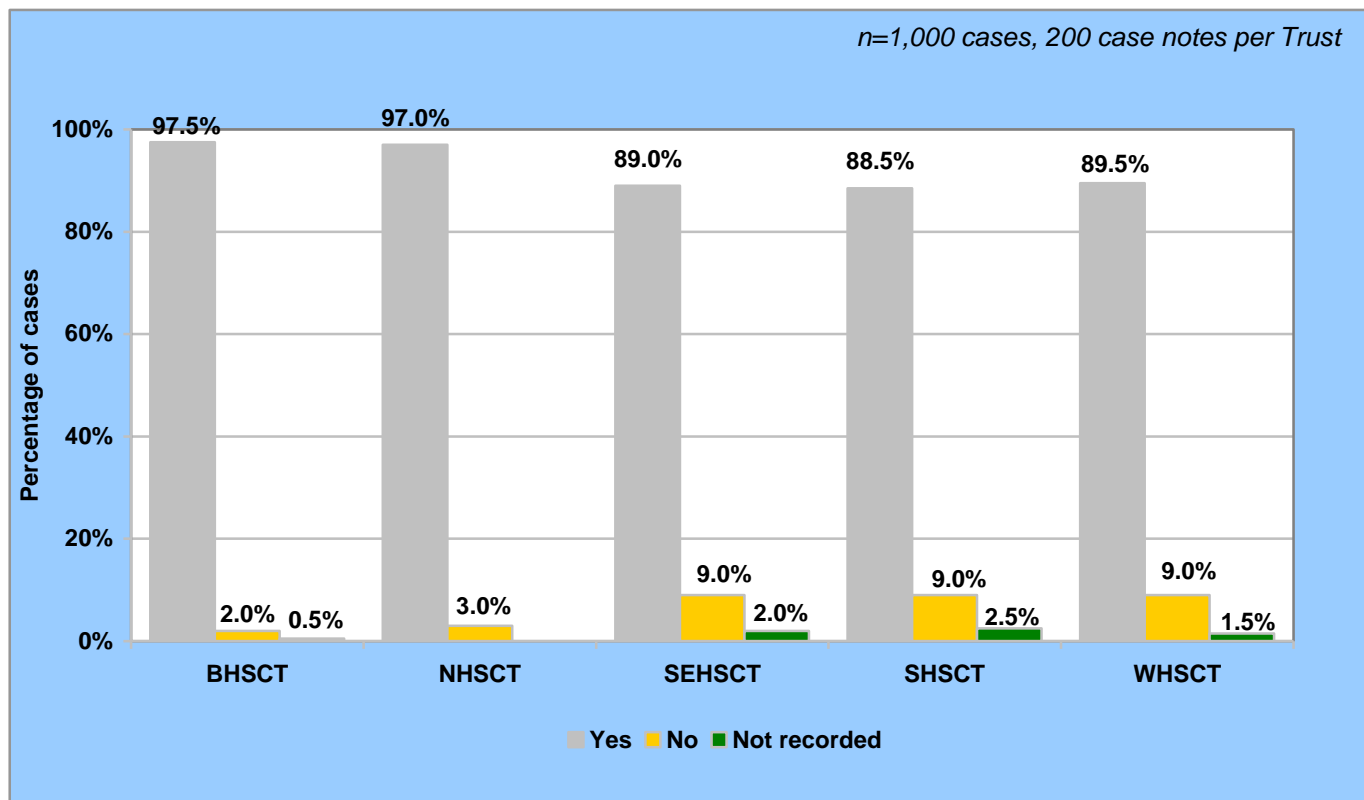
In total, 64 of the 1,000 (6.4%) cases audited had misfiled information. These related to the following specialties:

- Surgery – 31 of 248 (12.5%) cases
- Acute Medicine – 9 of 251 (3.6%) cases
- Gynaecology – 9 of 251 (3.6%) cases
- Cardiology – 15 of 250 (6%) cases

Table 7: Number of case notes with loose sheets/information

	Surgery	Acute Medicine	Gynaecology	Cardiology	Total
BHSCT	8 (30.8%)	9 (34.6%)	3 (11.5%)	6 (23.1%)	26 (100%)
NHSCT	22 (27.8%)	29 (36.7%)	12 (15.2%)	16 (20.3%)	79 (100%)
SEHSCT	14 (31.8%)	11 (25%)	4 (9.1%)	15 (34.1%)	44 (100%)
SHSCT	18 (20.5%)	30 (34.1%)	16 (18.2%)	24 (27.3%)	88 (100%)
WHSCT	21 (29.2%)	12 (16.7%)	26 (36.1%)	13 (18.1%)	72 (100%)
Total	**83 (26.9%)**	**91 (29.4%)**	**61 (19.7%)**	**74 (23.9%)**	**309 (100%)**

Three hundred and nine (309) of the 1,000 (30.9%) case notes audited had loose sheets/ information at risk of falling out and being lost. The nature of this information was wide ranging and included for example**:** GP referral letters, continuation sheets, investigation results including laboratory and x-ray results, nursing notes, kardex, daily fluid chart, PEWS sheets, SBAR handover sheets, physical examination sheets, consent forms and patient addressograph labels.

Whilst a specific question was not asked regarding the overall condition of the case notes this information was elicited in some cases from the additional comments question on the data collection form. In a few cases there were comments made in relation to the patient record being in very good order and intact however more comments were made about the poor condition of the case notes audited. For example:

- Patient's chart in quite a few parts held together with rubber bands
- Spine of chart has ripped
- The patient record is overfull. The record had notes from as far back as 1973; the outer cover is beginning to tear. It is heavy and awkward to handle
- Cover of chart ripped from top to bottom
- Chart cover is ripped at the spine
- This patient record is in poor state. It is too big (approx. 12cm thick). The ESL clip is not secure because of the thickness of the record. The contents of the record are in danger of coming completely out – they are only half-secured
- The record is approximately 8cm deep. Cover in poor condition. The front cover does not close completely over the chart contents. The cover of the record is completely detached and the front and back of the cover are sellotaped together. In use since at least 1978
- Cover of chart is attached by one piece of sellotape. Chart had old clip so it does not give the option of sub-dividing pages
- Cover of chart worn.

Standard 2
Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order

The section of the case notes where continuation sheets were filed varied across Trusts. These being filed in a variety of different sections including for example: inpatient episodes, doctors' notes, clinical information, medical notes or under specialty name.

**Table 8: Were continuation sheets filed appropriately?**

	Yes	No	Not recorded	Total cases
BHSCT	196 (98%)	2 (1%)	2 (1%)	**200 (100%)**
NHSCT	197 (98.5%)	1 (0.5%)	2 (1%)	**200 (100%)**
SEHSCT	163 (81.5%)	31 (15.5%)	6 (3%)	**200 (100%)**
SHSCT	181 (90.5%)	19 (9.5%)	--	**200 (100%)**
WHSCT	189 (94.5%)	7 (3.5%)	4 (2%)	**200 (100%)**
Total	**926 (92.6%)**	**60 (6%)**	**14 (1.4%)**	**1,000 (100%)**

Some of the reasons for continuation sheets not being filed appropriately included for example; no specific section in this chart, old style of chart, not in inpatient section, on top of file, in temporary file or misfiled in wrong section of file.

Table 9: Number and percentage of cases with entries on continuation sheets in chronological order

	Yes	No	Not known	Total cases
BHSCT	189 (94.5%)	7 (3.5%)	4 (2%)	**200 (100%)**
NHSCT	188 (94%)	12 (6%)	--	**200 (100%)**
SEHSCT	174 (87%)	18 (9%)	8 (4%)	**200 (100%)**
SHSCT	186 (93%)	12 (6%)	2 (1%)	**200 (100%)**
WHSCT	178 (89%)	21 (10.5%)	1 (0.5%)	**200 (100%)**
Total	**915 (91.5%)**	**70 (7%)**	**15 (1.5%)**	**1,000 (100%)**

Figure 7: Percentage of cases with entries on continuation sheets in chronological order
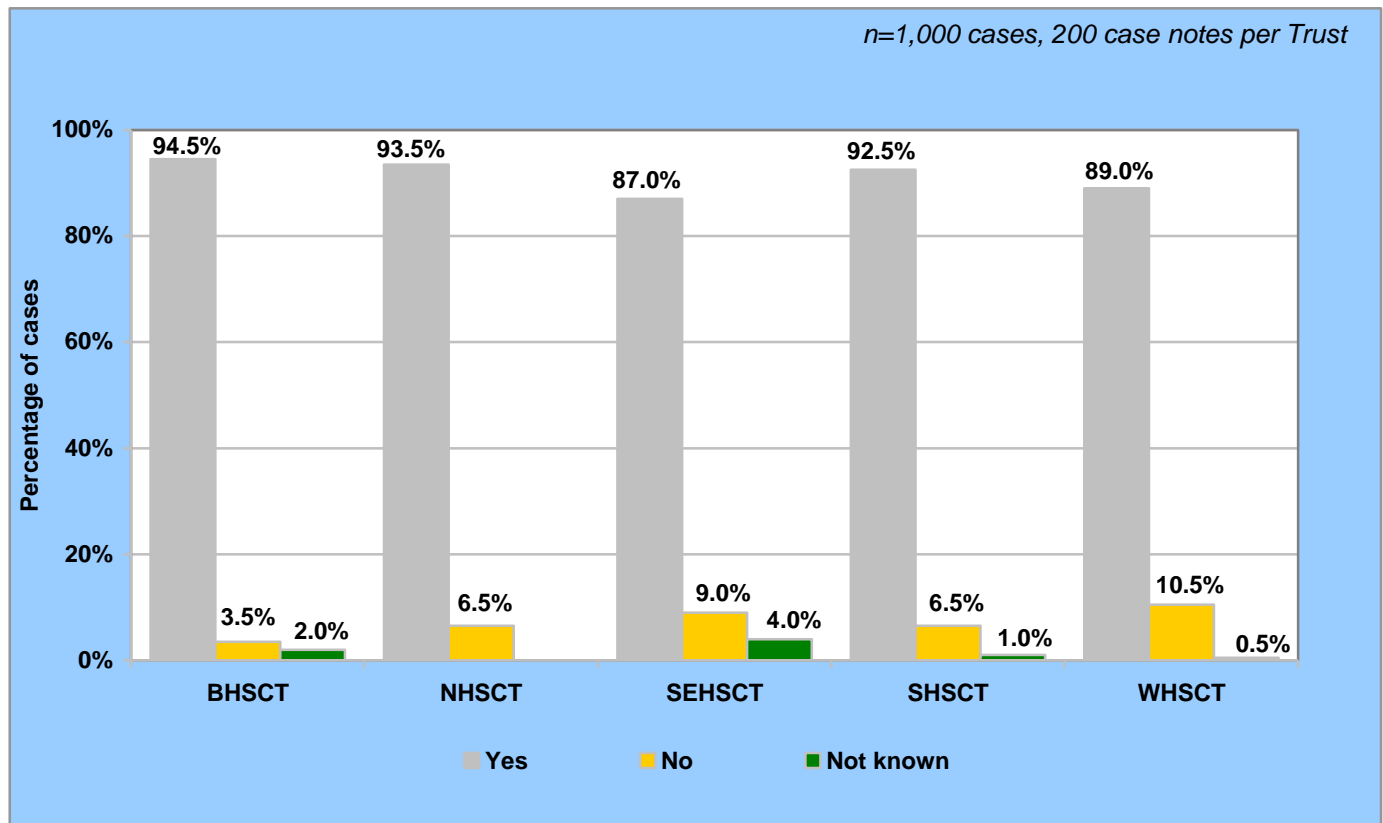
Of the 15 'not known' cases, 2 (13.3%) of these were undated and for the remaining 13 (86.7%) no data was recorded on the data collection form.

Nine hundred and fifteen (915) of the 1,000 (91.5%) cases audited had all entries in chronological order. Seventy (70) cases (7%) had entries not in chronological order. These related to the following specialties:

- Surgery – 25 of 248 (10.1%) cases
- Acute Medicine – 16 of 251 (6.4%) cases
- Gynaecology – 21 of 251 (8.4%) cases
- Cardiology – 8 of 250 (3.2%) cases

In total, this equated to 130 entries.

Table 10: Filing of entries on continuation sheets relating to admission period audited compared with previous admissions

Six hundred and fifteen (615) patients had previous admissions

	First in section (above previous admissions)	Last in section (after previous admissions)	Mixed amongst previous admissions	Held in separate folder	Total cases
BHSCT	67 (73.6%)	15 (16.5%)	5 (5.5%)	4 (4.4%)	91 (100%)
NHSCT	81 (55.5%)	57 (39%)	8 (5.5%)	-	146 (100%)
SEHSCT	42 (61.8%)	7 (10.3%)	19 (27.9%)	-	68 (100%)
SHSCT	--	179 (98.4%)	3 (1.6%)	-	182 (100%)
WHSCT	5 (3.9%)	121 (94.5%)	2 (1.6%)	-	128 (100%)
Total	195 (31.7%)	379 (61.6%)	37 (6%)	4 (0.7%)	615 (100%)

In BHSCT 4 of 91 (4.4%) applicable cases with previous admissions had relevant documents held in a separate folder for each admission and all folders were held in the patient's chart

Figure 8: Filing of continuation sheets within the case notes audited
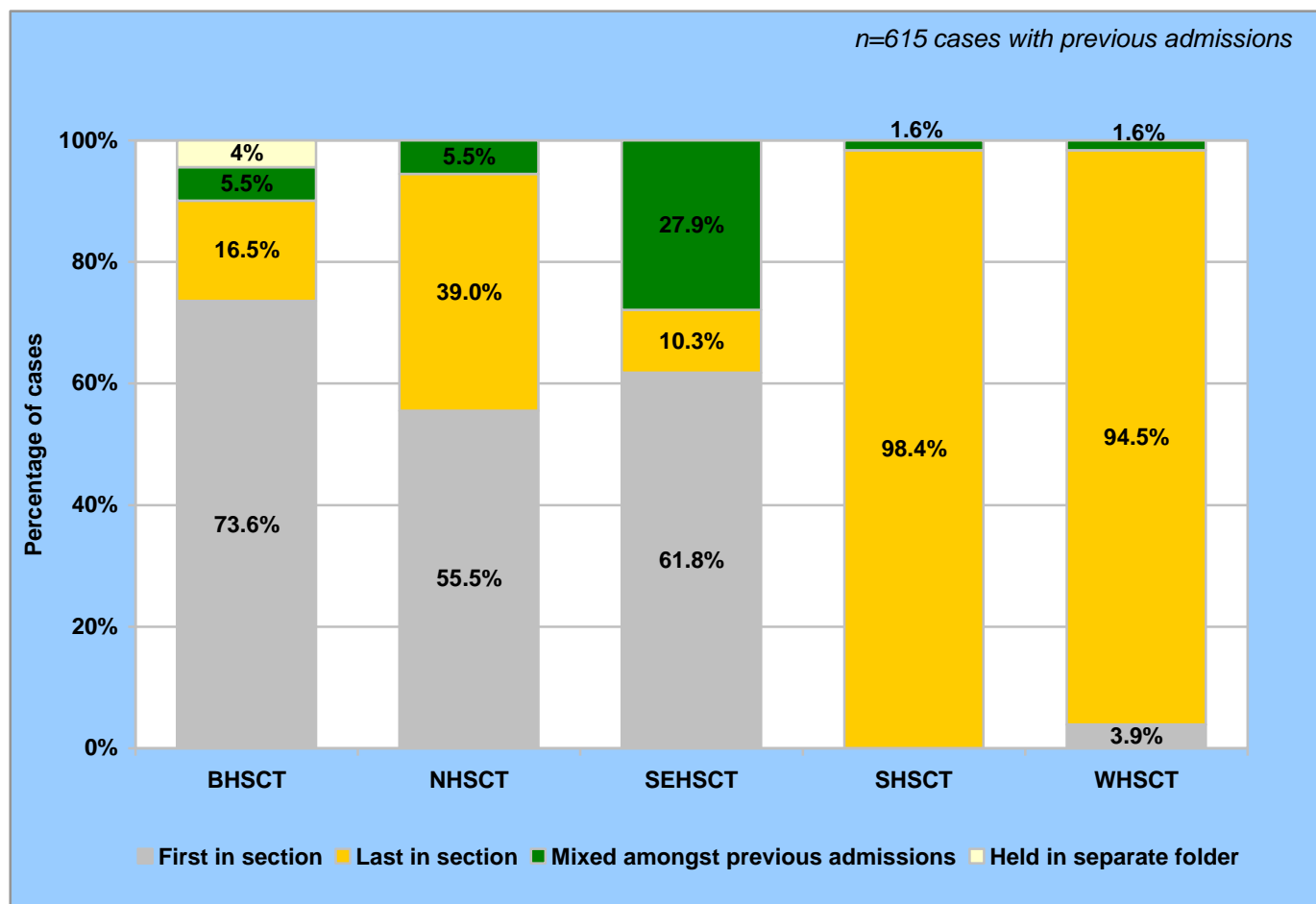
Thirty-seven (37) of 615 (6%) cases audited with a previous admission had continuation sheets filed amongst previous admissions. These related to the following specialties:

- Surgery – 15 of 142 (10.6%) cases
- Acute Medicine – 8 of 163 (4.9%) cases
- Gynaecology – 6 of 162 (3.7%) cases
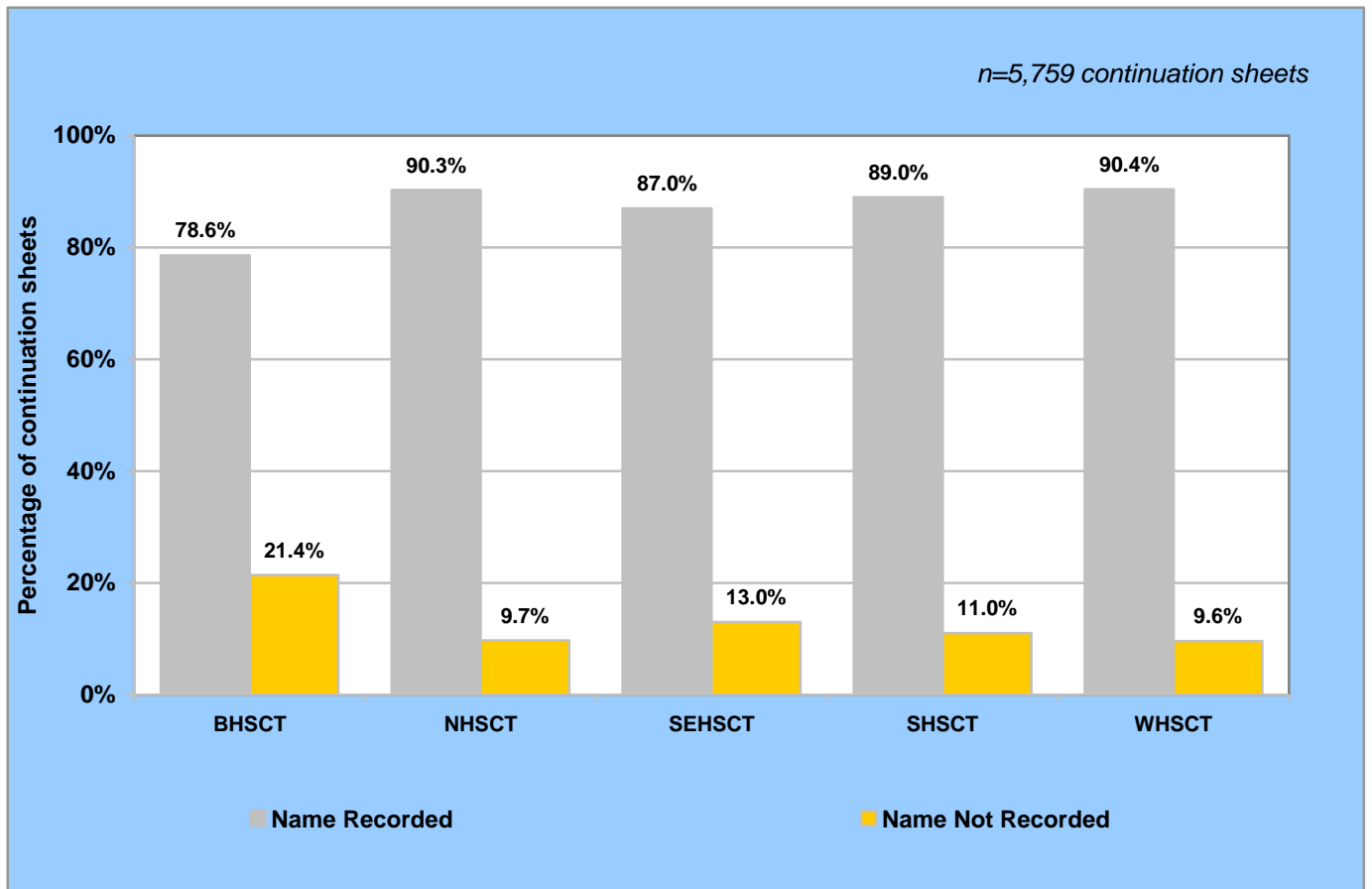- Cardiology – 8 of 148 (5.4%) cases

Standard 3
Every page in the medical record should include the patient's name and identification number (Hospital/Health and Social Care number)

Table 11: Frequency of recording of patient name on continuation sheets (either handwritten or pre-printed)

	Name Recorded (Handwritten or pre-printed)	Name Not Recorded	Total continuation sheets
BHSCT	1,214 (78.6%)	331 (21.4%)	**1,545 (100%)**
NHSCT	1,143 (90.3%)	123 (9.7%)	**1,266 (100%)**
SEHSCT	915 (87%)	137 (13%)	**1,052 (100%)**
SHSCT	816 (89%)	101 (11%)	**917 (100%)**
WHSCT	885 (90.4%)	94 (9.6%)	**979 (100%)**
Total	**4,973 (86.4%)**	**786 (13.6%)**	**5,759 (100%)**

For 31 cases audited (3.1%) patient name was not recorded on any continuation sheets for the admission being audited (65 continuation sheets included in the audit)

Figure 9: Percentage of continuation sheets where patient name was recorded

n=5,759 continuation sheets

Percentage of continuation sheets

- BHSCT: Name Recorded 78.6%, Name Not Recorded 21.4%
- NHSCT: Name Recorded 90.3%, Name Not Recorded 9.7%
- SEHSCT: Name Recorded 87.0%, Name Not Recorded 13.0%
- SHSCT: Name Recorded 89.0%, Name Not Recorded 11.0%
- WHSCT: Name Recorded 90.4%, Name Not Recorded 9.6%

■ Name Recorded   ■ Name Not Recorded

Table 12: Number and percentage of continuation sheets with patient Hospital Number or HSC Number on continuation sheets (either handwritten or pre-printed)

	Handwritten Hospital Number	Addressograph Hospital Number	Addressograph HSC Number
BHSCT n=1,545	130 (8.4%)	973 (63%)	564 (36.5%)
NHSCT n=1,266	82 (6.5%)	992 (78.4%)	743 (58.7%)
SEHSCT n=1,052	195 (18.5%)	557 (52.9%)	49 (4.7%)
SHSCT n=917	178 (19.4%)	392 (42.7%)	20 (2.2%)
WHSCT n=979	127 (13%)	643 (65.7%)	186 (19%)
Total	712 (12.4%)	3,557 (61.8%)	1,562 (27.1%)

Figure 10: Percentage of continuation sheets with the patient's HOSPITAL NUMBER or HSC NUMBER (either handwritten or pre-printed)
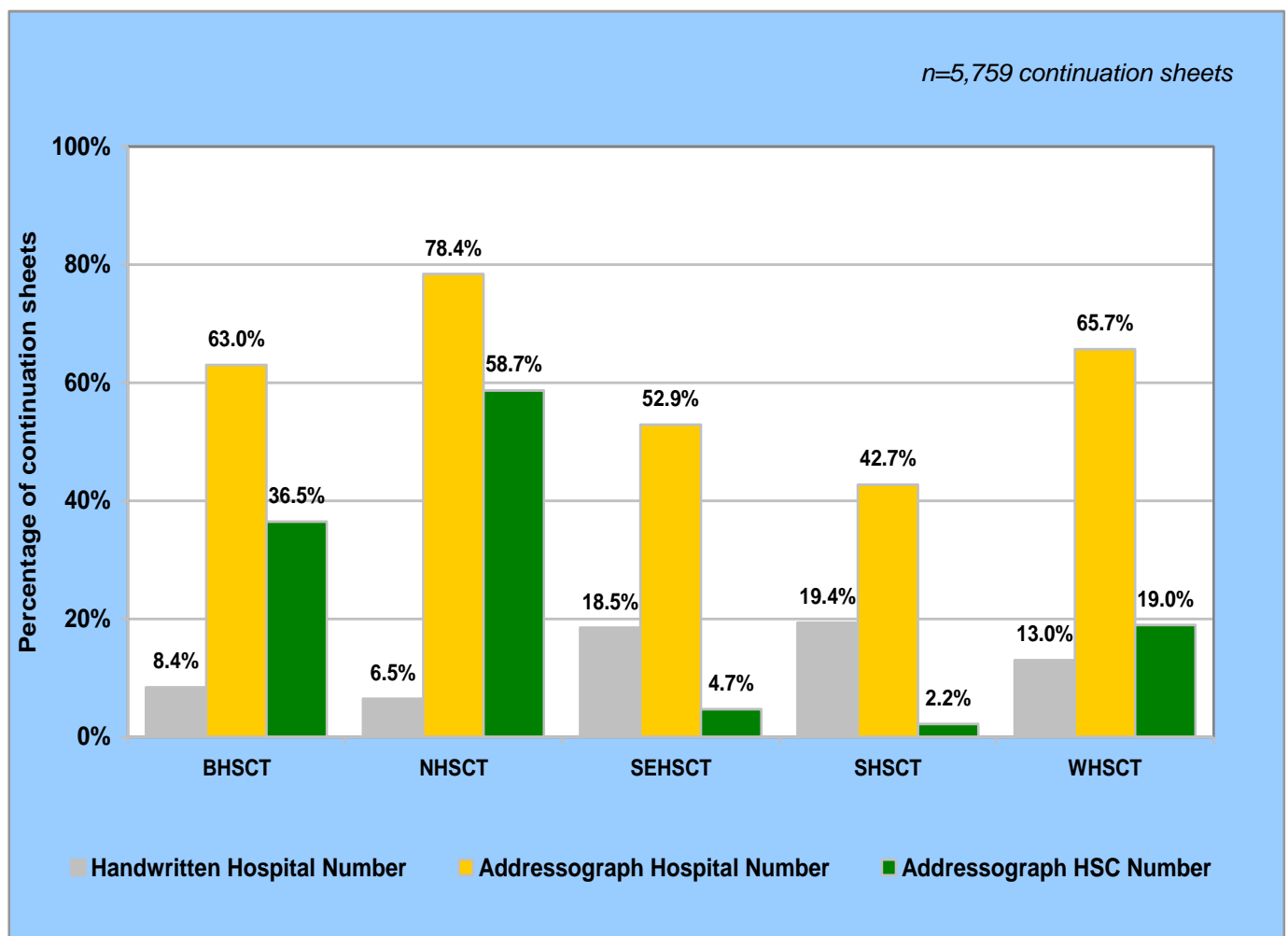
A patient identification number (Hospital Number/HSC Number) was not recorded on all continuation sheets.

At the time the audit was undertaken hospital number was recorded more frequently on continuation sheets rather than HSC Number. Where the HSC Number was used this was included on the printed addressograph labels with the Hospital Number.

Standard 4

Every entry in the medical record should be:

- o **Dated**
- o **Timed (24 hour clock)**
- o **Legible**
- o **Signed by the person making the entry**
- o **The name and designation of the person making the entry should be legibly printed against their signature**
- o **Deletions and alterations should be countersigned**

Table 13: Number and percentage of entries dated

	Dated	Not dated	Total entries
BHSCT	3,602 (72.2%)	1,389 (27.8%)	**4,991 (100%)**
NHSCT	5,026 (86.6%)	777 (13.4%)	**5,803 (100%)**
SEHSCT	3,954 (76.5%)	1,217 (23.5%)	**5,171 (100%)**
SHSCT	2,515 (98.4%)	40 (1.6%)	**2,555 (100%)**
WHSCT	2,573 (91.2%)	247 (8.8%)	**2,820 (100%)**
Total	**17,670 (82.8%)**	**3,670 (17.2%)**	**21,340 (100%)**

**Figure 11: Percentage of entries on continuation sheets DATED**
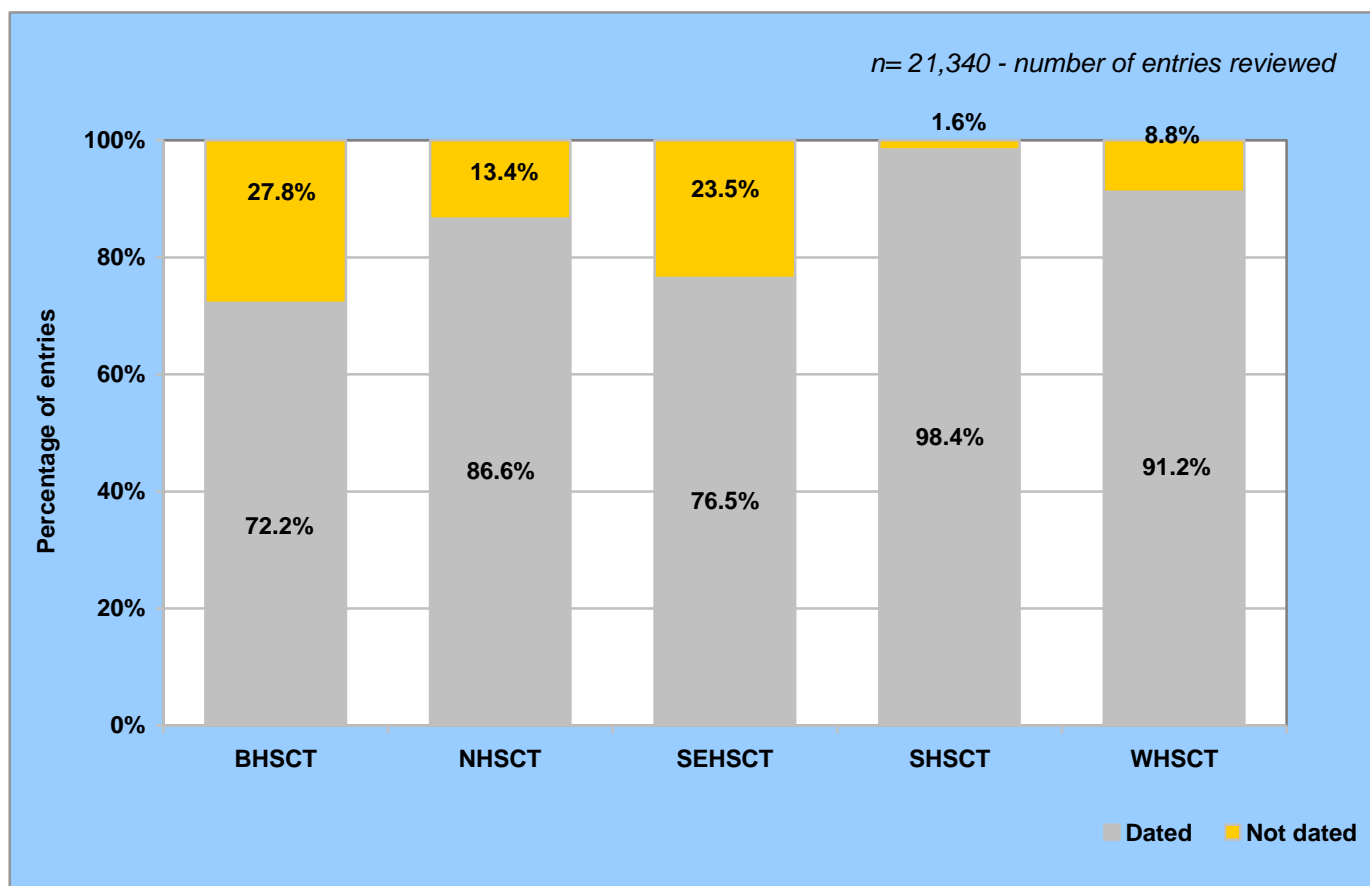
Eighty two point eight (82.8%) of the total entries audited were dated (17,670 of 21,340 entries). The proportion of total entries dated varied across the Trusts audited.

Table 14: Number of entries appropriately TIMED (24 hour clock or 12 hour clock where am or pm stated)

	24 hour clock or 12 hour clock where am or pm stated
BHSCT (n=4,991)	1,886
NHSCT (n=5,803)	2,881
SEHSCT (n=5,171)	3,021
SHSCT (n=2,555)	955
WHSCT (n=2,820)	870
Total (n=21,340)	**9,613 (45% of 21,340 entries)**

Figure 12: Percentage of entries within continuation sheets appropriately TIMED (24 hour clock or 12 hour clock where am or pm stated)

*n= 21,340 - number of entries reviewed*
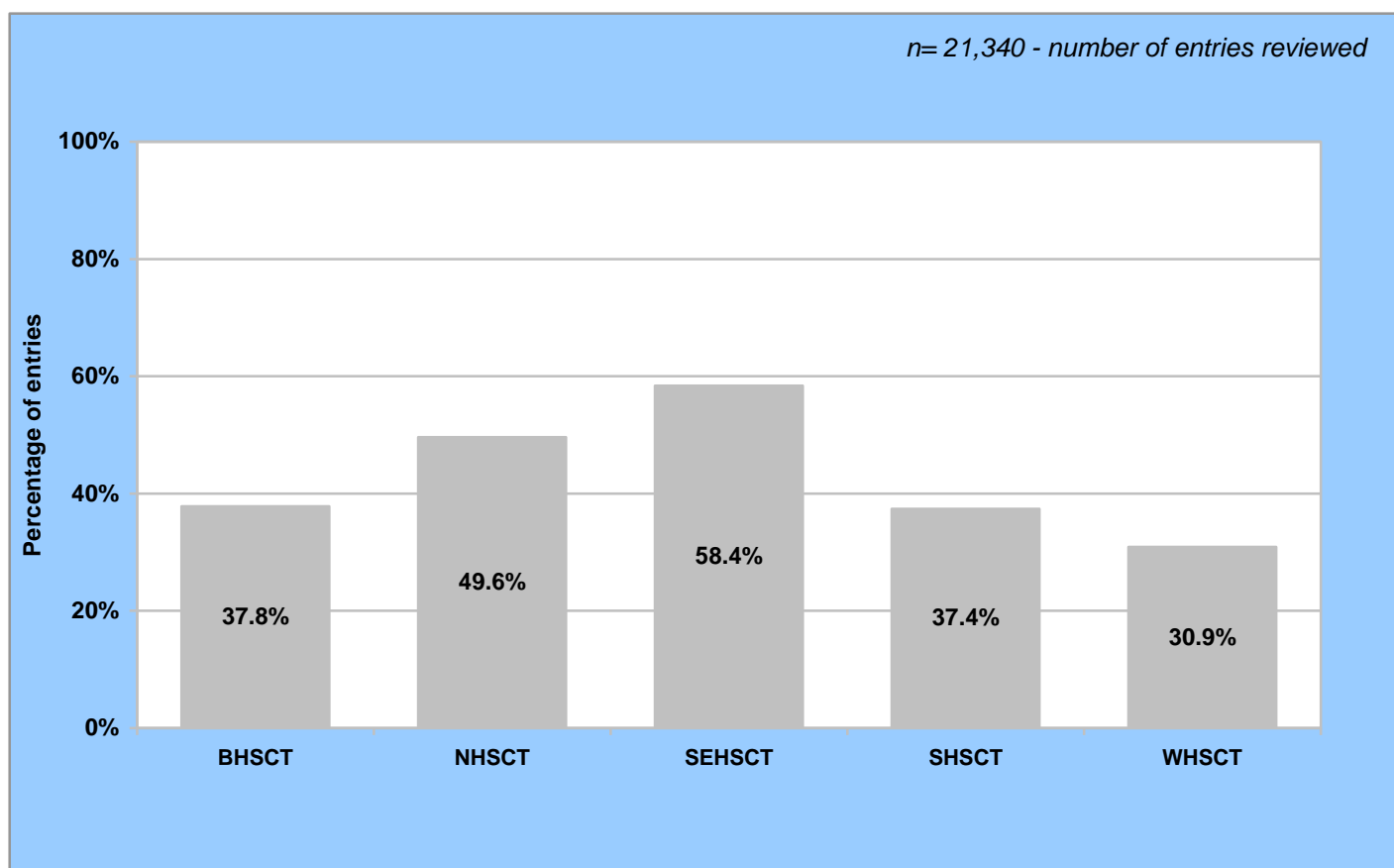
Overall, 45% of total entries recorded on continuation sheets had time of entry appropriately recorded. This did not mean all remaining entries were untimed however it was not always clear from time noted whether the entry was am or pm or a time range was given e.g. 09.30 – 11.00 which has been identified as being unacceptable by professional organisations/bodies.

Table 15: Number and percentage of legible entries (n=21,340)

	Legible	Not legible	Total entries
BHSCT	4,879 (97.8%)	112 (2.2%)	**4,991 (100%)**
NHSCT	5,802 (99.98%)	1 (0.02%)	**5,803 (100%)**
SEHSCT	5,050 (97.7%)	121 (2.3%)	**5,171 (100%)**
SHSCT	2,495 (97.7%)	60 (2.3%)	**2,555 (100%)**
WHSCT	2,629 (93.2%)	191 (6.8%)	**2,820 (100%)**
Total	**20,855 (97.7%)**	**485 (2.3%)**	**21,340 (100%)**

Figure 13: Percentage of LEGIBLE entries on continuation sheets
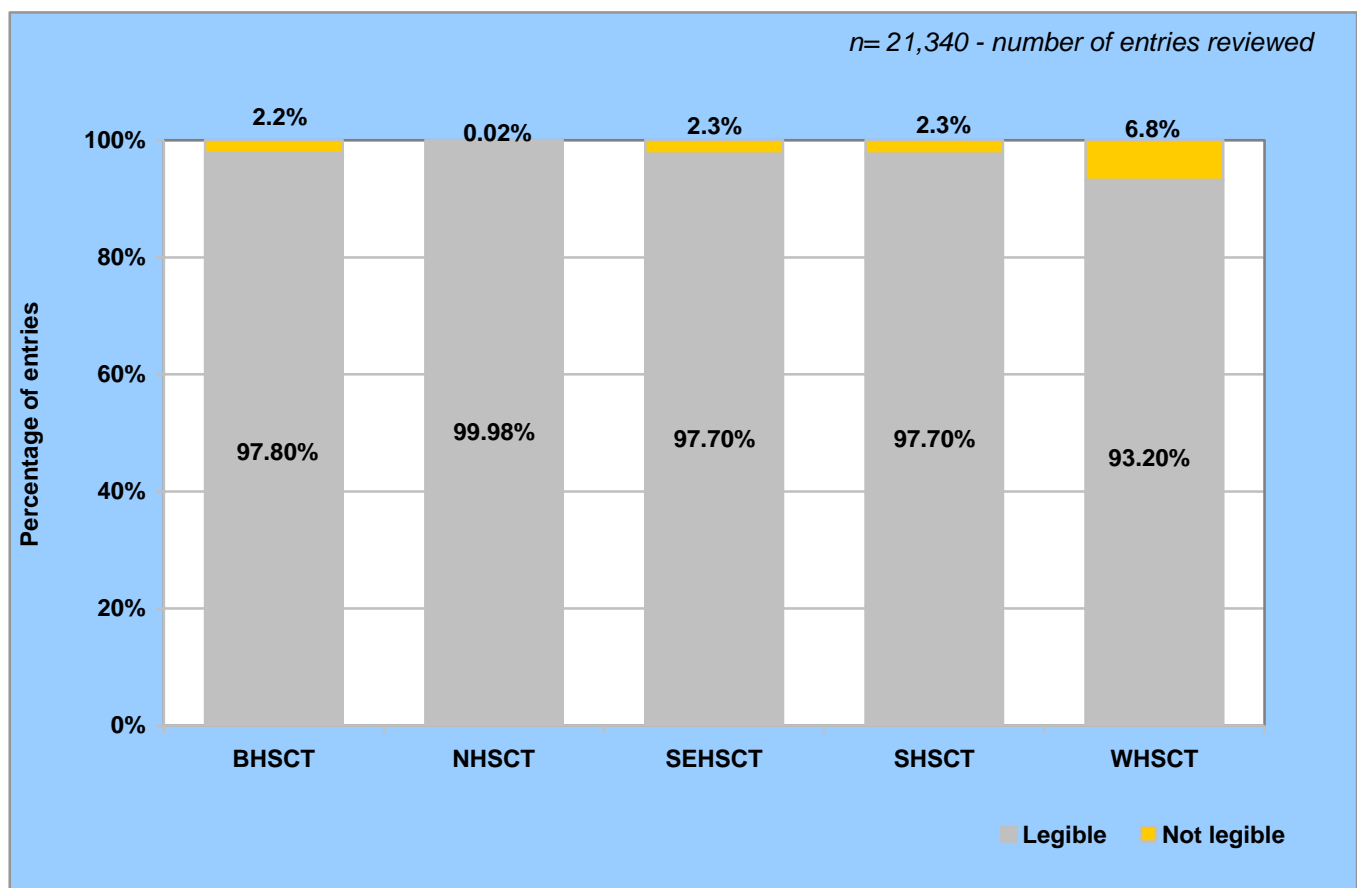

Ninety seven point seven percent (97.7%) of the total entries audited were legible (20,855 of 21,340 entries).

Overall there were 485 illegible entries within the 1,000 cases audited (2.3% of 21,340 entries). Illegible entries related to those made by the following professional groups:

- Medical – 397 of 12,629 entries
- Nursing – 17 of 4,907 entries
- Other health and social care professionals – 71 of 1,739 entries.

Figure 14: Percentage of entries where EVERY ENTRY on continuation sheets was SIGNED by the person making the entry

n= 21,340 - number of entries reviewed
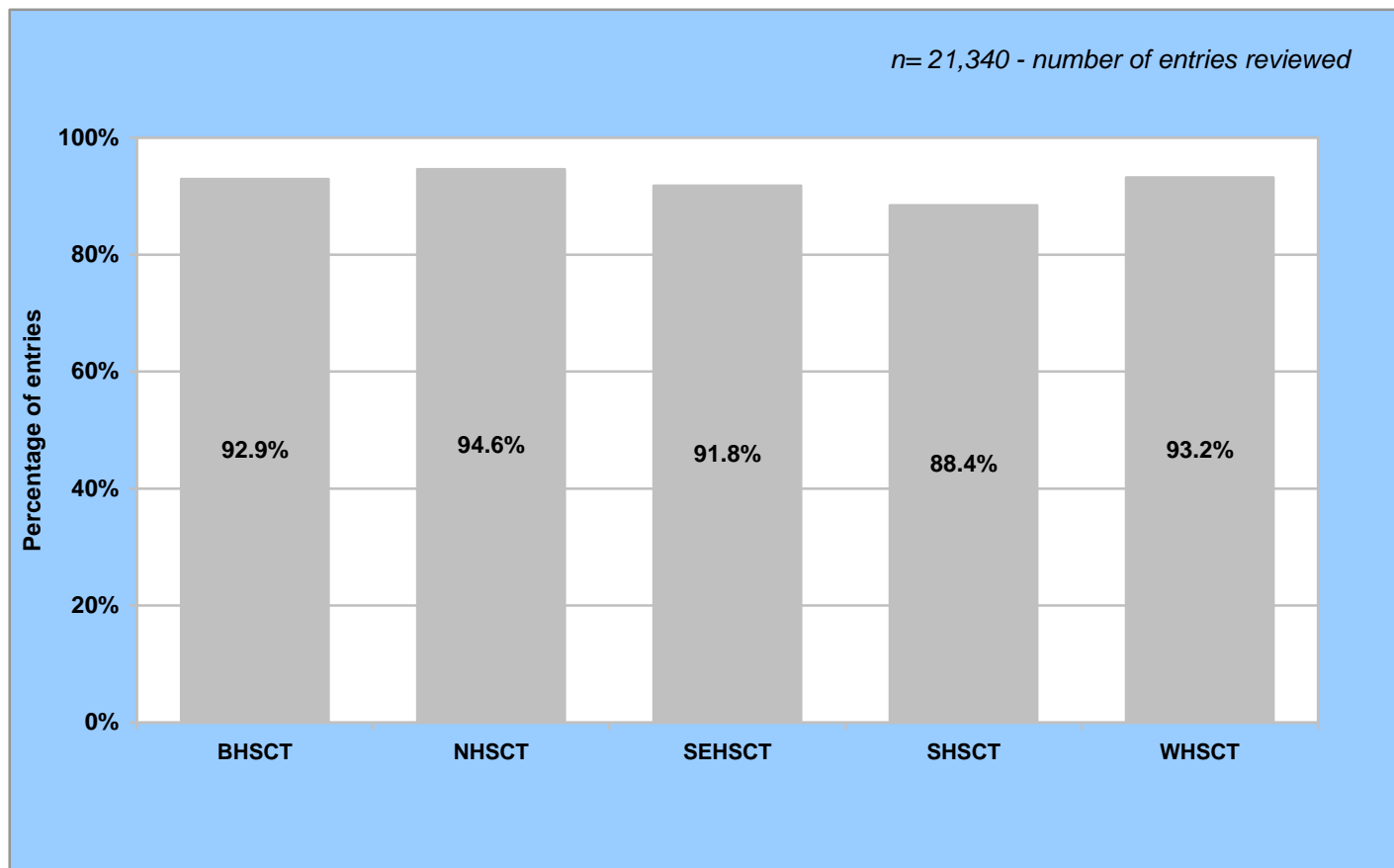
Table 16: Number of entries signed within case notes

|	Entry signed by the person making the entry
BHSCT (n=4,991)	4,638
NHSCT (n=5,803)	5,488
SEHSCT (n=5,171)	4,746
SHSCT (n=2,555)	2,259
WHSCT (n=2,820)	2,629
Total (n=21,340)	19,760 (92.6% of 21,340 entries)

Overall, 92.6% of total entries recorded on continuation sheets were signed.

Table 17: Number and percentage of signed entries with Name and Designation legibly printed against their signature

Number of entries signed = 19,760 (92.6% of all entries reviewed in the audit)

	Name legibly printed	Designation legibly printed	Total entries
BHSCT	653 (14.1%)	3,091 (66.6%)	**4,638**
NHSCT	786 (14.3%)	3,008 (54.8%)	**5,488**
SEHSCT	514 (10.8%)	2,790 (58.8%)	**4,746**
SHSCT	880 (39%)	1,393 (61.7%)	**2,259**
WHSCT	1,011 (38.5%)	1,329 (50.6%)	**2,629**
Total	**3,844 (19.5%)**	**11,611 (58.8%)**	**19,760**

Figure 15: Percentage of signed entries with name and designation legibly printed beside the signature

*n = 19,760 - number of entries signed*
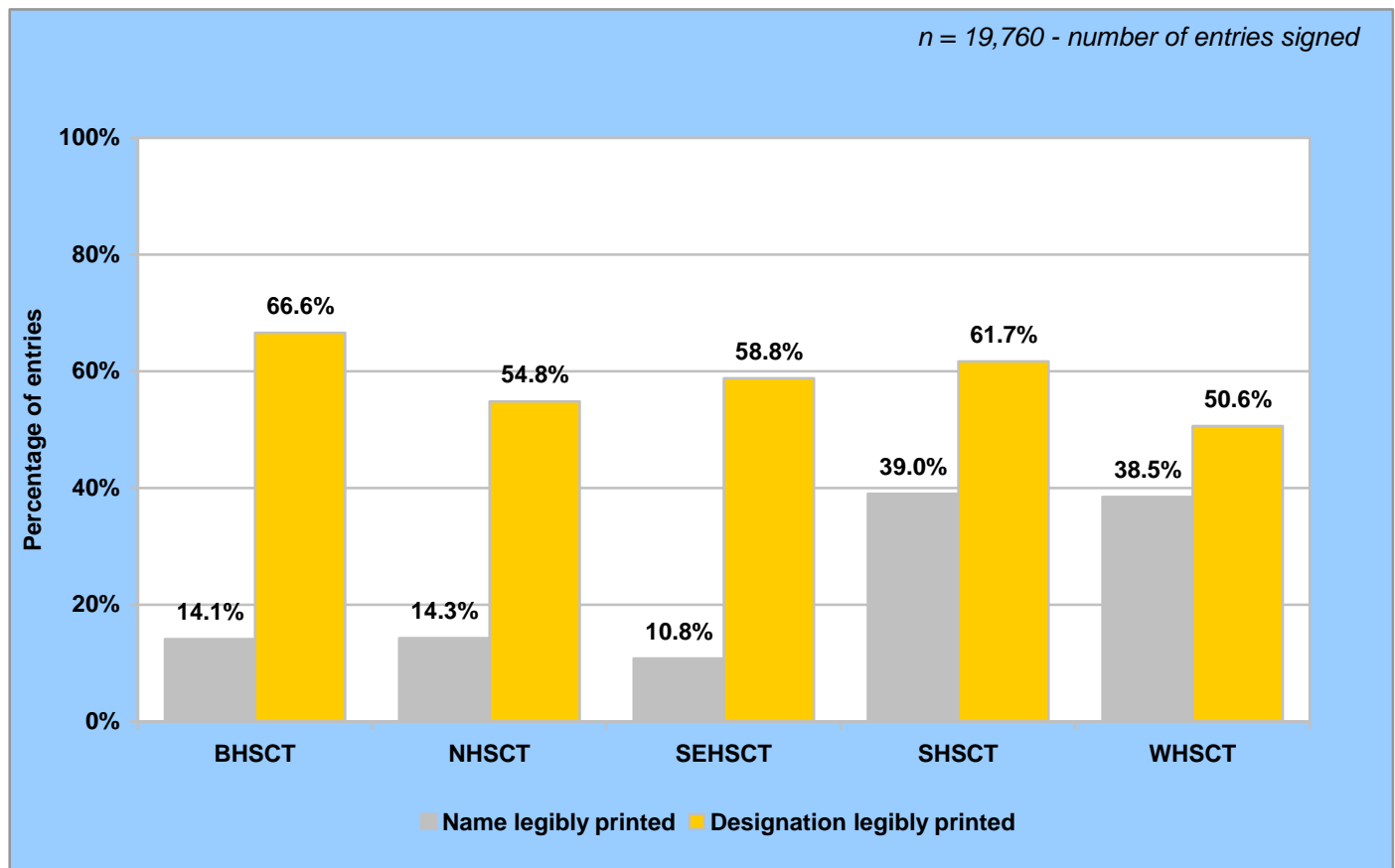
Whilst the majority of entries (92.6%) audited had been signed designation was more likely to be printed legibly against the signature rather than name, as depicted in Figure 15 above.

Deletions or alterations

Six hundred and forty (640) of the 1,000 (64%) cases audited had deletions or alterations to entries on continuation sheets during the hospital admission period audited. Deletions or alterations were present within the following cases:

- BHSCT – 125 of 200 (62.5%) cases
- NHSCT – 137 of 200 (68.5%) cases
- SEHSCT – 141 of 200 (70.5%) cases
- SHSCT – 132 of 200 (66%) cases
- WHSCT – 105 of 200 (52.5%) cases

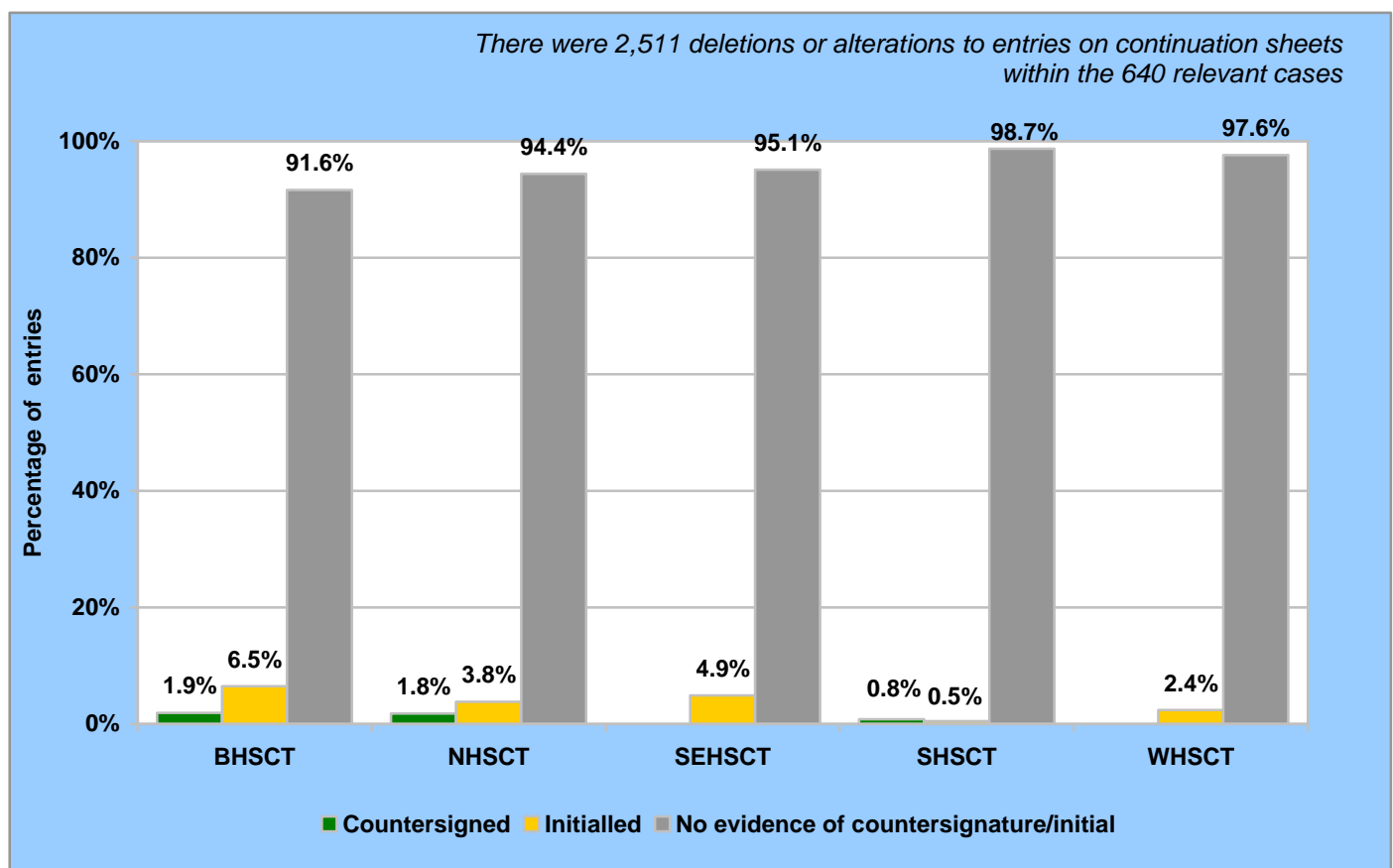**Figure 16: Total number of deletions or alterations during this admission**
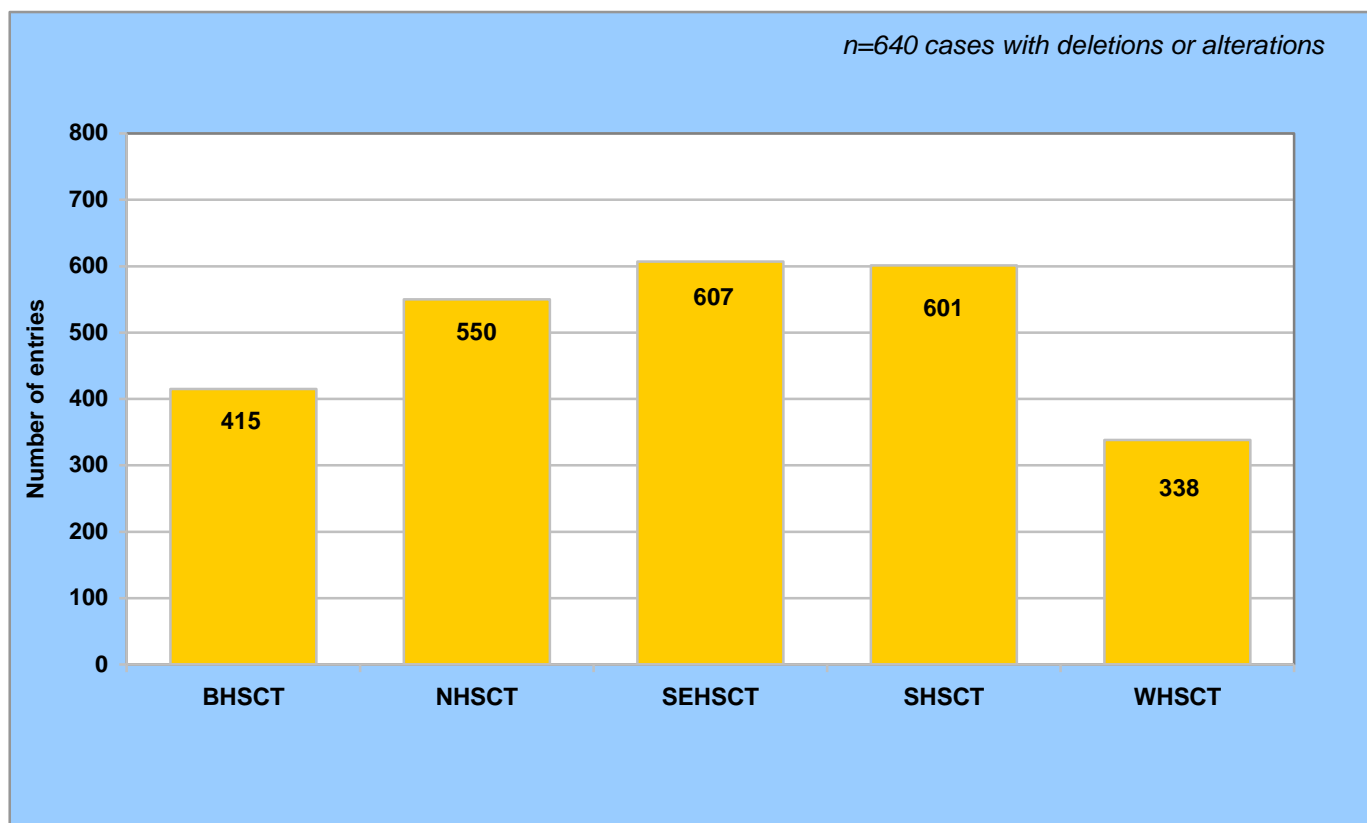
There were 2,511 deletions or alterations to entries on continuation sheets within the 640 relevant cases

Table 18: Number and percentage of deletions or alterations countersigned or initialled

	Number of deletions or alterations		
	Countersigned	**Initialled**	**No evidence of countersignature or initials**
BHSCT (n=415)	8 (1.9%)	27 (6.5%)	380 (91.6%)
NHSCT (n=550)	10 (1.8%)	21 (3.8%)	519 (94.4%)
SEHSCT (n=607)	--	30 (4.9%)	577 (95.1%)
SHSCT (n=601)	5 (0.8%)	3 (0.5%)	593 (98.7%)
WHSCT (n=338)	--	8 (2.4%)	330 (97.6%)
Total (n=2,511)	**23 (0.9%)**	**89 (3.5%)**	**2,399 (95.5%)**

Figure 17: Percentage of entries where deletions or alterations were countersigned or initialled

Only a very small number of deletions or alterations were countersigned or initialled within the relevant cases audited.

Standard 5

Retrospective entries to the medical record should be made as soon as possible after the event to be documented and before the relevant staff member goes off duty. If there is a delay the time of the event and the delay should be recorded

Retrospective entries recorded on continuation sheets for this admission

Fifty two (52) of the 1,000 (5.2%) cases audited contained retrospective entries. There were 59 retrospective entries in total.

Table 19: Cases with retrospective entries and frequency

	Number of retrospective cases	Number of retrospective entries
BHSCT	7	8
NHSCT	1	3
SEHST	14	17
SHSCT	11	10
WHSCT	19	21
Total	52 (5.2% of 1,000 cases)	59 (0.28% of 21,340 entries)

Table 20: Number of cases with retrospective entries by specialty

	Surgery	Acute Medicine	Gynaecology	Cardiology
BHSCT (n=7)	1	3	-	3
NHSCT (n=1)	1	-	-	-
SEHSCT (n=14)	3	5	1	5
SHSCT (n=11)	4	3	1	3
WHSCT (n=19)	4	5	7	3
Total (n=52)	13	16	9	14

Table 21: Retrospective entries by professional group n=59

	Number of retrospective entries
Medical	44
Nursing	6
Other	6
Not known	3
Total	**59**

A reason was not always evident for the retrospective entry but in some cases these were made on the same or next day and related to investigation or laboratory results or following discussion with another specialist service. In a few cases the retrospective entry had been made because notes were not available at the time or there had been a change to advice issued earlier.

The number of retrospective entries was very low i.e. 0.28% of total entries.

Standard 6

An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than 4 days for acute medical care the next entry should explain why

Table 22: Number and percentage of cases where entries were made on continuation sheets daily

	Yes	No	Not recorded	Total cases
BHSCT	145 (72.5%)	55 (27.5%)	--	**200 (100%)**
NHSCT	141 (70.5%)	59 (29.5%)	--	**200 (100%)**
SEHSCT	137 (68.5%)	61 (30.5%)	2 (1%)	**200 (100%)**
SHSCT	119 (59.5%)	81 (40.5%)	--	**200 (100%)**
WHSCT	86 (43%)	112 (56%)	2 (1%)	**200 (100%)**
Total	**628 (62.8%)**	**368 (36.8%)**	**4 (0.4%)**	**1,000 (100%)**

In 4 cases required information was missing from the data collection form which prevented a determination being made as to whether entries were made in the medical record daily

Figure 18: Percentage of cases where entries were made on each day/date during this admission
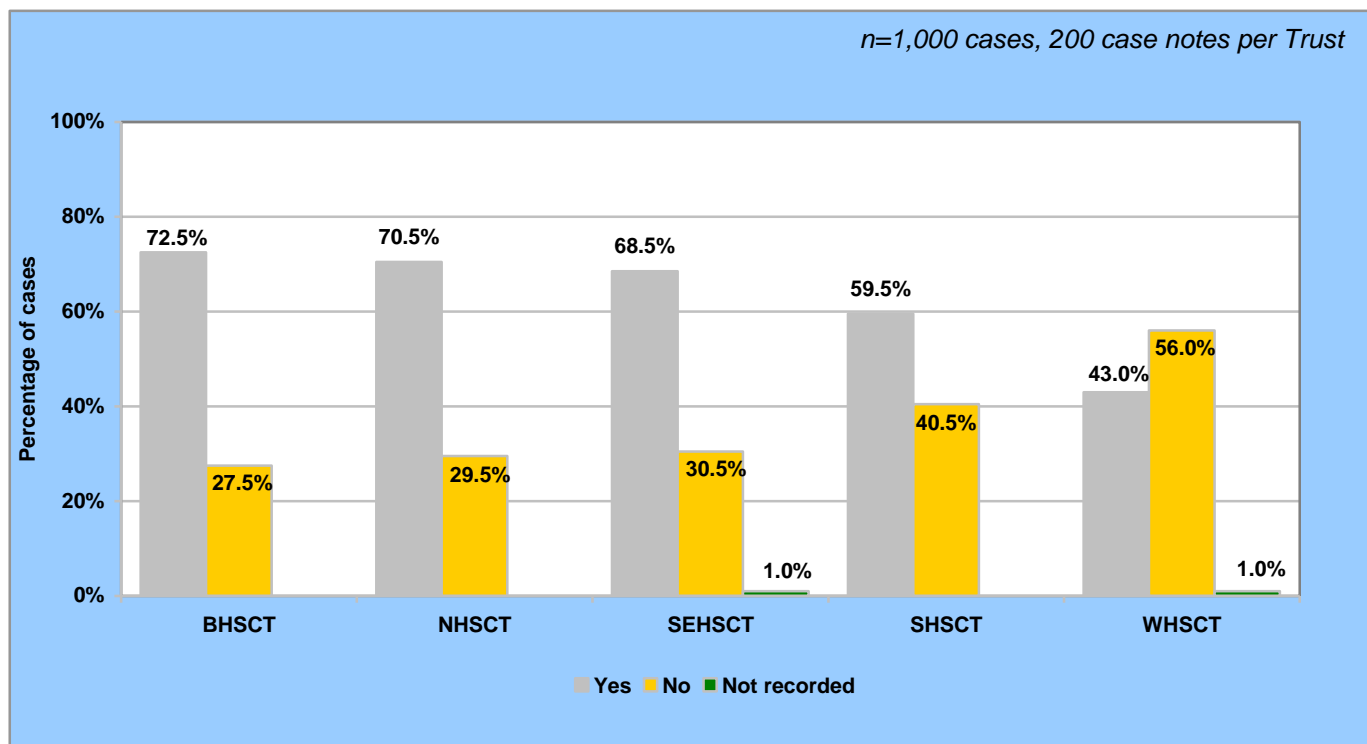
It is not unusual for a number of days to occur between entries on continuation sheets particularly over the week-end period. Two (2) of the 1,000 (0.2%) cases audited did not have an entry within the continuation sheets for more than 4 days. These two cardiology cases were reviewed to determine if the next entry explained why.

A NHSCT case was transferred to BHSCT for Coronary Angiography explaining why there was 6 days between entries. One SHSCT case had a gap of 5 days between entries and no reason was recorded on the continuation sheet for this. This 5 day period included 2 weekend days.

Standard 7
Consent must be clearly recorded in the medical record

Table 23: Number and percentage of cases where the patient underwent an operation or procedure
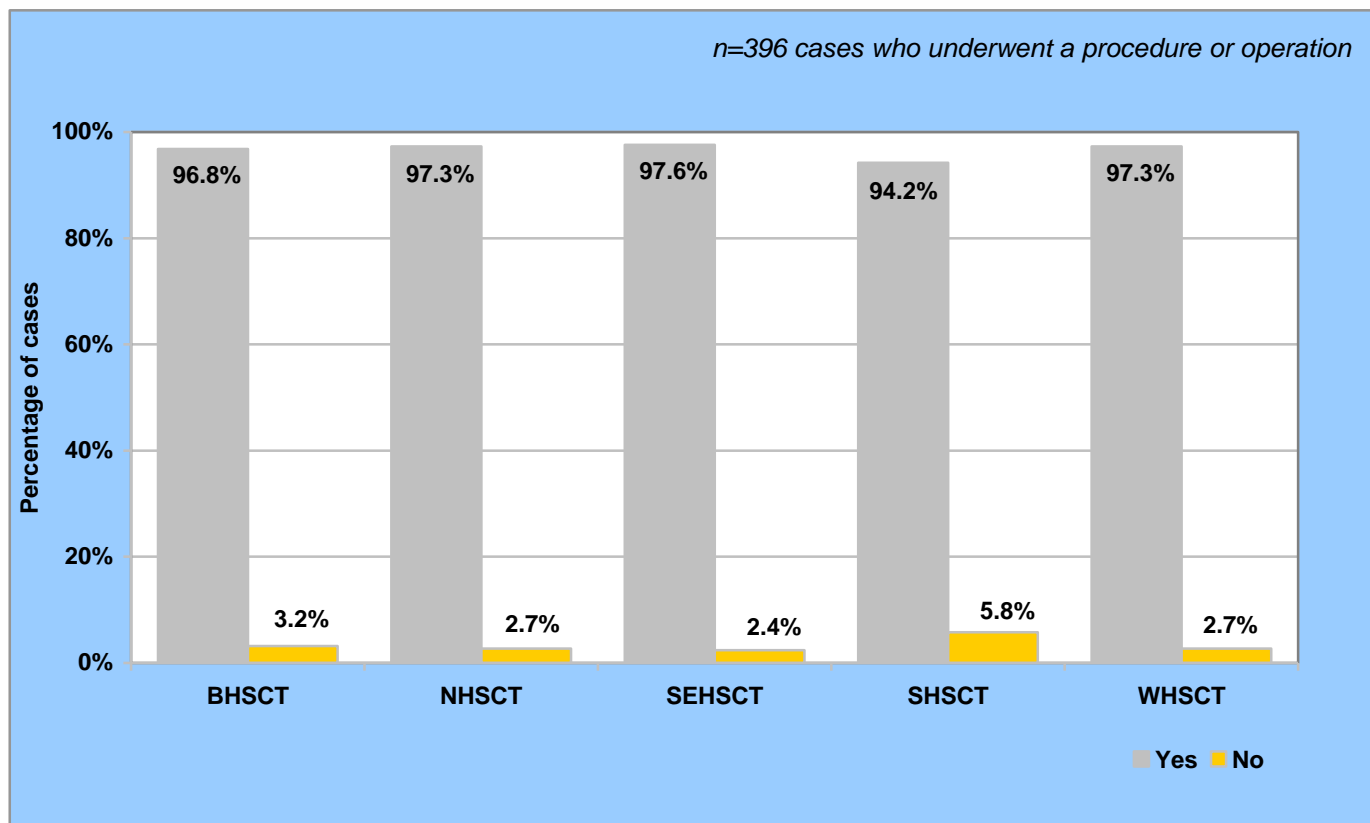
	Yes	No	Not recorded	Total cases
BHSCT	94 (47%)	106 (53%)	--	200 (100%)
NHSCT	74 (37%)	126 (63%)	--	200 (100%)
SEHSCT	85 (42.5%)	113 (56.5%)	2 (1%)	200 (100%)
SHSCT	69 (34.5%)	130 (65%)	1 (0.5%)	200 (100%)
WHSCT	74 (37%)	126 (63%)	--	200 (100%)
Total	**396 (39.6%)**	**601 (60.1%)**	**3 (0.3%)**	**1,000 (100%)**

Table 24: Number and percentage of cases where the consent form was present in the record

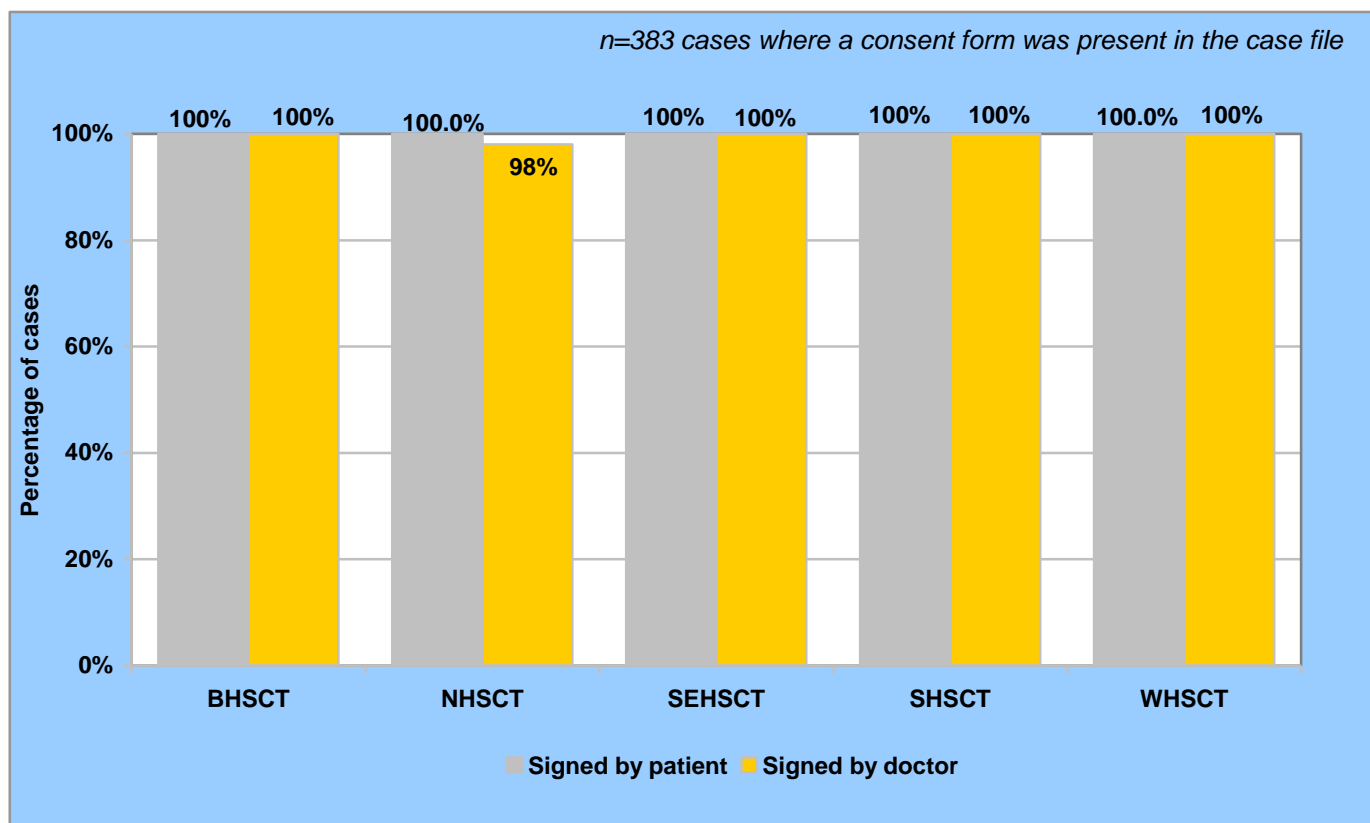*Three hundred and ninety six (396) patients underwent an operation or procedure*

	Yes	No	Total cases
BHSCT	91 (96.8%)	3 (3.2%)	**94 (100%)**
NHSCT	72 (97.3%)	2 (2.7%)	**74 (100%)**
SEHSCT	83 (97.6%)	2 (2.4%)	**85 (100%)**
SHSCT	65 (94.2%)	4 (5.8%)	**69 (100%)**
WHSCT	72 (97.3%)	2 (2.7%)	**74 (100%)**
Total	**383 (96.7%)**	**13 (3.3%)**	**396 (100%)**

Figure 19: Percentage of cases where a consent form was present in the record

n=396 cases who underwent a procedure or operation

	Yes	No
BHSCT	96.8%	3.2%
NHSCT	97.3%	2.7%
SEHSCT	97.6%	2.4%
SHSCT	94.2%	5.8%
WHSCT	97.3%	2.7%

No consent form was present for 13 of the 396 (3.3%) applicable cases audited. All 13 patients had underwent a procedure or operation

**Figure 20: Percentage of cases where the consent form was signed by the patient and a doctor**

n=383 cases where a consent form was present in the case file

	Signed by patient	Signed by doctor
BHSCT	100%	100%
NHSCT	100.0%	98%
SEHSCT	100%	100%
SHSCT	100%	100%
WHSCT	100.0%	100%

Whilst a consent form was present in 383 case files audited only 376 cases were included within figure 20 above for signed by patient. This was due to use of Consent Form 4 in 7 cases for Adults who are unable to consent. There is no requirement to sign in such cases.

Overall, 381 of the 383 (99.5%) applicable cases had a Doctor's signature on the consent form. In 2 NHSCT cases (0.5%) the consent form was not signed by a Doctor in relation to an Acute Medicine case and a Gynaecology case.

Figure 21: Percentage of cases where the consent form was dated by the patient and a doctor
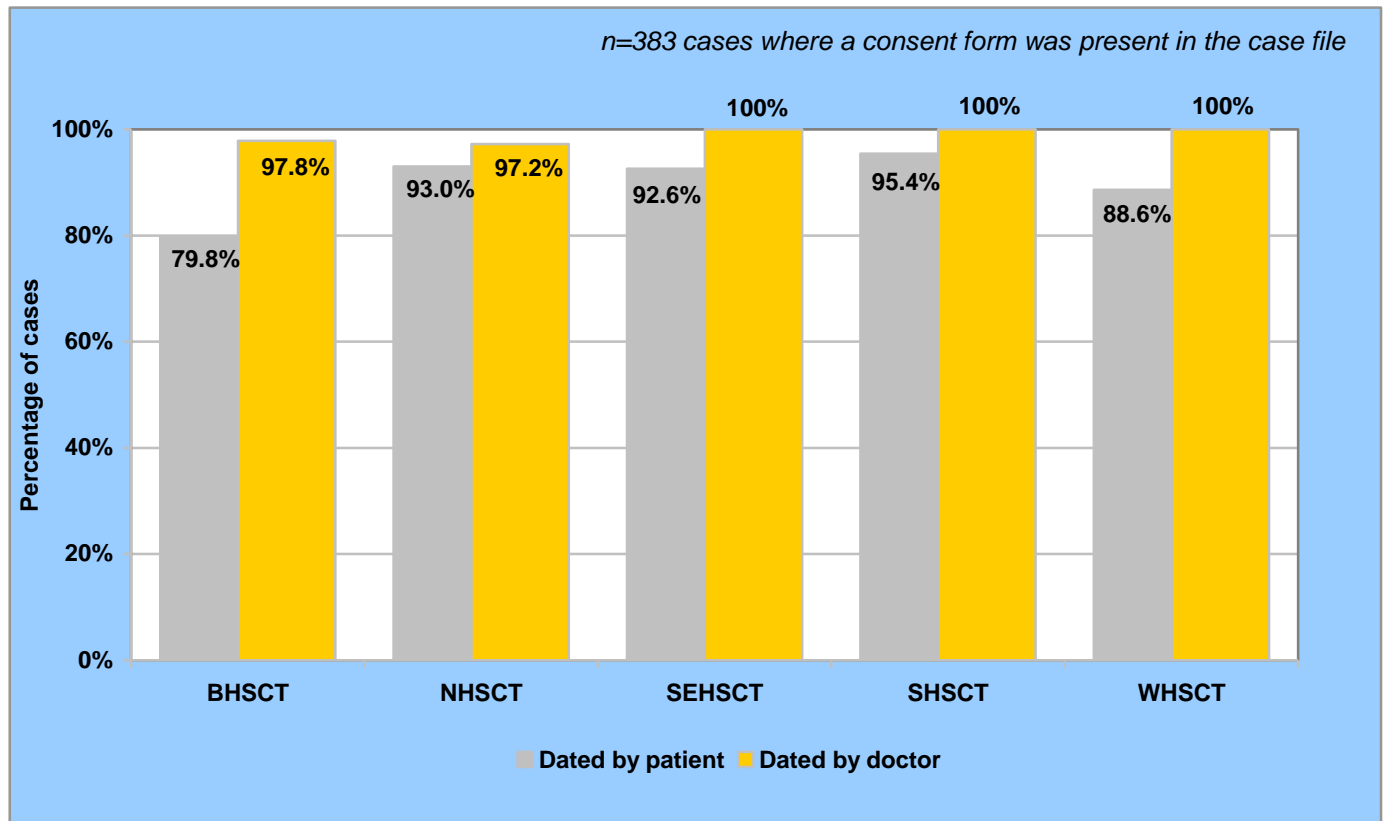
Whilst a consent form was present in 383 case files audited only 376 cases were included within figure 21 above for dated by patient. This was due to use of Consent Form 4 in 7 cases for Adults who are unable to consent. There is no requirement to sign or date in such cases.

Overall, the consent form was dated by a doctor in 379 of 383 (99%) applicable cases. The consent form was not dated by a doctor in 4 cases:
- BHSCT - 1 surgical patient and 1 acute medicine patient
- NHSCT - 2 gynaecology patients

For those cases (4) where the consent form was not dated by a doctor it had been dated by the patient in all 4 cases.

Table 25: Number of cases where the consent form was not dated by the patient

	Surgery	Acute Medicine	Gynaecology	Cardiology
BHSCT (n=18)	8	1	3	6
NHSCT (n=5)	2	2	1	-
SEHSCT (n=5)	2	1	-	2
SHSCT (n=3)	2	-	-	1
WHSCT (n=6)	1	1	1	3
Total (n=37)	15	5	5	12

In 37 cases the consent form was not dated by the patient:

- 15 surgical patients - 8 BHSCT, 2 NHSCT, 2 SEHSCT, 2 SHSCT, 1 WHSCT
- 5 medical patients - 1 BHSCT, 2 NHSCT, 1 SEHSCT, 1 WHSCT
- 5 gynae patients - 3 BHSCT, 1 NHSCT, 1 WHSCT
- 12 cardiology patients - 6 BHSCT, 2 SEHSCT, 1 SHSCT, 3 WHSCT.

Figure 22: Section of consent form present in the case file

n=383 cases where a consent form was present in the case file
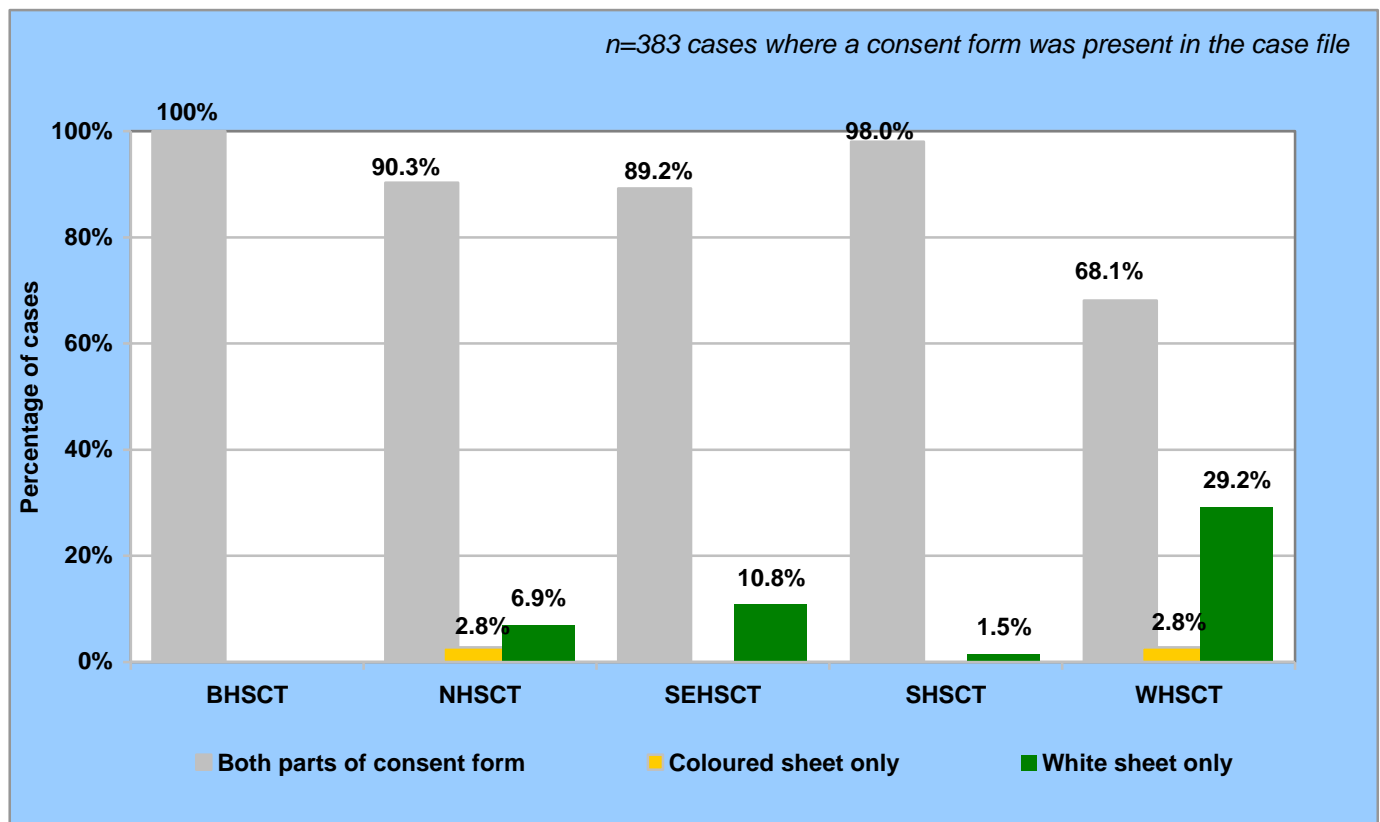
Where written consent is required completed forms should be filed in the medical record and the top copy of the completed DHSSPS consent form offered to the patient and this action recorded. Overall, in 343 of 383 applicable cases (89.6%) both parts of the consent form were present in the

case file namely both the top (white) sheet which should have been given to the patient as well as the section for retention with the case file. These related to the following types of consent form:

- **Form 1** for Adults (coloured white and pink) - 335 of the 383 cases
- **Form 4** for Adults who are unable to consent (coloured white and green) - 7 of the 383 cases
- **Form 2** to obtain Parental agreement for a child or young person (coloured white and yellow) - 1 of the 383 cases.

In only 3 of the 343 (0.9%) cases where both parts of the consent form were present in the case file was there a note made within the continuation sheets stating that the patient was offered the consent form and refused same. This was in relation to:

- 1 NHSCT surgical patient;
- 1 SEHSCT surgical patient; and
- 1 WHSCT cardiology patient.

Standard 8
Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma

Table 26: Number and percentage of cases where on admission to the ward (this admission only) initial information was recorded using a standardised admission/assessment proforma

	Yes	No	Not recorded	Not applicable	Total cases
BHSCT	152 (76%)	40 (20%)	7 (3.5%)	1 (0.5%)	**200 (100%)**
NHSCT	156 (78%)	44 (22%)	--	--	**200 (100%)**
SEHSCT	133 (66.5%)	61 (30.5%)	6 (3%)	--	**200 (100%)**
SHSCT	96 (48%)	4 (2%)	--	100 (50%)*	**200 (100%)**
WHSCT	59 (29.5%)	137 (68.5%)	2 (1%)	2 (1%)	**200 (100%)**
Total	**596 (59.6%)**	**286 (28.6%)**	**15 (1.5%)**	**103 (10.3%)**	**1,000 (100%)**

Note: * All 100 cases audited on a single hospital site

Figure 23: Percentage of cases where on admission to the ward (this admission only) initial information was recorded using a standardised admission/assessment proforma
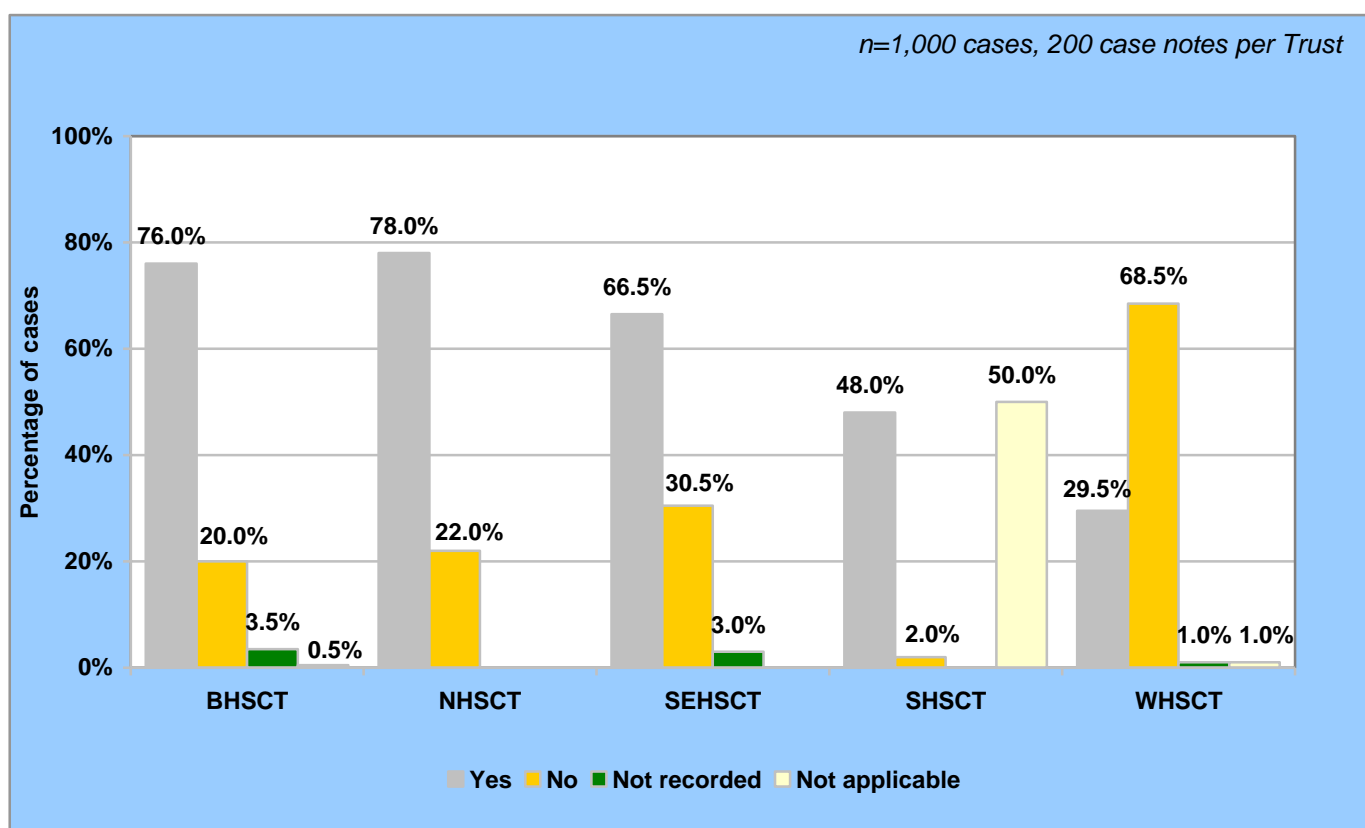
In 596 (59.6%) of the 1,000 cases audited initial information on admission was recorded using a standardised admission/assessment proforma. The name/title of the proforma in use varied depending on the specialty and hospital site.

Table 27: Examples of standardised admission/assessment proformas in use

BHSCT - Name/title of proforma
Acute Medicine
BHSCT Medical Admission
Gynaecology
Patient Assessment form – Biographical and Health Data
Cardiology
BHSCT Critical Care Unit – Admission Demographics
Surgery
Multidisciplinary Assessment Document
NHSCT - Name/title of proforma
Acute Medicine
NHSCT – Medical Admission Pack
Gynaecology
Gynaecology Inpatient/Outpatient
Cardiology
NHSCT Medical Admission Pack
Surgery
Surgical Admission
SEHSCT - Name/title of proforma
Acute Medicine
Sheet no. 4a Clinical History sheet Medication on admission
Gynaecology
Gynaecological in-patient record.
Cardiology
Patient History part of medical assessment pack
Surgery
No specific proforma used

Table 27: Examples of standardised admission/assessment proformas in use (cont'd)

SHSCT - Name/title of proforma
Acute Medicine
Medical Admission Unit proforma
Gynaecology
Gynaecology Assessment form
Cardiology
Patient Admission Details booklet
Surgery
Surgical Admission proforma
WHSCT - Name/title of proforma
Acute Medicine
Medical Clerking Sheet (New medical & Surgical Assessment Unit)
Gynaecology
Gynaecology History and Examination sheet
Cardiology
Care Pathway - Patients with chest pain
Surgery
M&SAU Surgical Assessment Form

Figure 24: Number of cases where a 'completed' discharge planner form was present

n=138 cases with completed discharge planner form
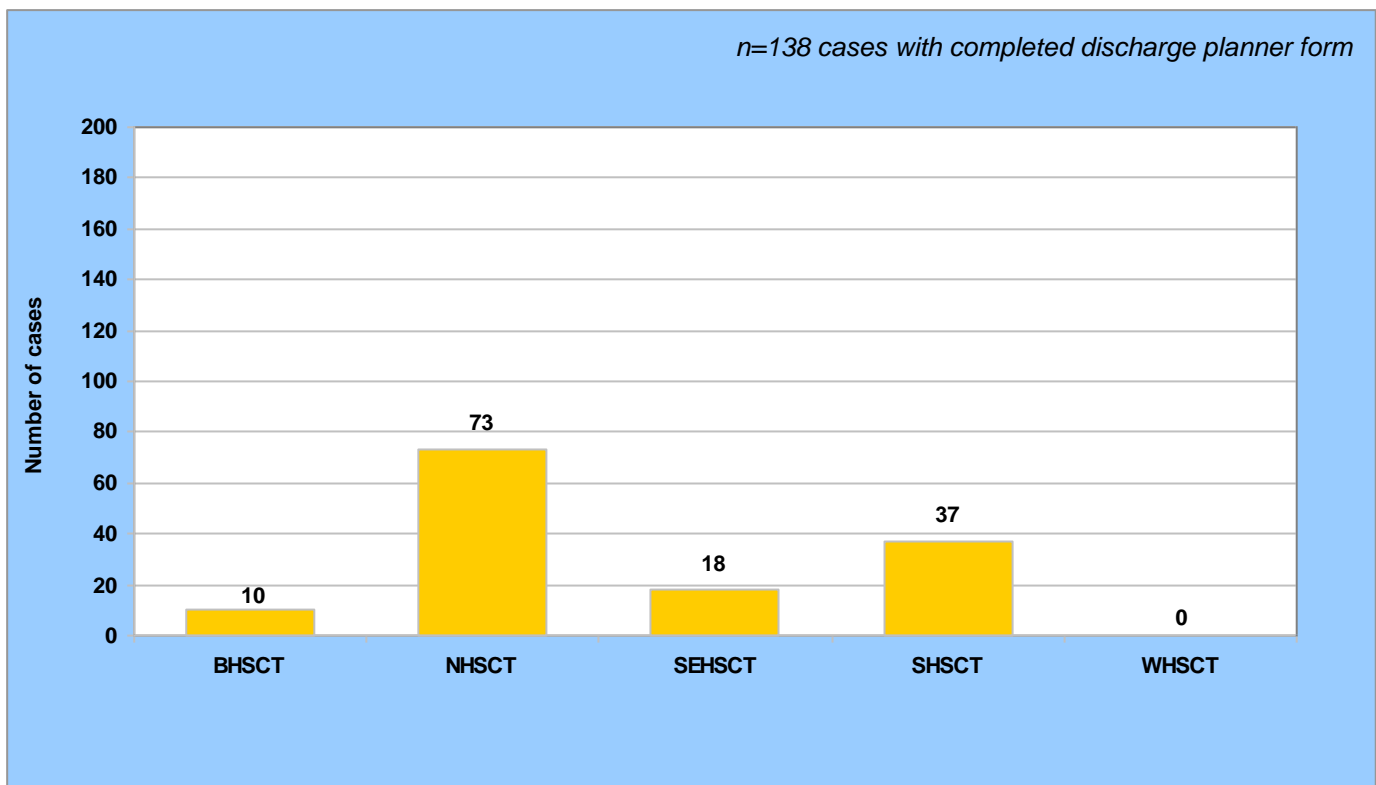
Overall 138 of the 1,000 (13.8%) cases included in the audit had a completed discharge planner form present in the chart

These were in use across the following specialties:
- Surgery - 36 of 248 (14.5%) patients
- Acute Medicine – 48 of 251 (19.1%) patients
- Gynaecology – 26 of 251 (10.4%) patients
- Cardiology – 28 of 250 (11.2%) patients

The name/title of the discharge planner proformas in use varied across Trusts although there was generally consistency in form type across specialties within individual Trusts where a discharge planner form was completed. For example:

- BHSCT – Specialist Medicine Discharge Plan
- NHSCT – Multidisciplinary Discharge Planner
- SEHSCT – Discharge Planning Form
- SHSCT – Patient Focused Discharge Plan, Discharge/Transfer Checklist, Nursing Discharge Planner

A Trust name/logo was not always present on the discharge planner forms which were in use.

Standard 9

The discharge letter should be available within the medical record in the case of all hospital admissions

Diagnosis should be clearly recorded on the discharge letter

The discharge letter should be forwarded to the patient's GP as soon as possible

Overall, 223 of the 1,000 (22.3%) cases audited did not have a discharge letter pertaining to the hospital admission audited within the case record

Figure 25: Percentage of cases where the discharge letter was present pertaining to the admission period being audited
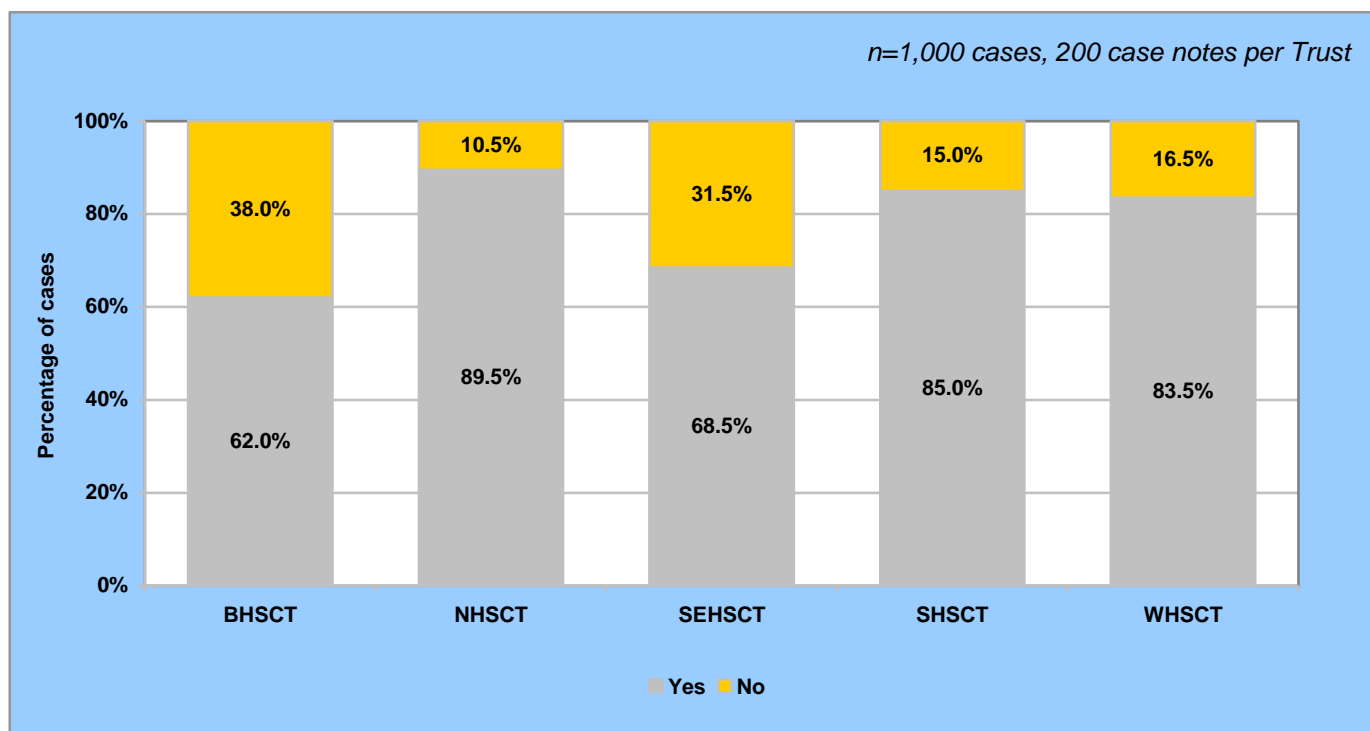
Table 28: Number and percentage of cases where the discharge letter was not present pertaining to the admission period being audited displayed by specialty

	Surgery	Acute Medicine	Gynaecology	Cardiology	Total cases
BHSCT	20 (26.3%)	20 (26.3%)	29 (38.2%)	7 (9.2%)	**76 (100%)**
NHSCT	6 (28.6%)	10 (47.6%)	1 (4.8%)	4 (19%)	**21 (100%)**
SEHSCT	5 (7.9%)	28 (44.4%)	6 (9.5%)	24 (38.1%)	**63 (100%)**
SHSCT	3 (10%)	6 (20%)	14 (46.7%)	7 (23.3%)	**30 (100%)**
WHSCT	11 (33.3%)	4 (12.1%)	6 (18.2%)	12 (36.4%)	**33 (100%)**
Total	**45 (20.2%)**	**68 (30.5%)**	**56 (25.1%)**	**54 (24.2%)**	**223 (100%)**

The length of stay of the 223 cases with no discharge letter present in the case file ranged from less than 24 hours – 85 days with an average length of stay of 8.7 days.

**Table 29: Number of cases with reason for no discharge letter being on file**

	Number of cases with valid reason for no discharge letter on file
BHSCT (n=76)	2
NHSCT (n=21)	2
SEHSCT (n=63)	16
SHSCT (n=30)	2
WHSCT (n=33)	10
Total (n=223)	**32**

For 32 of the 223 (14.3%) cases with no discharge letter reasons were identified as to why this was the case. Reasons noted were as follows:

- Patient was transferred to another hospital – 31 cases
- Patient had numerous admissions for hyperemesis and a previous recent admission – 1 case.

One hundred and ninety-one (191) of the 1,000 (19.1%) cases audited had no discharge letter and no clear reason was evident to auditors as to why this should be the case.

Figure 26: Percentage of cases where diagnosis was clearly recorded on the discharge letter for the admission audited
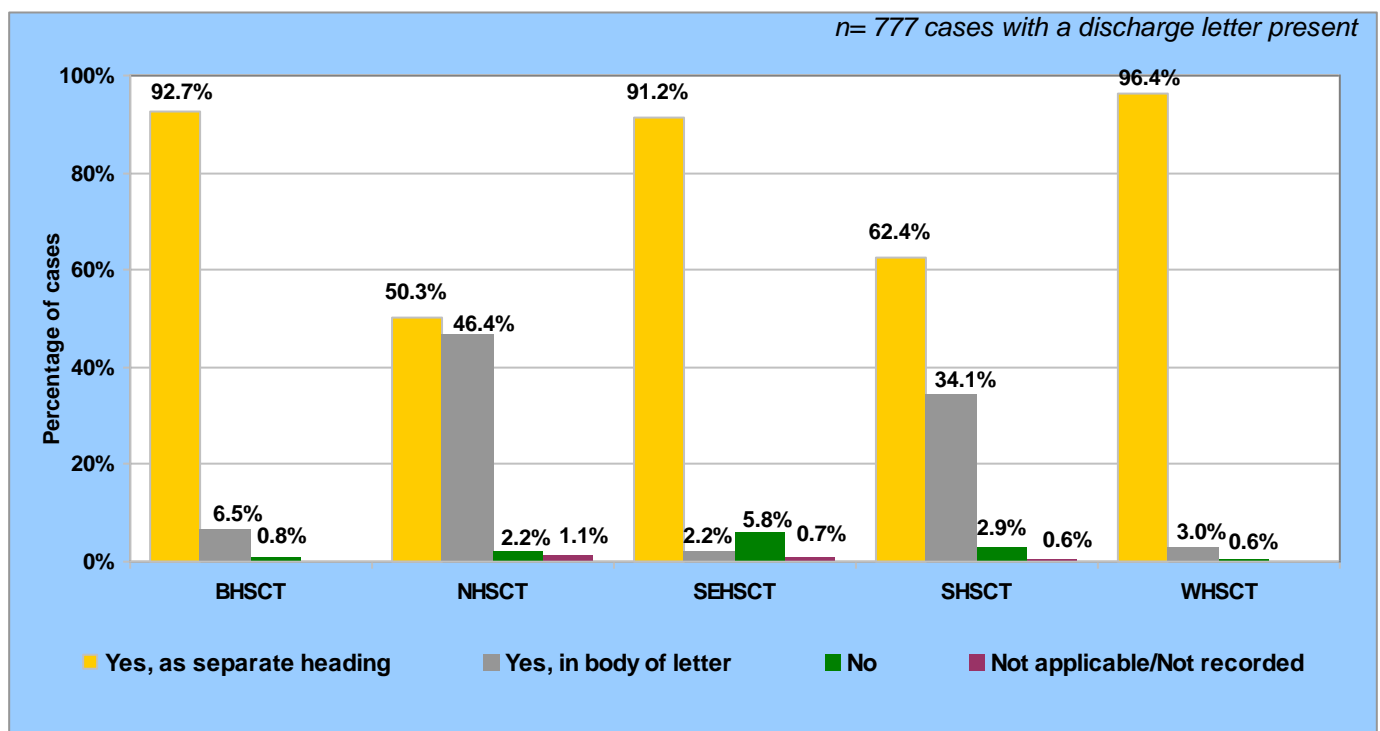
Table 30: Number and percentage of cases where diagnosis was clearly recorded on the discharge letter for this admission

	Yes	No	Not recorded	Not applicable*	Total cases
BHSCT	123 (99.2%)	1 (0.8%)	--	--	**124 (100%)**
NHSCT	173 (96.6%)	4 (2.2%)	--	2 (1.1%)	**179 (100%)**
SEHSCT	128 (93.4%)	8 (5.8%)	1 (0.7%)	--	**137 (100%)**
SHSCT	164 (96.5%)	5 (2.9%)	1 (0.6%)	--	**170 (100%)**
WHSCT	161 (96.4%)	5 (3%)	1 (0.6%)	--	**167 (100%)**
Total	**749 (96.4%)**	**23 (3%)**	**3 (0.4%)**	**2 (0.2%)**	**777 (100%)**

Note: Not applicable* - NHSCT (2) 'no diagnosis' was considered appropriate for the admission.

In total, 749 of the 777 (96.4%) cases with a discharge letter on file for the admission audited recorded the diagnosis clearly either as a separate heading (583 of 749 cases – 77.8%) or in the body of the letter (166 of 749 cases – 22.2%).

Twenty-three (23) of the 777 (3%) cases did not have a clear diagnosis recorded within the discharge letter. The cases in question related to the following HSC Trusts: BHSCT (1), NHSCT (4), SEHSCT (8), SHSCT (5), and WHSCT (5).

For 3 cases it was not possible to determine if the diagnosis was clearly recorded on the discharge letter as this information was not recorded on the data collection form.

The discharge letter should be forwarded to the patient's GP as soon as possible

Table 31: Length of time (days) between discharge and discharge letter typed

	30 days or less	31 – 60 days	More than 60 days	Unable to determine	Total cases
BHSCT	76 (61.3%)	34 (27.4%)	13 (10.5%)	1 (0.8%)	**124 (100%)**
NHSCT	132 (73.7%)	26 (14.5%)	11 (6.1%)	10 (5.6%)	**179 (100%)**
SEHSCT	19 (13.9%)	9 (6.6%)	9 (6.6%)	100 (73%)	**137 (100%)**
SHSCT	110 (64.7%)	29 (17.1%)	28 (16.5%)	3 (1.8%)	**170 (100%)**
WHSCT	130 (77.8%)	15 (9%)	13 (7.8%)	9 (5.4%)	**167 (100%)**
Total	**467 (60.1%)**	**113 (14.5%)**	**74 (9.5%)**	**123 (15.8%)**	**777 (100%)**

The length of time between discharge and discharge letter typed could not be determined in 123 of 777 (15.8%) cases as the date typed was not recorded on the discharge letter or dates were missing from the data collection form.

Figure 27: Length of time (days) between discharge and discharge letter typed (n=777)
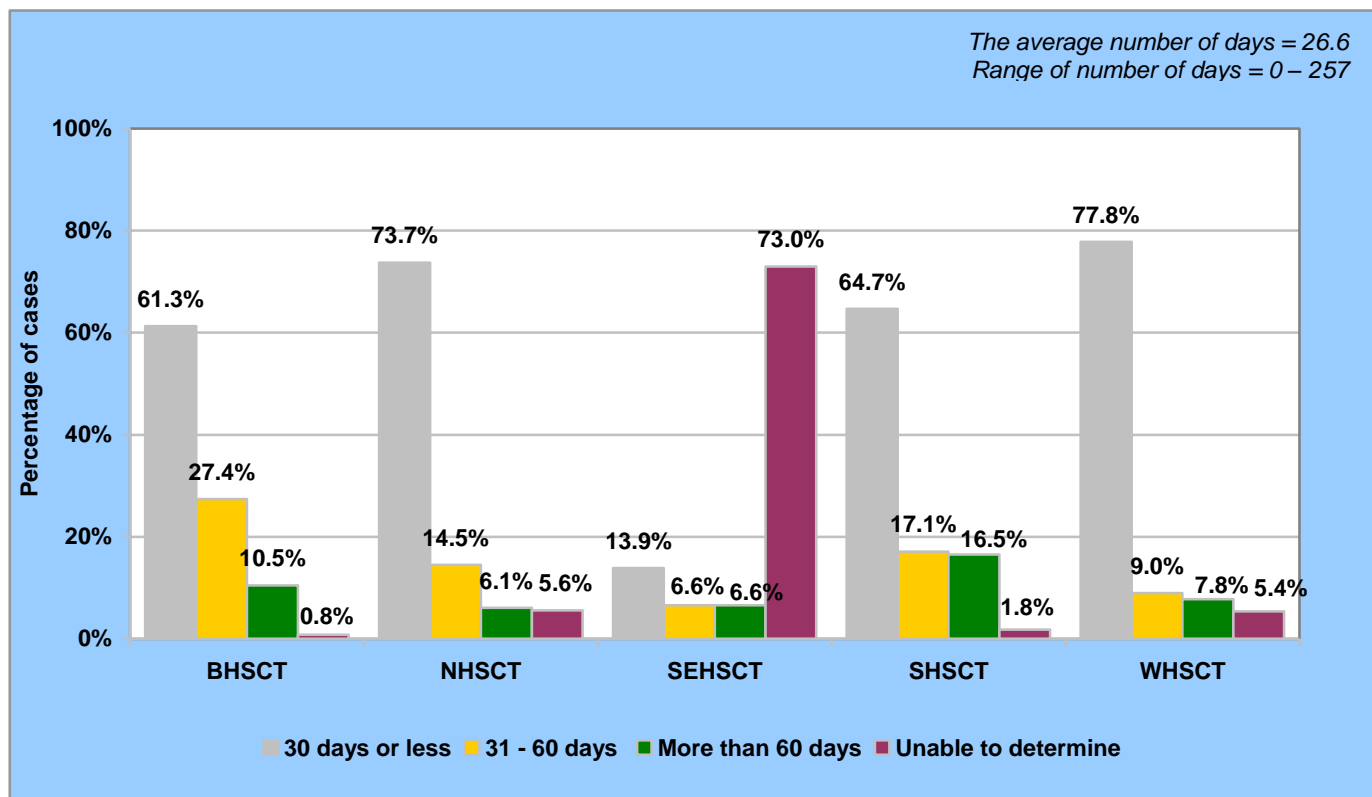
Table 32: Specialty of cases where length of time (days) between discharge and discharge letter typed exceeded 60 days (n=74)

	Surgery	Acute Medicine	Gynaecology	Cardiology	Total cases
BHSCT	4 (30.8%)	5 (38.5%)	2 (15.4%)	2 (15.4%)	**13 (100%)**
NHSCT	1 (9.1%)	4 (36.4%)	2 (18.2%)	4 (36.4%)	**11 (100%)**
SEHSCT	--	--	9 (100%)	--	**9 (100%)**
SHSCT	6 (21.4%)	13 (46.4%)	2 (7.1%)	7 (25%)	**28 (100%)**
WHSCT	3 (23.1%)	7 (53.8%)	2 (15.4%)	1 (7.7%)	**13 (100%)**
Total	**14 (18.9%)**	**29 (39.2%)**	**17 (23%)**	**14 (18.9%)**	**74 (100%)**

Discussion and summary of audit findings

Discussion

Hospital inpatient (acute) records contain information about a patient's condition, investigation and treatment upon which decisions about their care are met. The online Oxford Dictionary defines a record as 'a thing constituting a piece of evidence about the past, especially an account kept in writing or some other permanent form'.

Good record keeping is an integral part of clinical practice and whether at an individual, team or Trust level, has many important functions. These include a range of clinical, administrative and educational uses such as:

- Showing how decisions relating to patient care were made
- Supporting the delivery of services
- Supporting effective clinical judgements and decisions
- Supporting patient care and communication
- Making continuity of care easier
- Providing documentary evidence of services delivered
- Helping to approve accountability
- Promoting better communication and sharing of information between members of the multiprofessional health care team
- Helping to identify risks and enabling early identification of complications
- Supporting clinical audit and research; and
- Helping to address complaints or clinical negligence cases.

Errors or omissions in clinical records are frequently referred to within complaints, clinical incidents or serious adverse incidents including those which come to litigation and professional fitness to practice panels.

Common errors in record keeping include: for example illegible handwriting, delays in completing the patient record, lack of signature, inaccuracies in dates or times and inaccuracies in patient identification information. There is also a need to protect information within records from being lost.

Guidance issued by professional organisations for example; the General Medical Council (GMC) dictates that documentation to formally record work undertaken must be clear, accurate and legible. Records should be made at the same time as the events being recorded or as soon as possible afterwards. If information needs to be added to the medical record or corrected, the date of the amendment and name should be added.

The aim of this regional audit project is to improve record keeping within acute hospitals maximising patient safety and improving quality of care. This audit therefore attempted to measure practice regionally against standards/guidance relating to record keeping produced by the DHSSPSNI, 2008 and identify areas for improvement within individual Trusts.

The audit standards used define good practice for medical records and address the broad requirements that apply to all clinical record keeping and were developed by the Health Informatics

Unit within the Royal College of Physicians. The audit also included standards relating to admission, discharge and consent as:

- Patients have a right, supported in law, to make informed decisions about their care and treatment.
- Health professionals are required to obtain valid consent before starting any form of treatment or intervention. Even when they give consent, patients may withdraw it at any point, and professionals must generally respect patients' wishes, regardless of their own personal views.
- The positive impact of an admission/assessment proforma provides a clear boundary for the episode and clarity to clinical information including seeing when the episode started.
- Planning for discharge can reduce the patient's length of stay, prevent emergency re-admissions and reduce pressure on hospital beds. Getting hospital discharge summaries and letters to GPs is a critical safety issue as the GP may not have been aware of the patient's admission to hospital, the outcome, ongoing management and medication prescribed or stopped.

Summary of the Audit Findings

One thousand (1,000) medical records relating to patients admitted to 10 hospitals in 5 HSC Trusts were included in the audit. Such patients having been discharged from surgery, acute medicine, gynaecology and cardiology beds.

Five thousand, seven hundred and fifty-nine (5,759) continuation sheets were reviewed containing 21,340 entries made by a wide range of health and social care professionals for example; medical (59.2%), nursing (23%) and a wide range of other staff including specialist nursing, radiology, pharmacy, allied health professions (8.1%).

Of the 1,000 cases reviewed continuation sheets in use were uniprofessional (40%), multiprofessional (41.6%) or both uniprofessional and multiprofessional sheets were in use depending on the site, specialty and cases selected for audit.

Standard 1 – The contents of the medical record should have a standardised structure and layout. Appropriate information should be filed in the relevant sections

Sixty eight point seven percent (68.7%) of the cases audited were divided into sections. Section headings varied depending on the Trust, hospital site and specialty audited.

Generally, information within the medical record tended to be filed mostly in the relevant sections (compliance levels achieved by Trust ranged from 88.5% - 97.5%). Six point four percent (6.4%) of the records audited contained misfiled information and 30.9% contained loose sheets or information. This 'loose' information was wide ranging in nature and at danger of being lost.

Whilst there was not a specific standard pertaining to the overall condition of the medical record various comments made indicated the need for improvement particularly regarding opening of a new chart when the cover is damaged or before charts become overfull.

Standard 2 – Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order

Ninety one point five percent (91.5%) of the cases audited indicated that entries recorded on continuation sheets were in chronological order with most sheets (92.6%) being filed within the appropriate section of the medical record.

Cases of those patients with previous inpatient admissions were reviewed (615) to ascertain filing positioning of continuation sheets for newer admissions. In 31.7% of cases the most recent information was being filed on top i.e. first in section within the bulk of the remainder being filed last in section (61.6%) i.e. on the bottom/after previous admissions.

Standard 3 – Every page in the medical record should include the patient's name and identification number (Hospital/Health & Social Care Number)

The patient name was not recorded on all continuation sheets audited. Overall, the patient name was handwritten or an addressograph used which included patient name on 4,973 (86.4%) of continuation sheets.

At the time the audit was undertaken the patient's hospital number tended to be used more frequently on continuation sheets when compared to the HSC Number. An addressograph containing the Hospital (and in some instances the HSC Number) tended to be used more often rather than handwritten information.

Standard 4 – Every entry in the medical record should be dated, timed (24 hour clock), legible, signed by the person making the entry, have the name and designation of the person making the entry legibly printed against their signature; and deletions and alterations should be countersigned

Eighty two point eight percent (82.8%) of total entries audited were dated. The proportion of total entries dated varied across the Trusts audited.

Forty five percent (45%) of total entries audited were appropriately timed using the 24 hour clock although entries using the 12 hour clock where am or pm was stated were considered acceptable. In some instances a time range was specified which would be considered unacceptable by professional bodies.

Most entries audited (97.7%) were legible and 92.6% of entries were signed. Designation was more likely to be printed against the signature (58.8%) when compared with name also being printed (19.5%).

64% of the cases audited had deletions or alterations to entries made on continuation sheets. These were rarely countersigned (0.9%) or initialled (3.5%).

Standard 5 – Retrospective entries to the medical record should be made as soon as possible after the event to be documented and before the relevant staff member goes off duty. If there is a delay the time of the event and the delay should be recorded

Five point two percent (5.2%) of the cases audited had retrospective entries. Retrospective entries accounted for 0.28% of the total number of entries made. A reason was not always evident for the retrospective entry but in some cases these were made on the next or same day and related to laboratory or investigation results or following discussion with a specialist service. In a few cases the retrospective entry had been made because notes were not available at the time or there had been a change to the advice issued previously.

Standard 6 – An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than 4 days for acute medical care the next entry should explain why

Only 0.2% of the cases audited (2) did not have an entry on continuation sheets for more than 4 days. One case was transferred to another hospital for an interventional procedure and in the other case no reason was noted. In this case there was no entry for 5 days (which included a week-end).

Standard 7 – Consent must be clearly recorded in the medical record

Of the 396 patients who underwent an operation or procedure the consent form was present within the medical record in 383 cases (96.7%).

The consent form was signed by the patient indicating consent in all applicable cases (100%) and 99.5% also had a doctor's signature documented. However, 9.8% of patients had not dated the consent form but this had been dated by the doctor in 99% of cases. In those cases where the doctor had not dated the consent form it had been dated by the patient (4).

In 89.6% of applicable cases both parts of the consent form were filed within the medical record. DHSSPS Good Practice in Consent guidance states that the top copy of the completed DHSSPS consent form should be offered to the patient and this action recorded. In only 0.9% of cases where both parts of the consent form were present in the file was a note made which stated that the patient was offered the consent form but had refused same.

Standard 8 – Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma

Overall, on admission to the ward initial information was recorded using a standardised admission/assessment proforma in 59.6% of the cases audited. Different proformas were used across specialties and hospital sites.

Thirteen point eight percent (13.8%) of the cases audited had a completed discharge planner form present in the chart. Whilst the form in use varied there was some consistency in form type across specialties within individual Trusts.

Standard 9 – The discharge letter should be available within the medical record in the case of all hospital admissions. Diagnosis should be clearly recorded on the discharge letter. The discharge letter should be forwarded to the patient's GP as soon as possible

Seven hundred and seventy-seven (777) of the 1,000 cases audited contained a discharge letter. For 14.3% of the cases with no discharge letter reasons were identified as to why this was the case for example the patient being discharged to another hospital.

In 96.4% of cases a diagnosis was clearly recorded on the discharge letter either as a separate heading or in the body of the letter.

In 74.6% of applicable cases the discharge letter was typed within 60 days of discharge. However, in 9.5% of applicable cases (74) it took longer than 60 days for the discharge letter to be typed. The length of time from discharge date until discharge letter typed ranged from same day – 257 days.

Audit Limitations

When a number of auditors are involved there can be variations in interpretation of the information requiring to be recorded on the data collection form. A training session was held to encourage consistency in auditing however, not all auditors were present.

Missing data on data collection forms can impact on impact on interpretation and extrapolation of the audit data.

With hindsight, the data collection form used would now be designed differently to facilitate easier and speedier extrapolation of the data.

A wealth of data were collected from the 1,000 medical records audited which at times created challenges in terms of manipulation of such a large amount of data fields, collation and how to present information in a clear and uncomplicated manner.

SPSS software was used for data input and commencement of the analysis. Unfortunately issues associated with the product licence meant that access to the data was prevented for some time. An alternative statistical analysis package with comparable functionality had to be sourced. This package required trialling and once access to the data was obtained it was transferred into PSPP to complete the data analysis.

Whilst it has been some time since the original data were collected it is felt that the information is still topical and relevant to current professional practice. The Northern Ireland Ombudsman highlighted in his 2013/14 Annual Report that: *"It has become increasingly evident to me in the course of my investigations that there is a growing culture of poor record keeping within the health and social care sector.... it is essential that appropriate and accurate notes are made in relation to the care and treatment provided, medication prescribed and administered and communication which takes place with a patient and their family. Good record keeping is a requirement under both Nursing and Midwifery Council and General Medical Council guidance, and it is an essential factor in ensuring effective complaints handling should concerns arise. Accurate and contemporaneous record keeping allows for thorough independent assessment of the care provided and helps ensure transparency. Additionally it provides protection to clinicians and nursing staff involved in patient care by providing a clear picture of their actions and reasons for decisions. My investigation can be hampered by lack of records. Frequently I am unable to reach a determination or ascertain the quality of care provided due to a lack of recorded evidence. Such failure prevents the complainant from gaining the answer(s) they seek and leaves the body vulnerable to challenge. I would therefore urge all Trusts, general practitioners and independent healthcare providers to ensure that good record keeping is given prominence and invite those bodies to reinforce with all their staff the importance of clear, thorough and accessible records".*

Conclusions

This regional audit has measured practice regionally against standards/guidance relating to record keeping produced by the Royal College of Physicians (RCP) and endorsed by the DHSSPSNI in 2008. Whilst the 100% targets were rarely achieved in relation to the audit standards a good standard of record keeping was demonstrated for most standards although at times there were variations between specialties, hospital sites and Trusts.

However, there are areas which need to be addressed in relation to the:

- Structure and format of the medical record (including the overall condition of the record);
- Standardised proformas should be in place to record admission and discharge information;
- Recording of information:
    - Patient name and identification number (HSC number) should be recorded on all continuation sheets completed within the record
    - Every entry within the record should be dated and timed using the 24 hour clock
    - Name and Designation should be printed against the signature for each entry
    - Deletions and alterations should be countersigned, dated and timed
    - All entries should be made as soon as possible after the event to be documented. If there is a delay the time of the event and delay should be recorded
    - Patients undergoing investigations or procedures, as appropriate should be offered the top copy of the completed consent form and this action recorded including details if this has been refused; and
- Discharge information should be forwarded to the patient's GP in a timely manner.

The audit results will be shared with all HSC Trusts who participated in the audit and it is hoped these will improve record keeping practice, facilitate learning with the aim to maximise patient safety and improve the quality of care.

Recommendations

Recommendation 1 (R1)

Each Trust should have a common, agreed and consistent approach to medical record documentation used throughout all hospital sites

Each Trust should have an organisation-wide protocol in place for the organisation of documents within the medical records.

Recommendation 2 (R2)

Each Trust should have clear information in place for managers and staff related to the development, piloting, approval and introduction of new clinical proformas or care pathways for inclusion within the medical record. Such guidance should include information on processes for consultation with relevant staff groups/stakeholders (i.e. all staff groups/disciplines impacted by the new documentation including management), piloting, approval, printing and introduction of such items.

Recommendation 3 (R3)

Each Trust should ensure that the contents of the medical record should be such that there is minimal time consuming duplication of clinical data when a patient is admitted to hospital

Recommendation 4 (R4)

Trusts should reinforce with clinical and administrative staff that it is everyone's responsibility to ensure that notes are maintained in good order and that they have a professional duty to maintain high standards of record keeping. Doing it well and ensuring the required standards are met is fundamental to effective patient care.

Recommendation 5 (R5)

Each Trust should ensure regular audits of compliance of medical records with record keeping standards are undertaken within relevant specialties, shared with relevant staff and compliance levels reported to the appropriate Trust assurance or governance committee/s.

Such audits should include standards not only in relation to clinical practice but to organisation of documents within the medical record and the condition of the medical record being reviewed.

Specific audit tools are also available for more detailed review of standards relating to Hospital Admission and Discharge.

Various evidence based audit tools have been developed and are available for Trust use including those produced by the Health Informatics Unit within the RCP which are available for use on the Healthcare Quality Improvement Partnership (HQIP) website.

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Acknowledgements

Sources of advice in relation to the report

The GAIN Office should be contacted with regard to any queries regarding this report and they will liaise with the report authors, as appropriate.

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Appendix 3

AUDIT ON RECORD KEEPING IN THE ACUTE HOSPITAL SETTING

GAIN
GUIDELINES AND AUDIT
IMPLEMENTATION NETWORK

Proforma A

Trust code:

Hospital site code: _____

Specialty:

Surgery _____   Gynae _____

Medicine _____   Cardiology _____

Patient name	Patient hospital number	Patient code

Appendix 4

GUIDELINES AND AUDIT
IMPLEMENTATION NETWORK

**AUDIT ON RECORD KEEPING IN THE
ACUTE HOSPITAL SETTING**

Proforma B

Trust code:

Specialty:

Medicine		Cardiology	
Gynaecology		Surgical	

Hospital site code:

1. Care Pathway in use: ☐ Yes ☐ No

2. Are the continuation sheets:

Uniprofessional ☐

Multiprofessional ☐

3. Heading/title of continuation sheets used:

Name of Sheet	Number of Charts

4. Patients' charts divided into sections?   Yes ☐   No ☐

If Yes, detail section headings:

_____

_____

_____

Please return your completed data collection proformas to : Mrs Ruth McDonald
Assistant Clinical and Social Care Governance Manager, Governance
Department, Bush House, Antrim Hospital, Bush Road, Antrim, BT41 2QB

Appendix 5

GAIN
GUIDELINES AND AUDIT
IMPLEMENTATION NETWORK

Trust code: [ ]

AUDIT ON RECORD KEEPING IN THE
ACUTE HOSPITAL SETTING
Proforma C

Hospital site code: _____

Patient code: _____

Month & year of birth: _____ / _____

Specialty admitted to:

Surgery [ ]   Gynae [ ]
Medicine [ ]   Cardiology [ ]

Date admitted (to Ward): _____ / ___ / _____

Date discharged: _____ / ___ / _____

Primary diagnosis: _____

1a. Total number of continuation sheets used in this admission: _____

1b. Patient details recorded on continuation sheets:

	Number of continuation sheets/pages	
	Handwritten information	Addressograph/ preprinted label
Patient's name recorded		
Patient's hospital number recorded		
Patient's health & social care number recorded		
Address		
DOB		
Other		

If Other, please detail: _____

_____

_____

_____

2a. Specify total number of entries on <u>continuation sheets</u> for this admission by professional group:

Professional group	Number of entries
Medical	
Nursing	
Physiotherapy	
Social Work	
Dietetics	
Other, specify	
Not known	
Total entries	

2b. Number of entries on <u>continuation sheets</u> for this admission made in chronological (date) order: _____

3a. Where are entries on <u>continuation sheets</u> for this admission located?

i) Specify section of the record: _____

	Yes	No
ii) Is this where such entries should be located?		

If No, specify section of the record such entries should be located in:

_____

3b. How are entries on <u>continuation sheets</u> for this admission filed?

First in section (above previous admissions)	
Last in section (after previous admissions)	
Mixed amongst previous admissions	
Not applicable (no previous admissions)	

3c. Has patient had any further admissions?

Yes [ ]   No [ ]

If Yes, are the <u>continuation sheets</u> inserted above admission currently being looked at?

Yes [ ]   No [ ]

4a. Number of entries on <u>continuation sheets</u> for this admission dated: _____

Page 2   *Questions continued overleaf*

4b. Timing of entries on <u>continuation sheets</u> for this admission:

Number of entries

	Number of entries
24hr clock	
12hr clock but am or pm stated	
Timed but time range given (e.g. 09.30-15.30)	
Timed but unclear whether am or pm	
Not timed	

4c. If any entries on <u>continuation sheets</u> for this admission are illegible please state number of illegible entries for each professional group:

Professional group	Number of illegible entries
Medical	
Nursing	
Physiotherapy	
Social Work	
Dietetics	
Other, specify	

4d. Are there any retrospective entries on <u>continuation sheets</u> for this admission?

Yes ☐ No ☐

If Yes, please state professional group making retrospective entries:

Professional group

4e. Number of entries on <u>continuation sheets</u> for this admission signed by the person making the entry: _____

Number of entries

☐ Name legibly printed against signature

☐ Designation legibly printed against signature

4f. Number of deletions or alterations in <u>continuation sheet</u>s during this admission: _____

Number of deletions or alterations:

Number of entries   Number of entries

☐ Countersigned   ☐ Initialled

Page 3   *Questions continued overleaf*

5a. Were entries made on each day/date during this admission?

Yes ☐ **If Yes, go to question 6a**

No ☐

5b. Number of occasions where interval between entries exceeds 1 day (or a 24hr period) please give dates/times:

Date of previous entry: ____/____/____   Time of previous entry
(24hr clock):   ___:___

Date of next entry:____/____/____   Time of next entry
(24hr clock):   ___:___

Reason: _____

Date of previous entry: ____/____/____   Time of previous entry
(24hr clock):   ___:___

Date of next entry:____/____/____   Time of next entry
(24hr clock):   ___:___

Reason: _____

Date of previous entry: ____/____/____   Time of previous entry
(24hr clock):   ___:___

Date of next entry:____/____/____   Time of next entry
(24hr clock):   ___:___

Reason: _____

Note: If more than 3 incidences where interval between entries exceeds 1 day - please continue on back of sheet.

6a. Did the patient have an operation or procedure during this admission?

Yes ☐   No ☐ **If No, go to question 7**

6b. If Yes, is the consent form present in the record?

Yes ☐   No ☐

6c. Has the consent form been signed and dated?

i) Patient	Yes	No		*ii) Doctor*	Yes	No
Signed				Signed		
Dated				Dated		

6d. Which part/(s) of the consent form are present in the record:

☐ Pink sheet only   ☐ White sheet only   ☐ Both Pink and White Sheets

Page 4   *Questions continued overleaf*

6e. If both parts of consent form are present is there any note in the record which specifies that patient was offered consent form and refused same?

Yes [   ]   No [   ]

7. Generally, does the information in the record appear to be filed in the relevant sections?

Yes [   ]   No [   ]

If No, provide further details: _____

_____

_____

8. Are there any loose sheets/information within the record which could fall out?

Yes [   ]   No [   ]

If Yes, please provide further details:

Nature of information	Number of pages

9. Is there a **completed** discharge planner form in the record?

Yes [   ]   No [   ]

If Yes, please specify name/title and include any Trust name/logo:

_____

_____

10a. Is the discharge letter pertaining to this admission in the record?

Yes [   ]   No [   ]

If No, is there a reason for no discharge letter e.g. transfer to another hospital?

Yes [   ]   No [   ]

Reason: _____

_____

_____

_____

10b. Date discharge letter typed: _____/_____/_____

10c. Diagnosis recorded clearly on discharge letter for this admission:

Yes, as separate heading [   ]   No [   ]

Yes, in body of letter [   ]   Not applicable [   ]

11. On admission to the ward (this admission only) was initial information recorded using a standardised admission/assessment proforma?

Yes [   ]   No [   ]   Not applicable [   ]

If Yes, please specify name/title of proforma and include any Trust name/logo:

_____

_____

_____

_____

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12. Additional comments:

_____

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Please return your completed data collection proformas to : Mrs Ruth McDonald, Assistant Clinical and Social Care Governance Manager, Governance Department, Bush House, Antrim Hospital, Bush Road, Antrim, BT41 2QB

Page 6

Appendix 6 – Project Team

Name	Trust	Role
Dr Peter Flanagan, Medical Director *(since retired)*	NHSCT	**Project Supervisor**
Carolyn Kerr Deputy Director of Nursing *(since retired)*	NHSCT	**Project Supervisor**
Ruth McDonald Asst. Trust Governance Manager	NHSCT	**Project Lead**
Deborah Doole Governance Support Officer	NHSCT	**Project Assistant** with involvement in project planning and supervision of NHSCT data collection, data input, quality assurance and analysis
Conor Campbell Fintan McErlean Simon Dunlop Marie Weatherall R Craig	Belfast Health & Social Care Trust (BHSCT)	**Trust Co-ordinator** Data Collectors
Carol Lutton Jill Taylor	South Eastern Health & Social Care Trust (SEHSCT)	**Trust Co-ordinator** Data Collector
Anne Quinn Gail Watson Raymond Haffey	Southern Health & Social Care Trust (SHSCT)	**Trust Co-ordinator** Data Collectors
Elizabeth Gallagher Deirdre Kelly	Western Health & Social Care Trust (WHSCT)	**Trust Co-ordinator** Data Collector

Additional staff members were involved in data collection at individual HSC Trust level including medical and audit department staff. The names of the data collectors who attended the audit training workshop are detailed within the above table