An Audit Into Orthopaedic Surgical In-patient Record Keeping – Are We Doing Enough?

C Hill

Citation

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Abstract

This audit addresses the issue of the adequacy of case note recording. This prospective case note review, using a pre planned data collection sheet, looked at the last five entries in sixty-three sets of case notes on the orthopaedic surgical wards of a district general hospital, completing an audit cycle started four years previously. Appropriate patient identifiers on each case note page were found in only 49.84% and the number of entries with a legible printed name, grade and contact number were also well below the set standard. However the number of entries being written in appropriate coloured ink, and correctly timed, dated and signed had significantly increased from the first audit cycle. Reasons for these results were discussed. Identified areas for improvement include increasing awareness of the requirements for case note record keeping, including the production of a "dummy sheet" highlighting this to be included in staff induction packs.

INTRODUCTION

Everyday different health care professionals in a hospital setting will document in patient's case notes. It is essential that this documentation is done appropriately so that an accurate record of the patients stay is kept. This is important for those other health care professionals involved in the patient's care both now and in the future as it allows them to see exactly what has happened and who has been involved during the patient's journey. From a medico-legal point of view this is also crucial, as these are legally accepted documents when looking back through a patient's stay if an event isn't documented, then there is no proof of it ever occurring.

For such an important issue, there is however relatively little done in educating health care professionals in the best practice for writing in case notes. Generally it tends to get picked up in the early days of the job with experience and from observing others. However, if those being copied have never been formally taught how best to do it, then they may be passing on bad habits.

The Health Informatics Unit (HIU), part of the Clinical Standards Department of the Royal College of Physicians and the Department of Health have developed standards they feel should be met when documenting in case notes. The Department of Health for example have published the document "Records Management: NHS code of Practice, 2005" which set out these standards. Support for this comes from various hospital trusts around the country, and from the General Medical Council, as well WHO's Guide to Good Medical Practice stresses the importance of good record keeping.

In 2004 a case note audit was performed across the orthopaedic wards of the King's Mill Hospital, Mansfield, England. This showed many of the basic case note standards from the trust guidelines were not being met. This information was presented to those on the orthopaedic wards and suggestions for improvements made. It was recommended that this data be re-audited later to see if any improvements had been achieved. Therefore this audit sets out to complete what will be an on-going audit cycle.

METHOD

The audit type selected was a prospective case note review, using a pre planned data collection sheet (based on a template released by Clinical Record Keeping Standards and Audit Policy). The audit would be looking at all patients on wards 8 and 9 (orthopaedic surgical wards) at King's Mill Hospital, Mansfield, England, in order to help complete the audit cycle previously started in 2004 with a minimum of 50 patients case notes being audited as advised by trust policy.

The last five entries in the case notes would be scrutinised against the standards set out below, as advised by the Trust

Guidelines and Clinical Record Keeping Standards and Audit Policy (Approved by Quality Assurance Committee Sept 2006) in agreement with the Department of Health (Records Management: NHS code of Practice, 2005) and GMC guide to good medical practice stress the importance of good record keeping:

The health record contains a complete set of identification data (including address and postcode, date of birth, telephone no., sex, GP, next of kin or nearest relative/friend and contact details).

- The patient's name and date of birth are on every page including charts, ECG's, etc.
- Each entry in the health record is legible.
- Each entry is written in black/dark ink.
- All entries and amendments in the health record, including test results and investigations, are:
    - Dated
    - Timed
    - Signed.
- All entries have legibly printed against the signature the:
    - Name
    - Grade
    - Contact number
- of the entry author clearly and easily identified.

The final audit standard (number 6) was not included in the original audit in 2004, however it is an important issue firmly set into the Trust guidelines and Clinical Keeping Record Standards and therefore was felt vital to include it this time round.

The audit standard for each of these was realistically set at 75%, in agreement with Trust Guidelines and Clinical Record Keeping Standards and Audit Policy as approved by the Quality Assurance Committee (Sept 2006).

Using the last five entries in the case notes would give a more accurate and reliable picture of the quality of case note recording by reducing the impact of any anomalies.

Following data collection, an ordered collection of anonymous data summarised in table format was produced, and then be appropriately analysed and comparison made firstly with the standards set, and secondly with the previous data from the 2004 audit.

RESULTS

Overall, 63 sets of case notes of patients on the orthopaedic wards of 8 and 9 at King's Mill Hospital, Mansfield were audited. This was satisfactory and was above the minimum of 50 note sets and recommended by the Trust Policy.

Standard 1. The health record contains a complete set of identification data (including address and postcode, date of birth, telephone no., sex, GP, next of kin or nearest relative/friend and contact details).

Of all the case notes audited, every one had a health record sheet in the front that was filled out to a certain extent. Unsurprisingly however, many were incomplete. In fact only 44% were totally complete. Table 1 below shows the breakdown of health record details, and these are also displayed visually in Figure 1, also below:

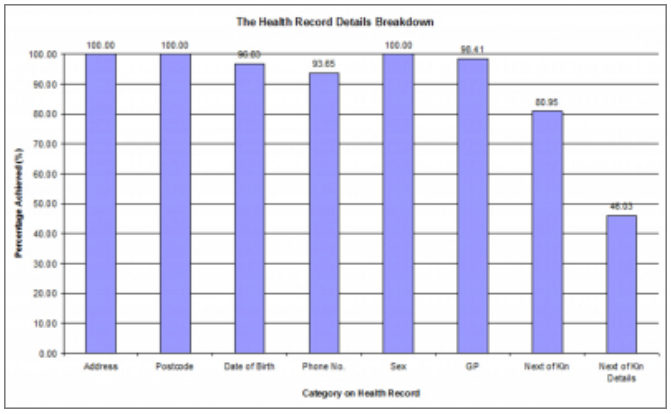
Figure 1

Table 1: Breakdown of Percentages Present of Health Record Data.

Health Record Data	Percentage Complete (%)
Address	100.00
Postcode	100.00
Date of Birth	96.83
Phone No.	93.65
Sex	100.00
GP	98.41
Next of Kin	80.95
Next of Kin Details	46.03

Figure 2

Figure 1: Graph displaying the Breakdown of Percentages Present of Health Record Data



It can immediately be seen that the majority of Health Record data was present in most cases and that the Next of Kin Details are the most obvious discrepancy, and the Next of Kin Name being the next downfall.

Standards 2-6

The data for Standards 2-6 is displayed in Table 2 below:

Figure 3

Table 2: Data for Standards 2-6.

Standard Criterion	Target Standard (%)	Percentage Achieved 2004 (%)	Percentage Achieved 2008 (%)
The patient's name and date of birth are on every page including charts, ECG's, etc.	75	54.30	49.84
Each entry in the health record is legible.	75	100.00	97.14
Each entry is written in black/dark ink.	75	68.60	98.73
All entries and amendments in the health record, including test results and investigations, are:			
Dated	75	74.30	96.51
Timed	75	82.90*	81.90
Signed	75	74.30	93.33
All entries have legibly printed against the signature the:			
Name	75	Not assessed	44.76
Grade	75	Not assessed	42.54
Contact number	75	Not assessed	63.81

*Previous audit assessed "episodes entered in chronological order"

Standard 2.The patient's name and date of birth are on every page including charts, ECG's, etc.

We can see from the results that this particular criteria did not reach the audit standard of 75% with less than half, (only 49.84%) of patients case notes audited having the patient's name and date of birth on them. This is in fact slightly worse than in 2004 when the number was 54.30%.

Standard 3.Each entry in the health record is legible.

Four years ago in the previous audit every single case note entry was deemed as legible. This time round the result is very similar with 97.14% of entries being readable. This is well above the standard of 75%.

Standard 4.Each entry is written in black/dark ink.

This was another criterion that scored well above the standard of 75%, with 98.73% of case note entries being written in the appropriate black/dark ink. This is a large improvement since 2004 when the percentage achieving this was only 68.60%, a figure below the standard set.

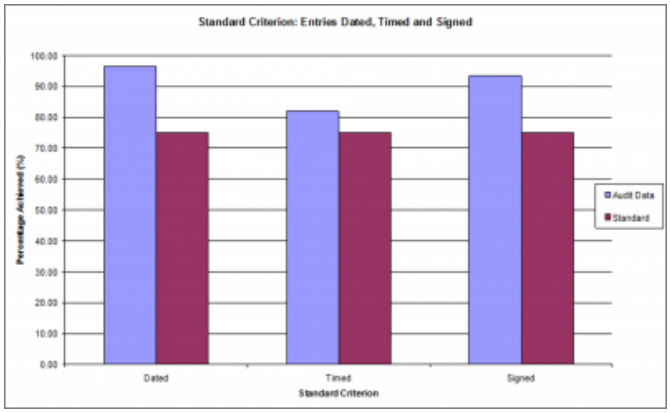
Standard 5. All entries and amendments in the health record, including test results and investigations, are:

Dated
Timed
Signed

The results for this standard were broken down individually to allow accurate comparison to the previous audit cycle. The results are clearly displayed in Figure 2 below:

Figure 4

Figure 2: Graph displaying entries dated, timed and signed compared to the audit standard.



The results clearly show that all three parts of the standard criterion exceeded the standard target value of 75% with 96.50% of entries being correctly dated, 81.90% being correctly timed and 93.33% being correctly signed. This again shows an improvement since the previous audit cycle in 2004. At that time only 74.30% of entries were dated and signed appropriately, a figure below the target standard. The previous audit did not assess precisely whether the entries were suitably timed, however it did show that in 82.90% of

cases, the entries were in chronological order.

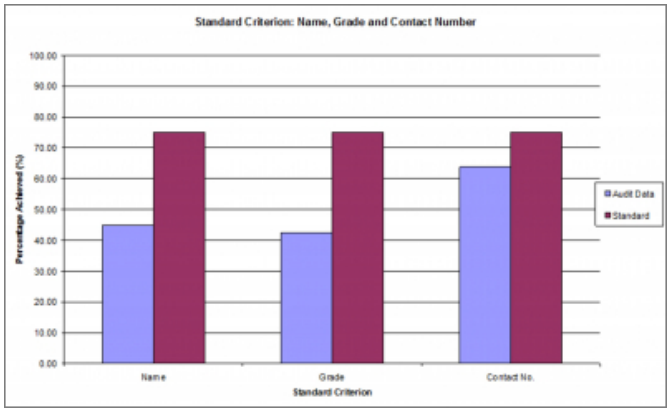
Standard 6. All entries have legibly printed against the signature the:

Name
Grade
Contact number
of the entry author clearly and easily identified.

This was a standard added into this audit from the previous audit cycle, so there is no previous data to compare it against. It showed that only 44.76% of the case note entries satisfactorily had the authors name legibly printed against the signature, 42.54% had the grade and 63.81% had the contact number. All three of these results came in below the standard of 75% as shown in Figure 3 below:

Figure 5

Figure 3: Graph displaying entries with authors name, grade and contact number legibly printed and clearly and easily identified compared to the audit standard.



DISCUSSION

These results show that there are clearly some key areas within clinical record keeping where notes authors' on the orthopaedic wards audited are failing. The first area is when ensuring that the patients name and date of birth are on every page. This criterion fell 25% short of the 75% target standard. This is an extremely important issue as often pages will be torn or fall out of notes or be left at nursing stations, and if there is not sufficient identification on the sheet as to where it came from then it can be lost. This can hold implications on the patient's health or in a court of law if vital information is missing. Plus on the odd occasion where two patients on the same ward have the same or similar names, further confusion can ensue and pages may even be refilled in the wrong notes which could have potentially dangerous results.

In the vast majority of cases where this was not achieved, only one identifying feature (usually the patient's name) was present at the top of the page. Trust guidelines state that the two identifying features required on each page are the patient's name and date of birth, however the Health Informatics Unit (HIU) advise that a name and any one other identifying feature is used. One of the presumed causes for only putting one identifying feature on a page of patient's notes though is ignorance on the part of the author as it clearly does not take much time or effort to write a date of birth as well as a name on each page. Therefore to help achieve this standard, further education with regards to correct case note recording should be given to the all health care professionals who write in case notes as each individual has a duty and responsibility to help achieve this standard. This could be initiated in part by presenting the audit findings at the departmental meeting, and highlighting the issues that need to be covered.

Another quick and easy method to help is to use the patient identification labels printed off with each set of notes. The problem with this is that often they are all used up, or are lost from patient's notes preventing this practice from occurring. The printing and provision of these stickers more often falls to the ward clerk, so improving communication between authors and the clerk over when further stickers are required could potentially help.

The other area where results appeared markedly short of the target were with the standard that all entries have the name, grade and contact number of the entry author easily identified and legibly printed against the signature. This was an added standard from the previous audit in 2004. The results showed that the criterion all came in below the 75% target, with name and grade being short of the target by approximately 30%, and contact number being about 10% insufficient. Again considering the time that it takes for one to print their name, contact number and grade or position next to their signature, the most likely reason for not meeting this target is due to a lack of knowledge. The issue of educating current members of staff with regards to correct case note reporting has already been covered. However, in order to achieve the target standards it is important to also educate those joining the trust. A template sheet of a dummy case note highlighting all the relevant areas, and how to write in case notes correctly could be produced and supplied in the induction pack of new staff members. Smaller, laminated copies could also be provided for new doctors and health care professionals to carry with them on the job as a

reminder, when they are initially finding their feet.

The results for note entries being legible and in black/dark ink were very impressive both almost being 100%, well above the 75% target standard. The figure for the appropriate ink being used is particularly striking as this is much improved from the 2004 audit when the figure reached was only 69%. This was presumably due to the issue being highlighted following the previous audit.

Other impressive results include the number of entries correctly dated, timed and signed as these criteria all met the target standard. However, there are still 5% of case notes where entries are not correctly dated, and 20% where the time is not recorded, highlighting room for improvement, and hopefully the suggestions already proffered will help improve these results further in the next part of the audit cycle.

On the whole, the health record in patient's notes was well filled out, with the only obvious downfall being the lack of next of kin details, which may well be difficult find out from patients. However, more should be done in pursuing these details to complete health record data sheets. Often the nursing staff will routinely take down the next of kin details when clerking patients onto the ward, so this is often a valuable source of information. Perhaps the job of ensuring that these details are correct should fall to that of the ward clerk again, who could easily liaise with the nursing staff to complete any details missing from the health record.

CONCLUSIONS

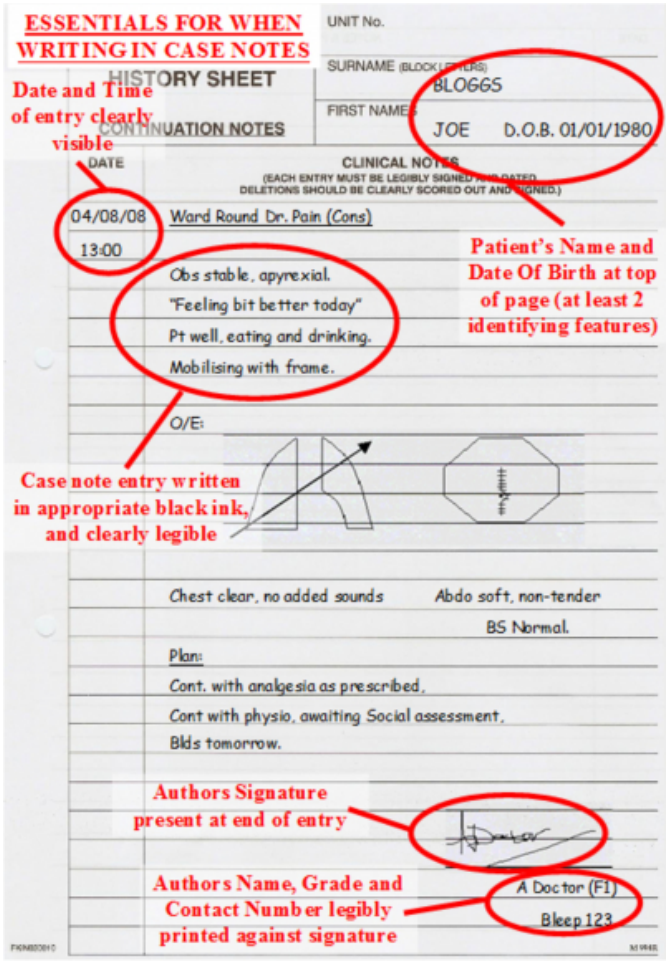
The above has shown that the quality of clinical record keeping on the orthopaedic wards at King's Mill Hospital, Mansfield has improved since the previous audit of 2004. However, there is still an obvious need for further improvement. Particularly in ensuring that the patient's name and one other identifying feature are present at the top of every page in the case notes, and that the authors name, grade and contact number are clearly visible and legibly printed next to the signature at the end of each note entry.

RECOMMENDATIONS

To present the findings of this audit cycle at the General Orthopaedic Surgical Meeting, to highlight the main problem areas, and in doing so re-educate those present of the Trust guidelines for clinical record keeping.

Figure 6

Figure 4: Case Note "Dummy Page"



To create a dummy page clearly demonstrating accurate record keeping and all the appropriate measures necessary to fulfil the trust guidelines with a hope that this will then be supplied to all those health professionals starting new jobs at the hospital in the future. (See Figure 4).

Smaller laminated pocketsize versions of this dummy sheet to be created and also included in newcomer induction packs.

Re-audit again in one year, after a new set of junior doctors will have been inducted to provide an on-going comparison and to monitor if further improvements have been made and to maintain that the trust guidelines are being adhered to.

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Author Information

Christopher E. Hill, BMBS
Orthopaedic Department, King's Mill Hospital, part of Sherwood Forest Hospitals NHS Foundation Trust