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AUDIT OF PATIENTS' RECORD KEEPING FILES IN GYNAECOLOGY AND OBSTETRICS WARD OF REHMAN MEDICAL INSTITUTE, PESHAWAR

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ABSTRACT

Introduction: Unfortunately, the standard of care, sense of responsibility among junior doctors, and efficacy and honesty is deteriorating day by day not only in public sector hospitals but also in private hospitals. This audit was done to know how far our record keeping is correct and up to date.

Materials & Methods: Medical audit of patient record files was carried out in the Department of Ob/Gyn of Rehman Medical Institute (RMI) from October 01to October 31, 2016, including both booked and emergency cases. The records of 209 patients who were admitted during this month were reviewed. The files of these patients were assessed daily upon discharge based on a checklist containing patient age, husband name, date and time of admission, findings of history and examination, procedure notes, daily progress notes, and notes signed by the doctor. Data analysis was performed through SPSS 15.0 for descriptive statistics.

Results: It was noted that most of the demographic entries of patients were missing; in 40% cases, ages of patients were not mentioned, and in 84% files the names of husbands were missing. The Obstetric history was incomplete in 15% cases, but the examination findings were written in 100% cases; 17% of patient files were not signed by doctors. The daily program reports were entered 100%.

Conclusion: The audit indicates that complete documentation of patients is essential for evidence of good clinical practice. This audit has an impact on the performance of Ward D staff as well, hence they will realize improvement in their conduct.

Keywords: Medical Audit; Nursing Audit; Quality Assurance; Medical Records; Hospital Records.

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INTRODUCTION

The assessment of quality of healthcare is fraught with difficulties. Even more difficult is the assessment of the many quality improvement programmes and activities that currently exist.[1] Clinical audit is a vital and essential component for improving the quality of care, although its usefulness has been questioned by some.[2]

Good record keeping is a sign of a skilled and safe practitioner and is the hallmark of professional practice, ensuring that safe and high-quality evidence-based health care is delivered to the patient.[3] Documenting everything about the patient from the time of admission to the ward for treatment is the essential need of every hospital. From patients' demography to thorough clinical examination, recording vital signs, documenting suspected disease, procedures done on patients, and documenting their daily progress, are the core roles of on-duty doctors and healthcare providers along with nurses in wards. Record keeping provides all the information, updates and the progress of patients; it also instructs personnel on what measures should be followed.[4] The purpose of assessment and record keeping is to facilitate inter-professional communication so that

patients receive timely and consistent care. Accurate documentation reduces the potential risk of errors and miscommunication It also promotes excellence in care by encouraging patients' reassessment and reporting of progress, allowing the practitioner to determine which interventions are effective and which are ineffective, and where changes are required in the management plan.[3] It also helps in meeting professional and legal standards. Proper record entry will also be helpful for the next generations for patient-based research or audit reports, primary documentation of a patient not only for making rapport but also to produce research in clinical case management, future plans for improvement in quality, upgrading the technology, collective reporting to higher authority and for medico-legal importance.[5] However, it is not always given the priority it deserves.

The aim of this audit is to improve record keeping within hospitals, maximising patient safety, and improving quality of care.

It will also ensure that all staff involved in clinical record keeping are aware of the relevant requirements and ensure efficiency, professionalism, and cost effectiveness in the clinical record keeping processes and procedures.

Objectives:

1. To audit the clinical record entries of patients admitted to the Gynaecology and Obstetrics ward of Rehman Medical Institute, Peshawar, Khyber Pakhtunkhwa, Pakistan.
2. To measure compliance with hospital standards and to identify areas where practices could be improved.

MATERIALS & METHODS

A medical audit of patients' record files was carried out in the Department of Gynaecology and Obstetrics of Rehman Medical Institute from October 1 to October 31, 2016, that included all patients (both booked and unbooked) admitted during this period to the ward. Only the patients who left the department without medical advice were excluded from the auditing. There is a set protocol for both doctors and nurses to follow for every patient admitted to the ward in Rehman Medical Institute. On visiting the hospital each patient is assessed by the Consultant who admits the patient to the ward when needed. In the ward, patients are assessed by both on-duty trainee (doctor) and nurses; both document their findings within 4 hours of admission. The assessment includes documentation of the patient's demographic information, health status, and the impact of their current illness, based on which treatment is started as required.

In this audit, patients' record keeping file was assessed based on a checklist containing patients' age, husbands' name, date/time of admission, history, physical examination, procedure notes, daily progress note and the reports signed by the doctor. The files of all admitted patients were collected after their discharge and checklist was processed on daily basis for the entire month of October 2016.

Data analysis for descriptive statistics was carried out using Statistical Package for the Social Sciences (SPSS) version 15.0.

RESULTS

The audit involved a prospective case note review of 209 patients admitted to the Gynaecology & Obstetrics ward in the month of October 2016. Figure 1 shows the demographic entries of patients in the medical record keeping files. As shown, majority of the demographic data of patients admitted to the ward were missing, even though such data are essential to maintaining patient profiles and contacts. Age was the only demographic variable which was entered with responsibility; even here, about

40% of the time, age of the patient was not mentioned. About 84% of the files did not contain the names of the patients' husbands.

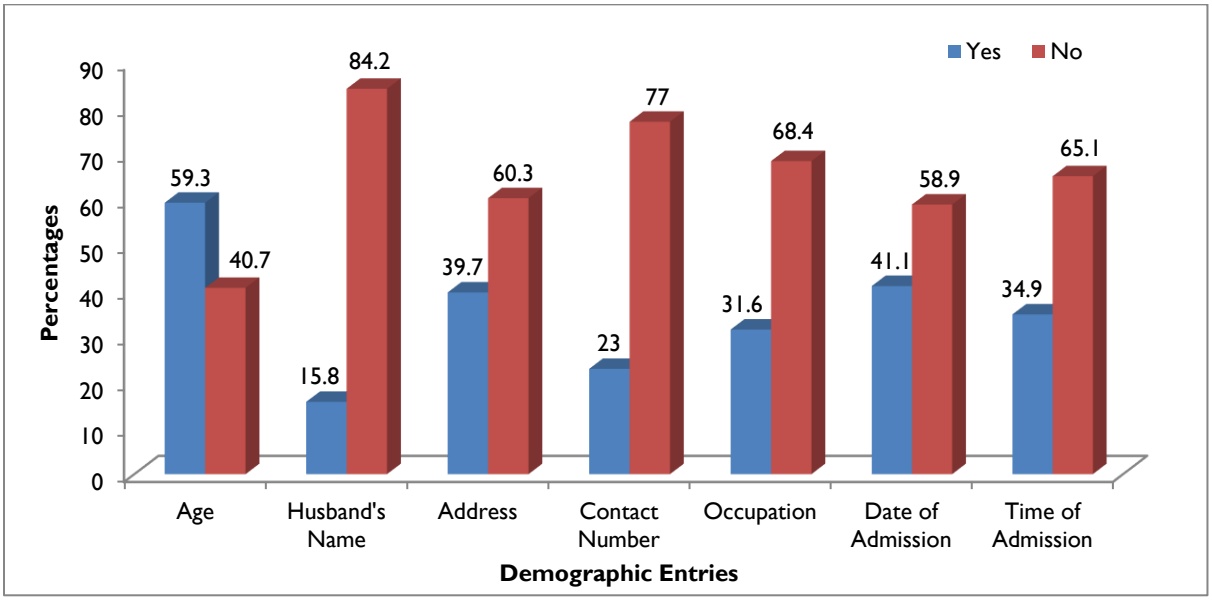

Figure 1: Demographic entries of patients admitted to Obstetrics & Gynaecology ward (n=209).

There are different aspects of history taking and to cover the patient from every aspect it is essential for correlating patients' current illness with other factors. History plays an important part in reaching a differential diagnosis; even sometimes provisional diagnosis can be made just based on thorough history taking. Figure 2 shows the different aspects of history taking which should be covered according to the ward protocol in managing every patient. The analysis of data showed that in keeping with the importance of this aspect of patient management, the documented files were more responsibly received. Only the Obstetrics history of the patient was lacking among documentations up to nearly16%.

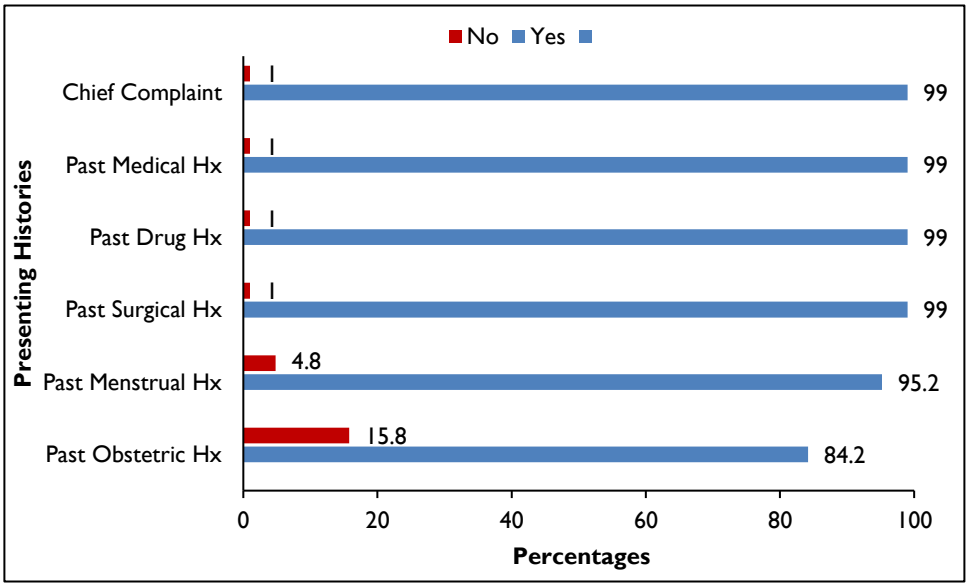

Figure 2: History taking entries of patients admitted to Obstetrics & Gynaecology ward (n=209).

The audit also assessed the entry of findings of a doctor on clinical examination of the patients. It is another important aspect of patient management. A doctor can correlate the findings with the history of the patient with the chief complaints and current health; only then prompt therapy can be initiated. As Figure 3 shows, this part of patient record keeping file is completed for almost every patient, as about more than 95% of the patient underwent systemic examination and about 86% of the patients were examined thoroughly for general body health. Audited data show low results for per vaginal examination; one of the important examination among obstetrics cases. It is worth mentioning here, that some Gynaecological cases admitted to the ward do not need per vaginal examination, hence could have contributed to this low percentage.

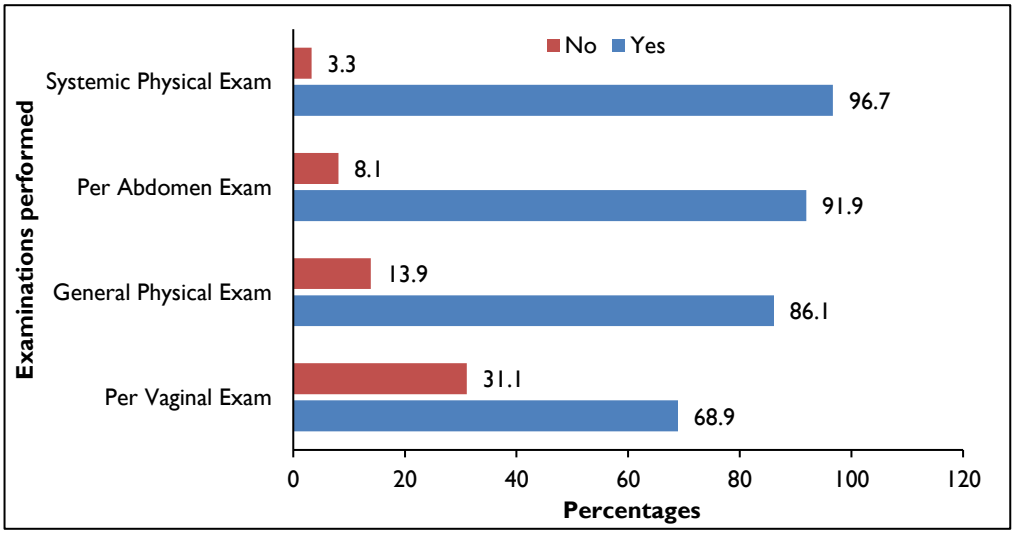

Figure 3: Clinical Examination entries of patients admitted to Obstetrics & Gynaecology ward (n=209).

On the completion of detailed history doctor reaches to the provisional diagnosis and order investigations needed. After writing his/her diagnosis at the end of histroy sheet on duty doctor is supposed to wirte own name and sign the sheet; according to the protocol. This is important because infuture the istory sheet can be re-evaluated and on duty doctor can present his/her findings and can suggest what else needed in a perticular patient.

Table 1 shows the audited data for both mentioning of diagnosis at the end of sheet, writing the names of attending physicians and signatures of on-duty doctors. Doctors appeared lax in signing the sheets, as almost 17% of the patients' files were not signed by them.

Table 1: Entries of diagnosis, physician names and signatures (n=209).

Variables	Number (%)
Diagnosis	
Yes	202 (96.7)
No	07 (03.3)
Name & Signature	
Yes	174 (83.3)
No	35 (16.7)

Documenting before-and-after procedure notes plays a vital role in managing patients within the ward.

Figure 4 shows the practice of documentation of different types of such notes in the patients' record keeping files. Procedure notes refer to any surgical procedure that a patient underwent; of these 78.9% were entered. Not relevant refers to the 18.7% patients who did not undergo any procedure during their stay in the ward. Similarly, baby notes refer to documenting the 1st day

checkup along with the general health of the baby delivered during the hospital stay and were documented for 69.4% of such cases; not relevant here points to the 28.7% of Gynecology (not Obstetric) patients admitted to the ward in the month of October. Daily Progress Reports (DPR) are the notes of the admitted patients recording daily health of the patient; this section of the patients' record keeping files was nearly fully documented. Admission notes, which are important to document the baseline condition of patients at the time of admission, were completed in 88% of record files.

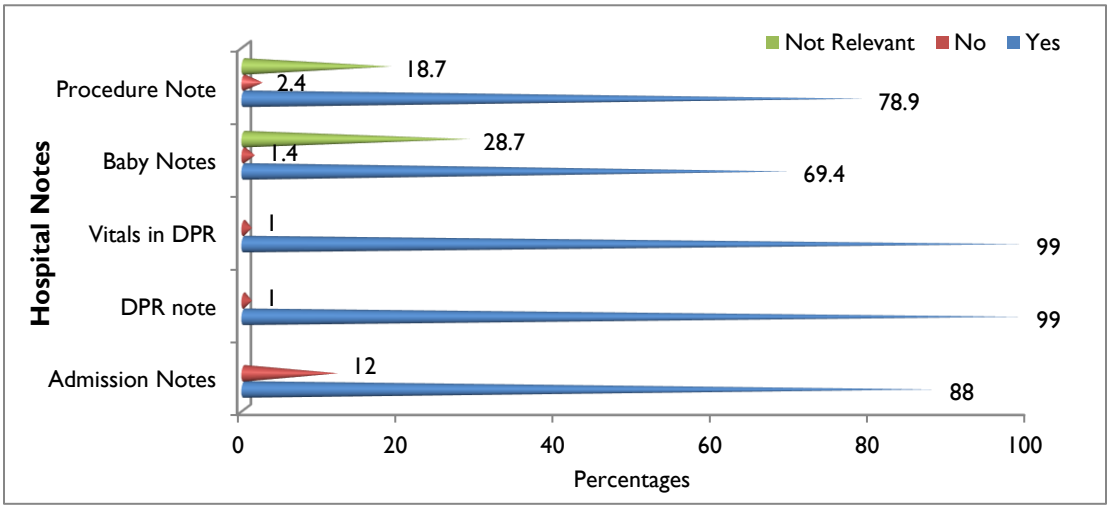

Figure 4: Hospital Notes entries of patients admitted to Obstetrics & Gynaecology ward (n=209).

The Daily Progress Report (DPR) of patients is the entry of written and signed patients' notes by physicians, and is an important area of completion of record keeping files; in only 26.3% of files were these notes completed and signed. In about 42% of files there was one progress note where doctor's sign was missing.

Table 2 shows the frequency distribution on number of notes missing in the particular files. Signing DPRs is important for clinical discussion during case presentation/bed case learning and to correlate the doctor's finding with ongoing treatment. Overall, 73.7% of the unsigned DPRs (ranging from 1-7) had such important documentation missing from the records.

Table 2: Daily Progress Reports of the patients not signed (n=209)

Unsigned DPR	Number (%)
0	55 (26.3)
1	87 (41.6)
2	39 (18.7)
3	14 (6.7)
4	9 (4.3)
5	3 (1.4)
6	1 (0.5)
7	1 (0.5)
Total	**209 (100.0)**

DISCUSSION

The quality of recorded information in patients' records is taken as a predictor of the quality of care. Better registration of patient information could contribute to better patient outcomes and safer healthcare.

In this study on medical record documentation by hospital departmental staff, very high levels of documentation were found for presenting complaints, history of presenting illness and past medical and surgical history, but lower levels of documentation were noted for demographic data, and examinations.

In most medical records. Documentation is not designed to be user-friendly, hence difficult to maintain. This deficiency was also seen in the present study. The instruction of writing case summaries in admission forms at the time of discharge is wrong, as there are separate forms available for writing the discharge summaries. It should be indicated that case summary should be written at the time of admission and not at the time of discharge.

In January 2008, the Department of Health, Social Services and Public Safety, Northern Ireland (DHSSPSNI), issued generic record keeping standards.[4] These were based on best practice guidance developed by the Health Informatics Unit within the Royal College of Physicians (RCP) in London.[6] These standards are considered applicable to the content of any patient's hospital medical record, regardless of the specialty or profession involved.[7,8] The record keeping standards produced by the RCP aimed to maximise patient safety and quality of care and to support professional best practices.[9] Maintaining recommended global standards ensure quality healthcare delivery; good record keeping is thus an integral part of clinical practice and whether at individual, team or Trust level, has many important functions that provide satisfaction about patient care and optimum healthcare.[10]

CONCLUSION

Documentation of patients' presentation in the Gynaecology & Obstetrics ward of Rehman Medical Institute, Peshawar, was generally at acceptable levels; weak areas were identified that would serve to further enhance the performance of departmental staff.

LIMITATIONS

The audit focused on record keeping only, and did not make inferences about quality of patient care, or analyse the clinical consultation notes.

RECOMMENDATIONS

Junior departmental staff should be made to realize their official responsibility and duty to ensure patient documentation entries.

A check and balance protocol should be maintained by the ward registrar to ensure proper entry system. Similarly, admitting consultants performing procedures on patients must ensure that all procedures are entered in the respective registers.

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