

MEDICAL RECORD DOCUMENTATION IN A LEARNING DISABILITY IN-PATIENT UNIT

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SUMMARY

Introduction: Consistency in clinical structure and content is an important aspect of clinical practice. The rising demands on healthcare systems and associated costs require a much more efficient and transparent means of recording and accessing reliable clinical information in order to manage and deliver good quality care to patients.

Aims: The audit has been completed with an aim to highlight the local standards set for medical record documentation and to assess if the outlined standards are being met in a learning disability in-patient psychiatric setting, the Coppice.

Methodology: Criteria based on GMC Good Medical practice guidelines (2013), RCPsych Good Psychiatric Practice (2009) and Records Management Policy.

Conclusions: Good practice was maintained for most parameters. Mild inaccuracies were noted with date of birth/ward name, timing and signatures.

Recommendations: This was presented locally and measures put in place to address the gaps. A re-audit should be performed within a year in order to complete the audit cycle and to ensure that the recommendations and action plan have been followed through.

Key words: medical documentation

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INTRODUCTION

Consistency in clinical structure and content is an important aspect of clinical practice. The rising demands on healthcare systems and associated costs require a much more efficient and transparent means of recording and accessing reliable clinical information in order to manage and deliver good quality care to patients.

Keeping this in view, the Local Trust policy also highlights the need to manage records properly to:

- Support patient care and continuity of care.
- Support day to day business which underpins delivery of care.
- Supports sound administrative and managerial decision making as part of the knowledge base for the NHS services.
- Meet legal requirements including requests from patients under access to health records legislation.

Support improvements in clinical effectiveness through research and also support archival functions by taking account of the historical importance of material and the needs of future research.

This Audit was done in a learning disability in-patient psychiatric setting, The Coppice which is a six-bedded Intensive Support Team (IST) Unit (South Essex Partnership University NHS Foundation Trust). The patients have complex diagnoses including learning disabilities, autism, schizophrenia, and epilepsy and mood disorders.

AIMS

This audit is a local audit and falls under the Services for People who have a Learning disability (SPLD) Inpatient, Beds and Luton. The audit has been completed with an aim to highlight the local standards set for medical record documentation and to assess if the outlined standards are being met in a learning disability in-patient psychiatric setting, the Coppice.

METHODOLOGY

In conjunction with the GMC Good Medical practice guidelines (2013), Royal College of Psychiatry Good Psychiatric Practice (2009) and the Records Management Policy of the local trust guidelines, the following criteria have been outlined to be the set standards upon which the medical records will be assessed:

- Patient Name, Date of Birth, NHS Number, Ward Name to be on every page.
- Printed Name of the Doctor, Signature and Designation to be recorded on each of the entries.
- Date and Time using 24 hour clock should be accurately recorded in each entry.
- Record Additions should be countersigned, dated and timed using 24 hour clock.
- Empty lines and blank spaces should be scored through.

- A single line should be used to cross out and cancel mistakes or errors and they should be signed, dated and timed (24 hour clock) by the person who made the amendment.

All the in-patient medical records at The Coppice were selected and the medical notes made over a six week period from October 13, 2014 to November 24, 2014 were examined for the presence of the set standards.

The audit tool was developed on the basis of the criteria listed above by the Clinical Audit team who also analysed the data following collection. The tool was developed with guidance from the Clinical Audit Department.

See appendix 1 for the Clinical Audit Tool. The data collection tool was developed on the basis of the standards mentioned above with guidance from the Clinical Audit Department.

FINDINGS

Full results can be found in table 1 and 2; however, the following illustrate the key findings.

Figure 1 shows that the First and Last names of the patients have been accurately documented in every page in 100 per cent of the medical notes. The NHS number of the patient was recorded in all but one of the medical notes.

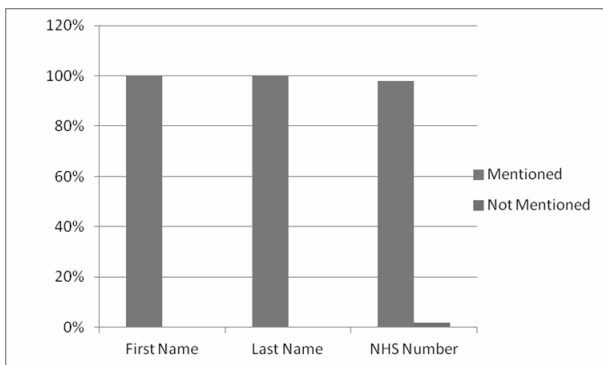


Figure 1. First and Last names

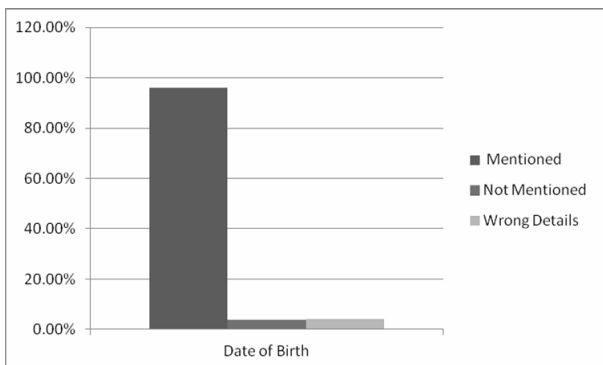


Figure 2. Date of birth

Figure 2 indicates that the Date of birth of the patients was recorded in 96.07 per cent of the medical notes. It was, however, mentioned incorrectly in 4.09 per cent of

the recorded dates. Two out of the fifty-one medical notes did not have the date of birth details (3.93 per cent).

Figure 3 shows that the Ward name has been mentioned in 94.11 per cent of all the medical notes. It was, however, not mentioned in 3 out of the 51 medical notes seen (5.89 per cent).

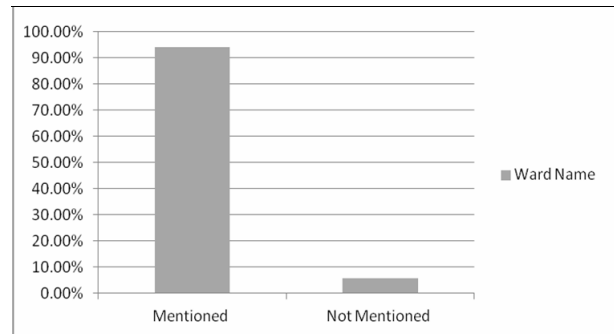


Figure 3. Ward name

Figure 4 depicts the 100 percent compliance in mentioning the Date of the medical note entry. The time using 24 hour clock was, however, mentioned in only 77.27 per cent of the medical notes.

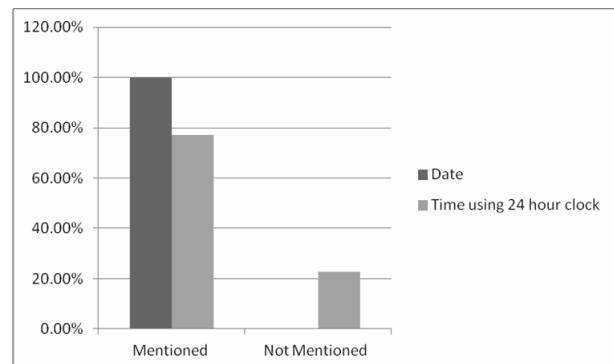


Figure 4. Mentioning

Figure 5 indicates that the Printed name of the Doctor making the entry was mentioned in 86.36 per cent of the medical notes. The designation of the doctor was mentioned in only 70.45 per cent of the entries. The signature of the doctor was, however, present in 100 per cent of the medical entries.

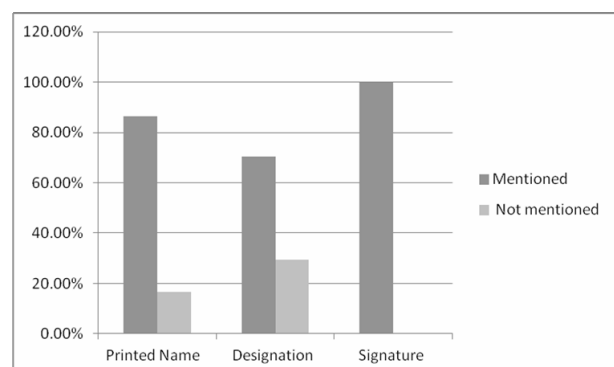


Figure 5. Printed name

Table 1. Full Results

1. Six of the in-patient’s medical records were selected for data analysis and a total of 44 medical notes (51 including the continuation pages) were observed to be made over a period of six weeks from 13th October, 2014 to 25th November, 2014.
2. Every page of the medical notes had the patient’s first and last name accurately recorded with a compliance level of 100 per cent.
3. The patient’s NHS number was recorded in every page of the medical notes including the continuation sheets with a compliance level of 98.03%. Only one continuation sheet did not have the NHS number of the patient.
4. With regard to the documentation of the patient’s Date of birth, in 96.07% of the medical notes the date of birth had been mentioned. However, 4.09 % out of these were incorrectly documented. The Date of birth details was not present in two pages, accounting to 3.93 per cent of the total medical entries.
5. The Ward name was not filled out in three pages of the medical notes resulting in a compliance level of 94.11%.
6. The data collected with regard to the documentation of Date of birth, NHS number and Ward name on every page of the medical note was found to fall short of a 100% compliance rate.
7. The Date of the medical note entry has been consistently mentioned with 100% compliance level. It was present in all the 44 medical notes assessed.
8. The time of entry using the 24 hour clock, however, was recorded in only 77.27% (34 out of the 44 medical entries) of the cases with 22.73% of the medical notes having no details of the time of entry.
9. The printed name of the doctor making the entry was mentioned at the end of each medical note in 38 out of the 44 medical notes with a compliance level of 86.36%.
10. The designation of the doctor making the entry was not mentioned in 13 out of 44 of the medical notes with only 70.45% of the notes complying with the set standards.
11. The signature of the doctor making the entry, however, was present in all of the medical notes with 100% compliance.
12. A total of 17 blank spaces were observed in all the medical notes out of which 7 spaces were scored through accounting to a compliance level of 41.17 per cent.
13. A total of 7 record errors were made in all the medical notes combined. The record errors were dated in only 28.57 % of the entries (2 out of 7 record errors) leaving 71.43% of them having no account of the date of record error correction. The time of correction of the record errors using a 24 hour clock was also recorded in only 3 out of 7 record errors resulting in a compliance level of 42.85 %.
14. The record errors have, however, been countersigned in 6 out of the 7 errors noted in the medical note entries.
15. There was only one record addition in all the medical notes assessed and it was found to have no date, time using 24 hour clock and signature of the person making the record addition.

Figure 6 shows that blank spaces were scored in every page in only 41.17 per cent of the medical notes.

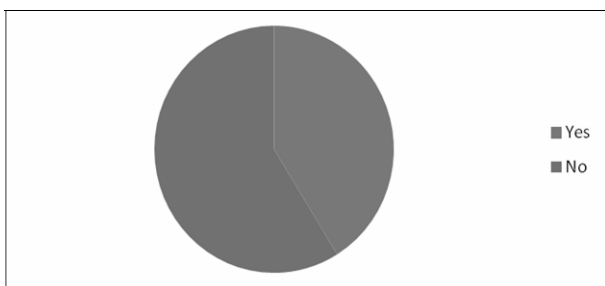


Figure 6. Blank spaces

Figure 7 is with regard to the Recorded errors in the medical notes. Six out of the seven record errors documented were counter signed (85.7 per cent). Only two out of the seven recorded errors were dated (28.57 per cent). Three out of the seven recorded errors were timed using the 24 hour clock (42.85 per cent).

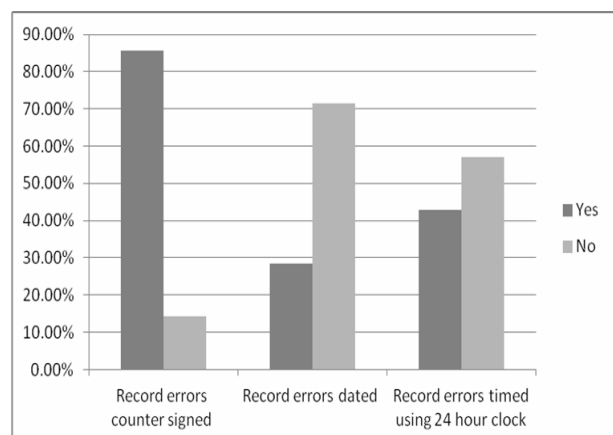


Figure 7. Recorded errors

Figure 8 is regarding the Record additions. There was only 1 record addition made in all of the medical notes, which was not counter signed, dated or timed using the 24 hour clock.

Table 2. Results

	Mentioned	Not Mentioned	Wrong
First Name	100%	0%	
Last Name	100%	0%	
NHS Number	98.03%	1.97%	
Date of Birth	96.07%	3.93%	4.09%
Ward Name	94.11%	5.89%	
Date	100%	0%	
Time using 24 hour clock	77.27%	22.73%	
Printed Name	86.36%	16.64%	
Designation	70.45%	29.55%	
Signature	100%	0%	
	Yes	No	
Blank spaces scored	41.17%	58.83%	
Record errors counter signed	85.70%	14.30%	
Record errors dated	28.57%	71.43%	
Record errors timed using 24 hour clock	42.85%	57.15%	
Record additions counter signed	0%	100%	
Record additions dated	0%	100%	
Record additions timed using 24 hour clock	0%	100%	

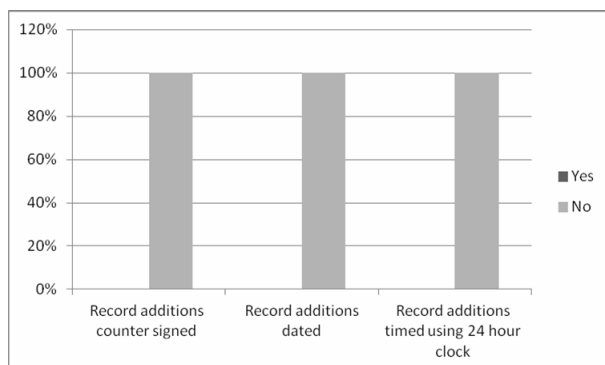


Figure 8. Record additions

CONCLUSIONS

In conclusion, it can be deciphered that good practice was maintained while recording the:

- First and last name of the patient on every page;
- NHS number on every page;
- Date on which the medical entry was made;
- Signature of the person making the entry.

Mild inaccuracies were noted pertaining to the recording of the Date of birth of the patient.

The Ward name was not mentioned in all the pages of the medical note entries resulting in a compliance rate of approximately 94 percent.

While all of the medical notes were dated accurately, it was noted that approximately only 77 per cent of the medical entries were timed using the 24 hour clock.

While the Signature of the doctor making the entry was present on all of the medical notes, the printed name and the designation of the person making the entry was absent in 16.34 percent and 29.55 per cent respectively.

Record errors were counter signed with a compliance of 85.7 per cent. But, the dating and timing (using the 24 hour clock) of the record errors showed much lower compliance rates of 28.57 per cent and 42.85 per cent respectively.

Only one record addition was noted which was, however, not countersigned, dated or timed using the 24 hour clock.

Blank spaces were not scored in more than half of the record entries with a percentage of 58.83.

RECOMMENDATIONS

Accurate record of time using the 24 hour clock while making a medical record should be maintained with a compliance level of more than 90 per cent as it is essential for good record keeping.

Printed name and designation of the person making the entry fell short of the recommended compliance level and have to be included strictly in order to adhere to the standards of the local trust.

Record errors and additions must be counter signed, dated and timed using the 24 hour clock in order to document when and by whom the error was made.

Care must be taken in ensuring that all blank spaces and empty lines are scored through.

A re-audit should be performed within a year in order to complete the audit cycle and to ensure that the recommendations and action plan have been followed through.

Acknowledgements: None.

Conflict of interest: None to declare.

Appendix 1. Data Collection tool

Criteria	Patient							
	Note 1	Note 2	Note 3	Note 4	Note 5	Note 6	Note 7	Note 8
First Name								
Last Name								
NHS Number								
Date of Birth								
Ward Name								
Date of Record Entry								
Time using 24 hour clock								
Printed Name								
Designation								
Signature								
Record Error Countersigned or not								
Record Error Date								
Record Error Time using 24 hour clock								
Record Addition countersigned or not								
Record Addition Date								
Record Addition Time using 24 hour clock								
Blank Spaces Scored								

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