Quality assessment of NCHD medical recording performance at Sligo University Hospital

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1 Background

The medical record contains valuable information about a patient's medical history and individual clinical interactions.

Such information supports the ongoing care for the patient by the physician and other provider.

In addition to its clinical significance, the medical record is also a legal document that can serve as evidence of the care provided.

2 Standards

The HSE Standards and Recommended Practices for Healthcare Records Management in 2014 describe the standards and recommended practices to guide the standards of practice required in the management of healthcare records in the HSE.

https://www.hse.ie/eng/about/who/qid/quality-and-patient-safety-documents/v3.pdf

3 Audit Process

The variables used to assess healthcare recording include:

1.Date
2.Bleep number
3.Time
4.Name of supervising consultant
5.Name
6.Specialty
7.Job Title
8.Addressograph pasted/ Handwritten patient name, PID, DOB
9.MCRN
10.Signature with print name

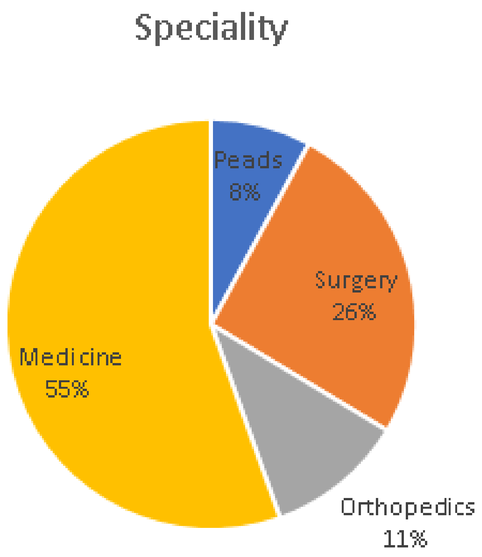
4 Methodology First Loop

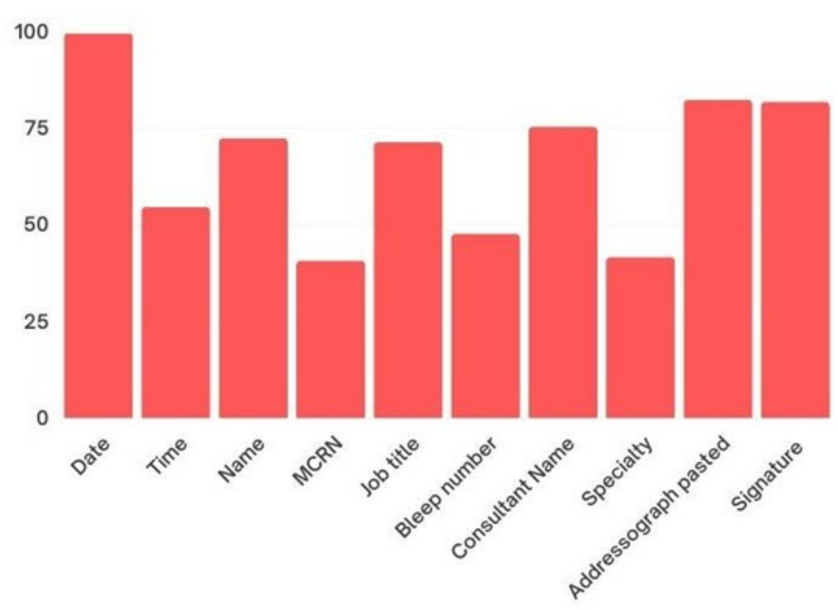
Data from 101 clinical notes were randomly collected,
64 from Medical teams (Medicine, Paeds)
37 from Surgical teams (GS, Urology, Orthopaedics, ENT, OB/GYN).
202 clinical notes were studied.
No notes from on call doctors or after 5pm were included

Methodology Second Loop

Data from 129 clinical notes were randomly collected,
69 from Medical teams (Medicine, Paeds)
60 from Surgical teams (GS, Urology, Orthopaedics, ENT, OB/GYN).
258 clinical notes were studied.
Data was collected from the 15th and 16th of November 2023

5 Analysis First Loop





Percentage Recorded

How did we bring improvements?

Posters:

Placed in doctors' rooms, residences, and wards throughout the hospital, providing clear instructions on completing patient notes.

Formal Teaching:

Presentations in all departments covered accurate documentation practices, common errors, and detailed steps for proper note-taking, with interactive discussions and Q&A.

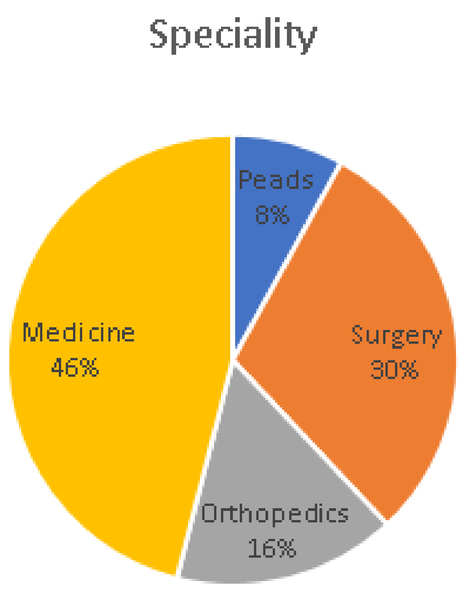
Email Communication:

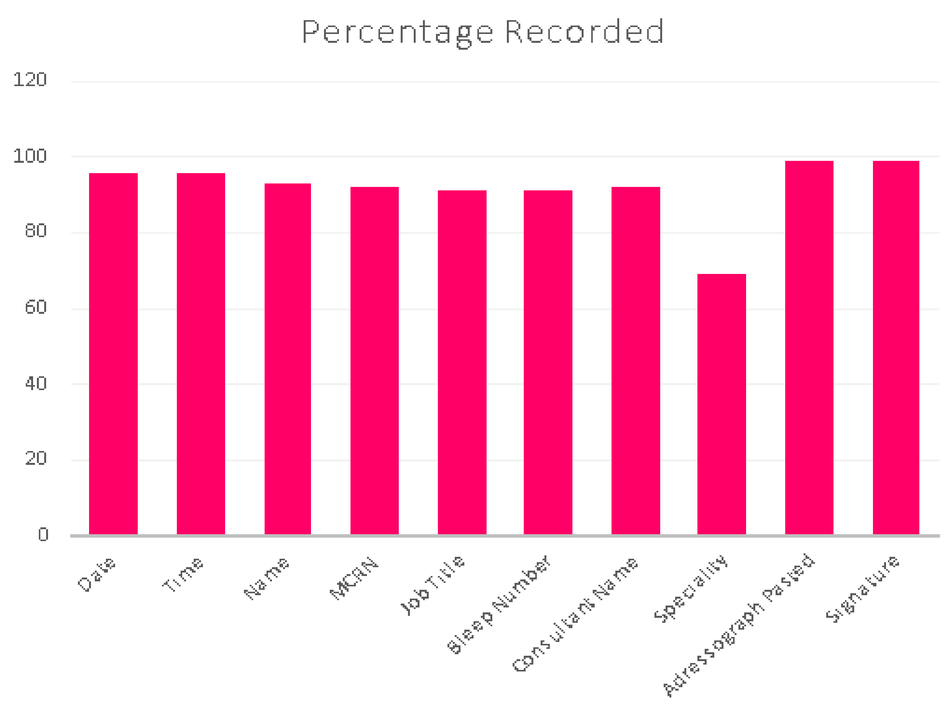
Emails sent to all Non-Consultant Hospital Doctors (NCHDs) included comprehensive guidelines and best practices for completing patient notes, ensuring information reached everyone.

Informal Teaching:

Staff provided training during daily rounds, reinforcing formal teachings and offering real-time feedback and correction.

7 Analysis Second Loop





8 Conclusion

There has been a substantial improvement in patient clinical notes by all NCHD's shown in our second loop.

We aspire to reach 100% on all markers of the HSE document.

SCAN FOR REFERENCES

9 Implications

It is very important that all NCHD's understand the importance of the standards set by the HSE on clinical notes.

We plan on circulating a poster on this audit to all hospital staff via email.

Posters to be set up across multiple areas in the hospital including wards, doctors rooms and the doctors residence.