Rolling audit: Defensible Record Keeping

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Objectives:
To observe the completeness and proper documentation of inpatients data, to compare the observed data of present rolling audit to previous rolling audit and also to observe implementation of recommendation made by previous rolling audit.

Material and Methods:
Retrospective study done on November 2009. Twenty files from each of eight departments having inpatient ward at TU teaching hospital was analyzed. Files were reviewed for completeness and proper documentation as per protocol laid down by Royal College of Surgeons.

Results:
Record keeping was appreciable in department of Pediatrics, Psychiatric and ENT-HNS. There was deteriorating trend of data recorded in admission and investigation form. Progress notes were properly filled daily in department of Medicine, Surgery, Pediatrics, ENT-HNS and Gynecology and Obstetrics. There was no significant implementation of recommendation of previous rolling audit in all the departments.

Conclusion:
Good medical practice is defensible practice. Rolling audit must be done at regular basis to implement change and further monitoring to confirm improvement.

Keywords:
Audit, data, record keeping.

INTRODUCTION:

The medical record is the primary source of evidence in any malpractice action. The first thing a plaintiff attorney does in the quest for evidence of liability is review the medical record. If the chart is orderly and the information is lucid, concise, consistent and accurate, the case likely will be dropped. Poor charting exposes the physician to significant liability even if the care provided meets the applicable standard of care. It is regrettable when chart inadequacies or inconsistencies make a case with no medical misadventure difficult to defend. Medical record does not simply recall what has happened to patient but should have everything so that anyone coming fresh to that patient care can pick up where other colleagues have left. Audit is a systematic critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient.Proper record keeping is of increasing importance in medical field. There is a growing need of accurate, legible and understandable maintenance of record.[1] Record keeping is essential for audit, research, in providing data for public health purposes. It is also critical in a variety of legal contexts, including defensible malpractice claims. Thorough medical record keeping can reduce risk of litigation.[2] Styles of record keeping may vary from practitioner to practitioner or in different institution. In our study we have followed protocol laid by the Royal College of Surgeons. The objective of this study was to observe the completeness and proper documentation of inpatients data by various department of TU,Teaching hospital, to compare the observed data of present rolling audit to previous rolling audit and also to observe implementation of recommendation made by previous rolling audit.

MATERIAL AND METHODS:

It is a retrospective study conducted in TU, Teaching Hospital, November 2009. Eight departments having inpatient wards were included; twenty files from each department were randomly selected from medical record department for the study. Department included were Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, Orthopedics, Ophthalmology, Psychiatry and ENT-HNS. All files were studied for complete and proper documentation as per inclusion criteria laid down in protocol by Royal College of Surgeons in admission note, daily progress notes, and investigation form. Implementation of recommendation laid by previous rolling audit in October 2008 was analyzed and compared with present audit.

Table: 1. Analysis of the admission note showing the numerical values, which are the percentage of files fulfilling the criteria

	Medicine		Surgery		Gyn&Obs		Ped		Ortho		Oph		Psy		ENT	
	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009
Use of capital letters	40	40	80	50	45	50	50	100	40	10	40	40	65	80	80	75
Entry of full department	80	80	85	90	90	70	100	75	100	40	70	70	100	75	85	55
Avoidance of initialsof consultants name	45	100	0	50	40	40	30	--	40	10	40	45	80	80	50	75
Entry of provisional diagnoses	100	90	100	100	100	100	100	90	100	100	95	100	100	100	100	100
Entry of final diagnoses	40	60	30	30	30	30	5	20	20	10	5	50	75	30	50	50
Entry of full address	55	30	75	50	75	70	95	75	95	70	80	80	75	90	100	100
Understandablesignature of the Doctor	0	0	0	0	20	25	85	80	15	10	25	30	25	15	35	100
Entry of the admission date	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

P.S. Gyn&Obs= Gynecology and obstetrics, Ped= Pediatrics,Oph= Ophthalmology, Psy= Psychiatry, ENT= ENT & HNS

RESULTS:

Variable analyzed in admission note were; use of capital letters when specifically asked for, entry of full name of department, avoidance of initials of consultant name, entry of full address of patient, entry of provisional diagnosis, entry of admission date, entry of final diagnosis,

Table: 2. Showing in percentage the presence of a progress note in files of various department

Department	Audit October 2008	Audit November 2009
Medicine	20	100
Surgery	40	90
Gynecology and obstetrics	90	80
Pediatrics	100	100
Orthopedics	95	70
Ophthalmology	70	60
Psychiatrics	80	15
ENT-HNS	100	80

entry of understandable signature of doctor as shown in Table-1

Data that were analyzed in daily progress note were; presence or absence of daily note, entry of subjective complaints, entry of objective findings, entry of assessment and plan, over written, erased or tippexed note and presence of understandable signature of doctor as shown in Table -2 and Table -3

In the present study, medical records regarding proper entry of data in admission form, daily progress notes and the investigation form were analyzed. We followed the protocol laid down by Royal college of Surgeons for analysis of records.[6] Eight departments of TU, teaching hospital having inpatient wards were included for the study. Files were studied on random basis by residents of three different departments to decrease the biasness of the study. Record keeping

Table: 3. Analysis of the daily progress note showing the numerical value which are the percentage of files fulfilling the criteria

	Medicine		Surgery		Gyn&Obs		Ped		Ortho		Oph		Psy		ENT	
	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct 2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	
Nov2009 Entry of subjective	75	100	85	88	85	45	100	100	75	100	30	40	95	100	100	100
complains Entry of objective	100	100	100	100	100	100	100	100	95	100	85	60	95	100	90	100
findings Assessment	75	80	90	100	90	75	100	95	95	100	85	80	95	100	90	100
and plan Entry of signature	25	0	25	0	55	50	65	0	40	0	0	0	15	66	95	100
(understandable) Written over, erased or tippexed notes	0	0	25	0	15	0	15	0	15	0	0	0	30	0		0

P.S. Gyn&Obs= Gynecology and obstetrics, Ped= Pediatrics,Oph= Ophthalmology, Psy= Psychiatry, ENT= ENT & HN

Entry of date, ward , bed number and diagnosis were the data analyzed in investigation form as shown in Table- 4.

of patients' document was appreciable in the department of Paediatric, Psychiatry and ENT-HNS. There was no significant improvement in

Table: 4. Analysis of investigation note showing the numerical values which are the percentage of files fulfilling the criteria

	Medicine		Surgery		Gyn&Obs		Ped		Ortho		Oph		Psy		ENT	
	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009	Oct2008	Nov2009
Entry of date	85	100	100	80	100	100	100	95	100	100	95	100	100	100	100	85
Entry of Ward and bed number	100	90	80	55	90	80	95	80	90	80	40	50	100	85	80	65
Entry of diagnoses	60	10	20	15	75	75	90	75	40	20	40	40	75	65	65	30

P.S. Gyn&Obs= Gynecology and obstetrics, Ped= Pediatrics,Oph= Ophthalmology, Psy= Psychiatry, ENT= ENT & HNS

The recommendations that were made in rolling audit October 2008 were: use of capital letters in admission note when specifically asked for, avoidance of initials of consultant name, entry of final diagnosis in admission note, proper filling of daily progress note, entry of diagnosis in every investigation form and conduction of rolling audit in every six month. Implementation of recommendation made by rolling audit October 2008 was also analyzed in this rolling audit. Variable which deteriorated from previous rolling audit were use of capital letters in admission note, entry of final diagnosis in admission note, entry of diagnosis in investigation forms. Daily progress note were inadequately filled in files from department ophthalmology, psychiatry and orthopedics. Finally rolling audit was done after 13 months which also didn't follow the recommendation of previous audit.

DISCUSSION:

Rolling audit is very important for proper record keeping. Audit is now an integral part of medical practice. One of first ever clinical audits was undertaken by Florence Nightingale during the Crimean War of 1853-1855 health care delivery. The National Institute for Health and Clinical Excellence (NICE) defines clinical audit as a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement. According to General Medical Council we must work with colleagues to monitor and maintain the quality of the care we provide and maintain a high awareness of patient safety. In particular, we must take part in regular and systematic medical and clinical audit, recording data honestly. According to NHS, Defensible documentation policy board, 2005 poor record keeping is the major factor in litigation cases and which hinder the defense of defensible cases. So failure of proper record keeping results in reduced quality of care, increase chances of litigation and defensible cases becomes indefensible. [3] Communicating with patient, keeping accurate records and actually taking time to examine patients are three of the top10 ways to avoid a lawsuit.[4] Practical implications of proper record keeping and importance of record keeping in peer reviews, audit and research has been highlighted by Hutchinson et al.[5] Proper record keeping is very important in the medical field to avoid the increasing lawsuits. There is a growing need to keep records in medical fields since doctor have to justify their patient management in malpractice claims.[1,5]

record keeping as per recommendations of previous rolling audit. There was deteriorating trend of data recorded in admission form. Daily progress notes were properly filled in department of Medicine, Surgery, Pediatrics, ENT-HNS and Gynecology and Obstetrics, but progress notes of department of ENT-HNS fulfilled all the criteria followed by department of Psychiatry and Gynecology and Obstetrics. We also found no improvement in entry of data in investigation forms. This rolling audit was done 13 months after the previous one, which also didn't follow the recommendation made by previous rolling audit.

CONCLUSION:

Challenges to clinical management are a fact of professional life. Every doctor must expect to become embroiled in complaints and claims from time to time, so he should be prepared to justify. Good medical practice is defensible practice, which depends upon staying within the limits of every ones own expertise, keeping up to date and conducting audit. So all the departments must be serious in proper record keeping and should be aware of consequences of poor record keeping. Rolling audit must be done at regular interval to implement change and further monitoring to confirm improvement. Recommendations are made for regular rolling audit at least 6 monthly, new residents joining the programme should be made aware of importance of record keeping and should be provided with opportunity to attain defensible documentation training. Use of capital letters, entry of full name of department and avoidance of initial of name of consultant is must in admission note. Entry of final diagnosis in admission note at time of discharge should be properly done and finally progress note must be written daily with understandable plan and signature and investigation form should be adequately filled.

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