An Audit of Clinical Documentation from Inpatient Medical Records in Warringal Private Hospital

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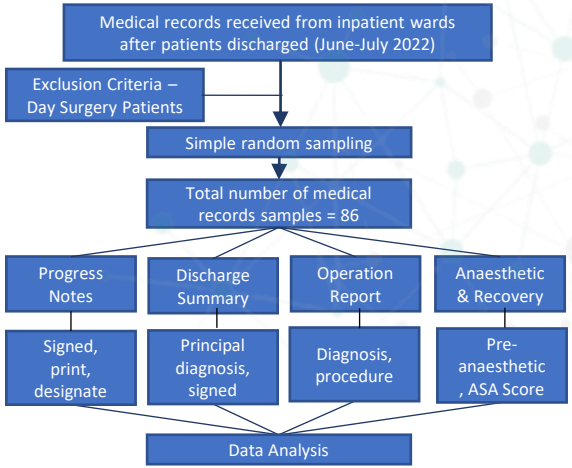
Background

Information is important in health care services. Access to medical documentation in a timely and correct manner is crucial for providing the best quality of healthcare.

Aims

To determine documentation deficiencies and establish areas for improvement.

Methods



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Results

Records from five wards (A, n = 20, 23.3%; B, n = 12, 14%; C, n = 11, 12.7%; D, n = 32, 37.2%; E, n = 11, 12.8%) were evaluated. Overall, 73 out of 86 medical records analyzed (84.88%) showed deficits in documentation. Deficits shown by form and ward are depicted in figure 1.

There are inconsistencies across the wards regarding documenting in progress notes. All wards have deficits above 45% for the discharge summaries.

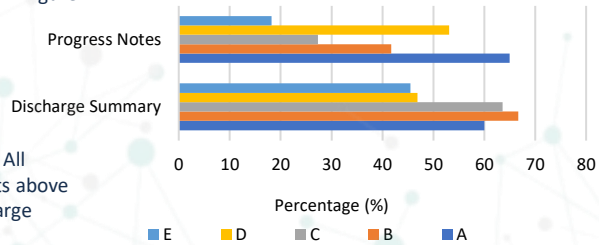

Figure 1. Incompletion of Documentation in Each Ward

Percentage of the completion on procedure areas are shown in figure 2. In the procedure form, less than half of the documentation was incomplete on the pre-anaesthetic form and the operation report, with the percentages of 35% and 17%, respectively.

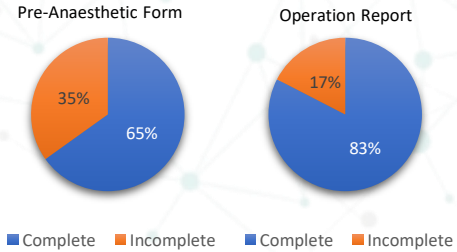

Figure 2. Percentage of procedure areas' documentation

It is essential that the medical record reflects the standard of care provided for our patients. This study demonstrates there are some gaps in the medical record documentation reviewed. Reasons for these deficits may include the limitation of systems, such as the absence of EMR and inadequacy of the collaboration processes (e.g. staff is unaware of the importance of documenting this information).

Conclusions

- Medical records are vital for communicating patients' information and reflection of the care given for current and future hospital admissions as well as being a legal document.
- This audit shows deficits across the wards and procedure areas.
- Due to deficiencies in documentation, it is necessary to educate the clinical staff on the significance of accurate record keeping from the perspective of patient care.
- Standardization of medical record documentation practices across Ramsay hospitals is notable to support best practice.

Acknowledgments

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References

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