

Clinical
Audit

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Clinical audit on record keeping standards at a specialized out-patient child psychiatry service in Sri Lanka

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Abstract

Background: Accurate and up-to-date patient records are essential to ensure high standards of clinical care and achieve professional standards from a medico-legal perspective.

Objectives: This clinical audit aimed to investigate record keeping practices including documentation of the evaluation, execution of management plan and confidentiality of record organization.

Methods: Paper-based clinical records of 250 outpatients were reviewed randomly using an evaluation form.

Results: Although the confidentiality of record organization and execution of the management plan were satisfactory, serious concerns were identified regarding the documentation of evaluation.

Conclusions: The audit showed current record-keeping deficiencies, highlighting the need for record-keeping procedures and policies.

Keywords: *Medical records, quality standards, audit*

INTRODUCTION

“Verba volant, scripta manent” (spoken words fly away, written words remain)

Caius Titus

Clinical record keeping is an essential component of good medical practice and ensures delivery of high-quality health care. [1] Medical records serve a variety of functions in modern health care. These range from primary functions such as aiding patient care, serving as an ‘aide memoir’ and

clinical communication, to secondary functions such as serving as medico-legal records, sources for clinical audit and research, epidemiology, resource allocation, service planning and performance monitoring. [2] It has been reported that poor clinical records misinform healthcare professionals and patients, increase medico-legal risks, lead to unnecessary repetition of tests/investigations, prolong hospital admissions,



jeopardize patient care and may lead to serious incidents. [1] Keeping accurate and up-to-date patient records is a fundamental duty of a medical professional.

However, medical record keeping is often given a low priority. Poorly maintained notes, illegible/inconsistent entries, offensive comments and missing information are commonplace occurrences. [3] In addition, poor record keeping is a main factor which is brought up against medical practitioners in litigation for malpractice. [3] In this context, evidence-based interventions for the improvement of record keeping standards is a timely need.

This clinical audit aimed to investigate current record keeping practices and to propose areas for improvement at a specialized out-patient child psychiatry service at the Lady Ridgeway Hospital, Colombo, Sri Lanka.

METHODS & STATISTICAL ANALYSIS:

Paper-based clinical records of 250 outpatients from January 2019 to December 2020 were reviewed randomly using an evaluation form, designed based on the General Medical Council, UK recommendations. [4] The three main areas of focus were, documentation of the evaluation, execution of management plan and confidentiality of record organization. The data was recorded in an electronic database and analysed using the Statistical Package for the Social Sciences (SPSS) version-22.

RESULTS:

Each patient had a separate medical record with pages fastened appropriately. These were stored in an organized manner in a secure location which ensured patient confidentiality and were available to the treating practitioner where the patient

generally receives care. However, there was no mechanism to monitor missed appointments, apart from the maintenance of an 'at-risk' patient register.

Regarding completeness of records, significant missing data in mode of referral (3.5%), socio-demographic details including; child's education (17.89%), family structure (7.36%), father's education/occupation (30.5% / 24.6%), mother's education/occupation (33.6% / 30.8%), family income (98.2%), family history of mental illness (5.3%), specification of type of psychoactive substance use in family (6.3%) and parenting style (72.6%) were noted. (Table-1)

In 88%, a clinical diagnosis (based on ICD-10 criteria) was recorded, with a treatment plan consistent with evidence-based practice standards. Appropriate use of referrals/consults, investigations was documented and follow-up offered to 97.2%. At least one follow-up visit was attended by 37.8% within an appropriate timeframe. Unresolved issues from the first visit were addressed during subsequent visits. There was evidence of coordination of care within the multidisciplinary team. Education, including counselling, was rarely documented.

DISCUSSION & CONCLUSIONS:

Medical record keeping is an art that has evolved since the inception of modern medicine. It is reported that physicians at the Mayo clinic, Minnesota kept all their patients' records in a personal leather-bound ledger in the 1880s. [2] Patient-based records were first used in 1907, and the first major effort to standardize medical records was in 1965, with the publication of the Turnbridge report in the UK. [2] The Kennedy report, a historic document from the Bristol inquiry investigating the deaths of 29 babies undergoing heart surgery at the Bristol Royal infirmary in the late 1980s, criticized the record-keeping practices and standards in that era. [5]

Table 1: Summary of record keeping deficiencies in patient evaluation highlighted in the audit

Component	Missing data
A. Patient assessment documentation	
1. Mode of referral	3.5%
2. Socio-demographic details-	
Education (of child)	17.89%
Family structure	7.36%
Father's education/occupation	30.5% / 24.6%
Mother's education/occupation	33.6% / 30.8%
Family income	98.2%
3. Family history of mental illness	5.3%
4. Specification of psychoactive substance use in family	6.3%
5. Specification of nature and extent of child abuse	92.3%
6. Parenting style	72.6%
B. Problem evaluation and management	
1. Diagnosis- according to ICD 10 criteria	12.1%
2. Treatment plans are consistent with evidence-based care and with findings/diagnosis	12.1%
3. Appropriate use of referrals/ consults, studies, tests	2.8%
4. Documentation of offering follow up	2.8%
5. Documented attendance of at least one follow up visit	62.2%
6. Timeframe for follow-up visit was appropriate	62.2%
7. Unresolved issues from the first visit followed-up on the subsequent visit	3.8%
8. Evidence of coordination of care	2.5%
9. Documentation of patient education, including counseling	96.1%
10. Member input and/or understanding of treatment plan and options (Documented Formulation)	87.4%

Decades following this initial lobby, problems regarding standards of record keeping still continue to plague the medical profession.

Current evidence suggests that developing evidence-based standards for record keeping, such as structuring the record can bring direct benefits to patients by improving patient outcomes and doctors' performance. [2, 6, 7, 8] These benefits

include: improved quality of records (including completeness and accuracy of information), better patient information with improved communication and greater patient involvement in decision-making, improved patient outcomes, improved data validity for secondary purposes i.e. improved central returns, accurate performance data, better research data, more efficient health services and improved public health. [2] Although

there is a lobby for computerization of medical records, especially in the west, adopting this to our practice may not be prudent in the current context, i.e. a mess that is computerized will be a computerized mess. [2, 9, 10]

This audit showed current record-keeping deficiencies, highlighting the need for record-keeping procedures and policies. Although the confidentiality of record organization and the execution of the management plan were satisfactory, serious concerns were identified regarding the documentation of evaluation. From a legal standpoint, any information/intervention that is not documented, is considered to have not been done. [3] The GMC clearly states that 'clinical records should include relevant clinical findings; decisions made and actions agreed, who made the decisions and agreed to the actions; information given to patients; any drugs prescribed/ investigations/ treatment; and details of who is making the record and when it was made.' [4]

A limitation of this study is that COVID pandemic related difficulties were not accounted for when analysing low follow-up rates and lack of patient tracing, especially with regards to following up of missed appointments. Given the scope and general objectives of the present audit, we did not examine the clarity/ legibility of the records in detail. These are areas we wish to explore in further evaluating the outcomes.

Based on the results and current evidence, a structured format was developed to record patients' information. The members of the multi-disciplinary team were involved and educated regarding necessary practices to ensure proper documentation. We have implemented the initial steps for computerization of patient records for children with autism spectrum disorder, with the hope to maintain an accurate database. We hope to extend these measures with re-evaluation of feasibility and sustainability within our system. A major limitation in planning these measures was the unavailability of a workforce sufficient to cope

up with the administrative needs which arise with additional responsibilities in an already overburdened health-care system. This study highlights the importance of agreed policies and procedures for out-patient record keeping and the need for a mechanism to identify system weaknesses.

Author declaration

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None

Author contribution

PKDHJLDSR was responsible for concept, literature review, design, data interpretation and writing the manuscript.

RMW and BDJVP were responsible for data collection, data entry, analysis and interpretation.

DMAD was responsible for concept, supervision, interpretation, revision and approval of final version to be published.

Conflict of interest

Authors declare that there is no conflict of interest.

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Data availability

All data related to this study will be kept confidential and in password protected computers for a period of five years after which they will be confidentially destroyed and deleted respectively. The data collected for this research project will not use for the establishment of a data bank.

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