

## 455: Ensuring quality of the patient course through patient record audits

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### **Objective:**

The patient record constitutes the most significant tool for keeping systematic documentation of the clinical assessments and interventions during hospital care. Without clinical documentation, it is not possible to reconstruct the course of treatment, thus to have a tool to determine whether the quality is satisfactory. The objective of this project was to monitor whether requirements defined by Danish legislation in addition to the accreditation standards, are met. This was undertaken with a view to creating a performance improvement process, through which documentation of the above mentioned is improved. Due to the desire for more systematic and consistent patient record keeping, the CHC agreed to carry out the same patient record audit at six hospitals.

### **Methods:**

The audit project began in 2000, and since then audits have been performed every six months, with few exceptions. Patient record audits have been performed a total of seven times. All individual departments at the six CHC hospitals participate – usually with twenty patient records at each audit. The topics that are subjected to audit have developed along with the changing of requirements for documentation. The audit questions have had to be revised in order to meet with the new and altered requirements. Focus is on the admission, timely and correct documented assessment and priority processes, screening on different patient needs, information to and education of patients, consent processes, rehabilitation, nutrition and so forth.

Initially, only questions relating to surgery were included, but gradually more and more fields and departments were assessed. During the spring of 2003, the audit questions were revised, which lead to the inclusion of both JCI requirements and legal requirements. During this process a line of questions were rephrased in order to comply with the alterations of CHC's guidelines in the different areas. Some questions became more precise at the expense of being able to compare the responses over time.

The number of questions was approximately 100, and at the audit in September of 2003, 1,417 patient records were included in the sample.

### **Results:**

Aside from the experiences with the process, which clarified the difficulties with developing and phrasing precise and unambiguous questions, which could be answered in all clinics, irrespective of specialty and patient profiles, the patient record audits have brought along a much greater focus on satisfying requirements of Danish legislation as well as in relation to accreditation. An example of this is the recent definition of a goal in CHC describing a patient's rights to get one health care professional coordinator or contact person appointed and that the name of this person be documented in the record. To make this goal a reality has been and continues to be a challenge in day-to-day clinical work. Patient record audits have helped direct focus on this problem. When measured in September 2003, the rate was 49% and when measured in March of 2004, 58%. Patient record audits have also revealed a lack of compliance with Danish legislation's requirements for informed consent for treatment. At the initial time of measuring consent for procedures, such as anesthesia, was never documented, but upon repeated measuring the rate increased to 93% in March of 2004.

### **Conclusions:**

The auditing process has brought along a discussion of how to provide information, both so that it may be understood by the recipient, as well as illustrating the necessity for accurate documentation of informed consent. The latter has been brought about in part due to the patient's compliance with the treatment, and in part due to legal considerations, should the patient complain afterwards. Patient record audits have also resulted in the adjustment and adaptation of guidelines so that requirements for documentation are more concrete and more visible to the health care staff. Guidelines that used to be diffuse and superior are now more action-oriented and explicit.

The work on patient record audits has however revealed that the work on performance improvement is a continuous process. The maintenance of results that have been achieved previously, constitute a challenge, especially when new requirements are placed upon hospitals. We have learned that data must stay in the departments along with data to compare across clinical borders and specialties.