

048: GENERIC CLINICAL INDICATORS - PATIENT RECORD REVIEWS: SELF-EVALUATION OF THE CLINICAL DOCUMENTATION IN PATIENT RECORDS IN COPENHAGEN HOSPITAL CORPORATION (CHC)

Bagger D., Skjøt P., Riisberg K.

Objective:

Joint Commission International accredited all six CHC hospitals in 2002. Many of the accreditation standards focus on the quality of the clinical documentation in the patient records, and the main issues of assessment of patients, nutrition, plan for care of patient, informed consent, pain assessment, medications, patient information and discharge planning. All of which showed plenty of room for improvement.

The objective was to develop a mutual electronic tool for uniform self-evaluation of patient record documentation in all departments and hospitals in the CHC that would enable departments and hospitals to follow local improvements over time and to be able to compare the results across specialities, departments and hospitals.

Methods:

The tool is based on a simple Excel pre-coded spreadsheet, in order to minimise key errors and provide immediate results to the leaders and staff members, with both the present and previous results for comparison. Furthermore, with the spreadsheet a guide for use is provided plus an explanation or clarification of the indicators and questions and links to clinical guidelines and relevant laws.

A few question samples:

B.1 Has primary nutritional screening been performed within the first 24 hours of admission?

B.2 Has nutritional screening been repeated once a week?

B.3.

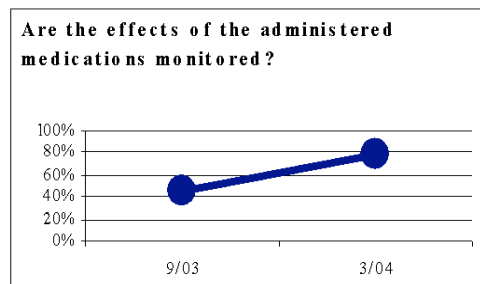
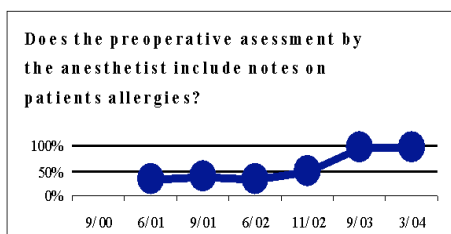
1 If patient has a score larger than 3 - has nutritional therapy been initiated?

B.3. If patient has a score larger than 3 - has nutritional therapy covered more than 75% of the calculated need in 3 out of 4 days?

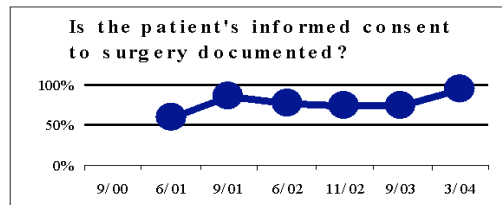
Since 2002, all departments perform an audit twice a year using all 119 indicators on 20 closed patient records (for all CHC = 1,500 records), supplemented when necessary with additional focused reviews on a small number of indicators. Since September 2003, it has been mandatory to use the electronic tool for reporting. Each department designates an interdisciplinary audit team to review the patient records. The results are aggregated on department-, specialty-, hospital and CHC level. To ensure an easy oversight of the many numbers, the results are presented in the sheet with different colours, when below 50% compliance it turns red, below 85% yellow and over 85% black. This helps to identify target areas.

Results:

Below are a few samples of graphs that are drawn from the data collection tool. Improvement of up to 5 - 50% was obtained for 60% of the indicators and reduction in compliance for some 5 parameters. The overall picture is a steady improvement over the last year. These graphs can be aggregated from the tool and if you click on them you are able to obtain more detailed information on a hospital level (on hospital level the graphs are not translated)¹.



¹ In the enclosed excel sheet you can see the way results are presented on hospital level and on CHC level



Conclusion:

By developing a joint tool for evaluation of patient record documentation, the Copenhagen Hospital Corporation now has a unique opportunity to monitor the development of the quality of clinical documentation, and the clinical management has a way to identify target areas and to plan improvement efforts. The results of the record reviews are also essential for the hospitals Quality Committee and governing leaders.