 10.7861/fhj.7.1.s26

A closed loop audit to analyse the documentation by medical and healthcare staff in clinical oncology patients to assess quality of inpatient documentation against a standard set by the GMC and the RCP

Authors: Ghania Ilyas[A] and Andrea D'Souza[A]

Table 1. Number and percentage of entries meeting the parameters

	Ward round						Clinic note					
	Name	%	Bleep	%	Saved	%	Name	%	Bleep	%	Saved	%
May 2019	426/444	95.94	393/444	88.51	420/444	94.59	743/924	80.41	714/924	77.27	863/924	93.39
Oct 2019	173/174	99.4	144/174	82.75	172/174	98.85	420/478	87.86	372/478	77.82	460/478	96.23

Background

The main focus of healthcare delivery is to ensure patient safety while practising evidence-based medicine. While doing so the medicolegal safety of the healthcare professional is also of utmost importance. We noticed that a large number of E-noting entries made for inpatients did not have enough information to ascertain accountability for that entry. This intrigued us to look into set standards for documentation and then compare them to practice generally adopted on the ward to assess if these standards were being met.[1,2]

Aims and objective

The purpose of this audit was to assess the documented entries on inpatient notes, with the aim of improving efficiency, ensuring patient safety and supporting medical professionals in having medicolegally binding documentation.

Method

We conducted a closed loop audit to analyse inpatient e-noting documentation entries, using three main parameters:

- Name of the individual/team making the entry.
- Bleep or contact details of the person/team making the entry.
- Whether or not the entry was saved.

We collected quantitative data on a selected group of individuals (clinical oncology inpatients). The first set of data was collected in May 2019 and presented in an audit meeting in June 2019. We consulted oncology and outlier wards and spoke to healthcare professionals within multidisciplinary teams regarding the importance of accountability and accurate documentation. We have individually emailed allied healthcare professionals to alert them on the importance of being contactable when documenting on clinical records. We waited for 2 weeks after the action and then did a prospective analysis of the documented entries in first 2 weeks of October for clinical oncology inpatients to complete the audit cycle.

Results

The numbers and percentages of entries meeting each of the three parameters are given in Table 1.

Conclusion

Based on the initial audit results, the set standard of 100% documented entries having all three parameters was not met. The re-audit results showed that overall there was a general improvement in terms of names and saved entries. This improved the accountability and safety of both patients and healthcare professionals. However, the ideal of 100% was still not achieved. There is a slight decline in number of entries including bleep numbers, suggesting that more education and training is needed within the oncology department to highlight the importance of medicolegally binding documentation for safe practice. ■

Conflicts of interest

None declared.

Authors: [A]Guy's and St Thomas Trust, London, UK

References

1 General Medical Council. *Ethical guidance for doctors, good medical practice*. GMC, 2013. www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-1—knowledge-skills-and-performance#paragraph-19 [Accessed 25 March 2019].

2 Royal College of Physicians. *Generic medical record keeping standards*. RCP, 2015. www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards [Accessed 25 March 2019].