Introduction

The mission of Joint Commission International (JCI) is to improve the safety and quality of care in the international community through the provision of education, publications, consultation and evaluation services. The 6th edition takes into account developments in science of quality improvement and patient safety as well as the experiences of the organizations to improve the safety and quality of care in their organisation.

Aim

- Improve the standard of clinical records documentation at SGH.
- Ensure case notes and clinical documents become an important reference source in the event of medico-legal cases.
- Enable the hospital to meet the set criteria as per JCI re-accreditation standard.

Methodology

- Development of a detailed requirements and common documentation issues to aid reviewers during the intended review audit process.
- Introduce the 4 main indicators as well as the criteria to our department quality officer (DQO).
- Evaluation audits using proposed HOD reports for our department quality officer would ensure that audit feedback and update is likely to have maximum impact and timely corrective action.

Outpatients

<table>
<thead>
<tr>
<th>Standard Documentation Requirements</th>
<th>Common Documentation Issues/Problems</th>
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<tbody>
<tr>
<td><strong>AOP 1.1 Initial Assessment of Patients</strong></td>
<td>The assessment includes: 1. Health history 2. Physical Examination</td>
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<tr>
<td><strong>AOP 1.5 Pain Assessment of Patient</strong></td>
<td>Patients are screened for pain and assessed when pain is present</td>
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<tr>
<td><strong>MOI 11.1 Authorship, Date and Time</strong></td>
<td>Every patient clinical record entry identifies its author and when the entry was made in the record.</td>
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<tr>
<td><strong>ACC. 3.2 (Documentation of Consultation Notes)</strong></td>
<td>&quot;Consultation notes includes: *Significant findings&quot; *Any diagnosis; *Any procedures performed *Any medications and treatment; *Follow-up instructions.</td>
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Detailed requirements and common documentation errors made are shown in the table above.

Outcome

- Tangible improvement of clinical records documentation after the implementation of HOD reporting to DQO.
- Distinctive improvement shown in data for audit period Apr- Jun 2018 and Oct-Dec 2018.
- Discrepancy and errors are rectified in-situ thus making care delivery safer.
- Physicians are better informed & educated on JCI standards related to documentation.
- Provide feedback and update to the respective department quality officer on improvement on clinical records auditing.
- Ensure constant interaction with our physicians on the results of their department every quarter.