

# Creation of a dynamic audit-feedback-improvement loop to improve clinical records documentation



Singapore Healthcare Management 2016



Singapore General Hospital  
SingHealth

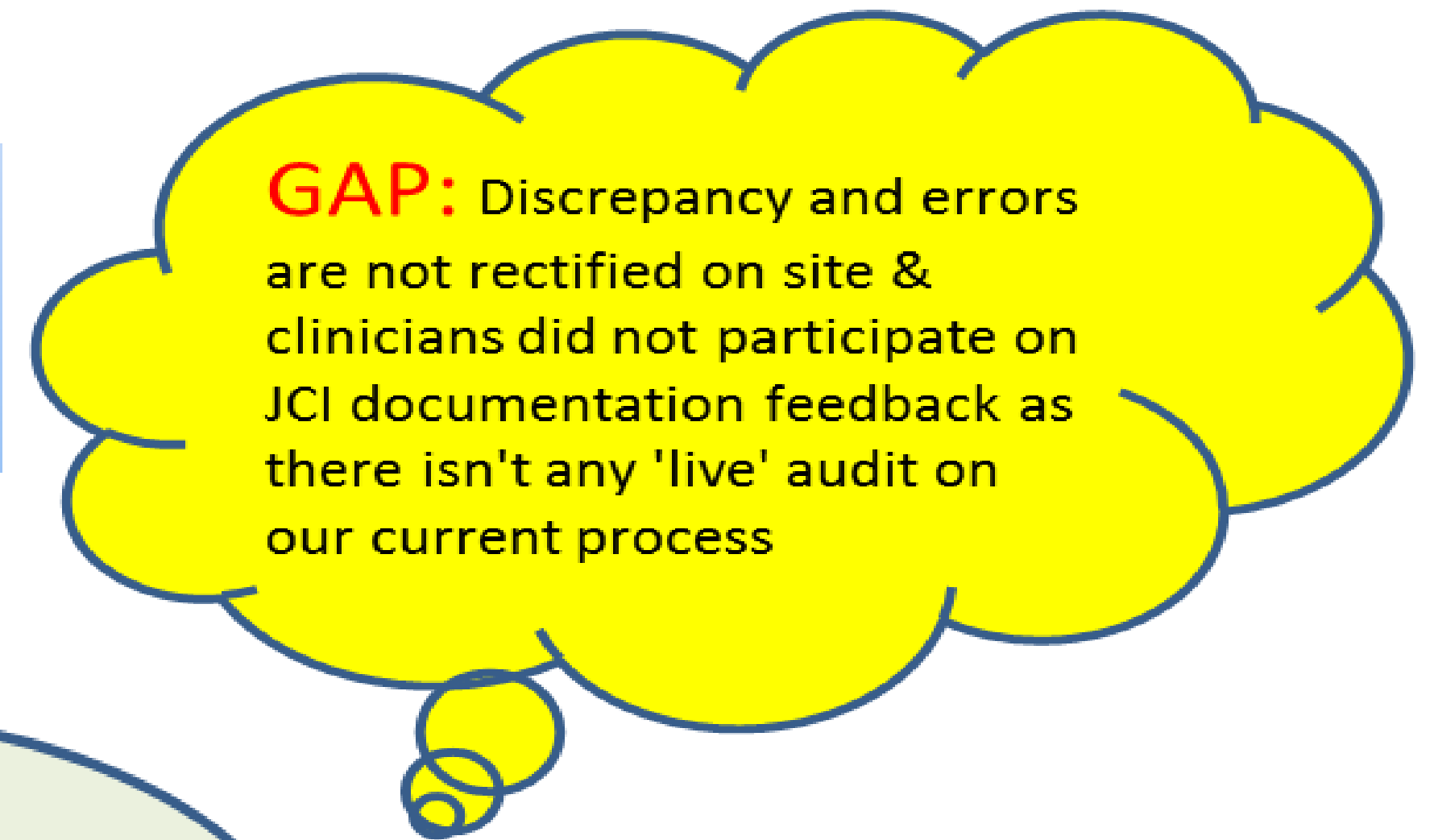
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## Introduction

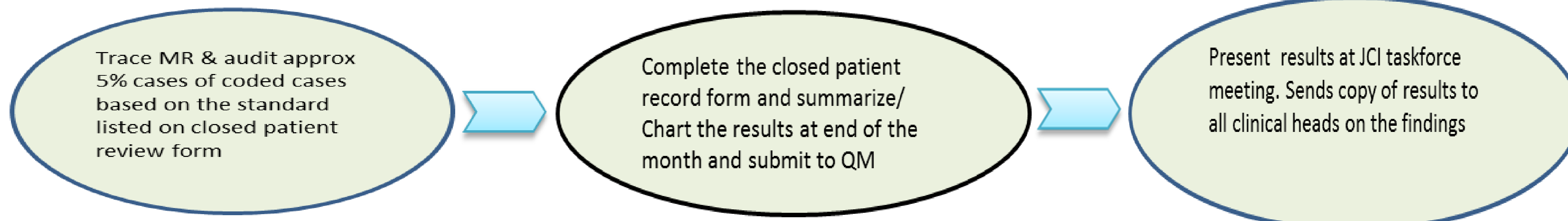
The mission of Joint Commission International (JCI) is to improve the safety and quality of care in the international community through the provision of education, publications, consultation and evaluation services. The intent of MOI.11.1 within the JCI Standards is to ensure that only authorized individuals makes entries in patient clinical records and that each entry identifies the author of the entry, time and date.

## Aim

- Improve the standard of clinical records documentation at SGH.
- Ensure casenotes 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



## Process before intervention



## Methodology

- Development of a detailed template to aid reviewers during the intended open review audit process.
- Evaluation audits using proposed process would be incorporated within patients' journey through the hospital, thus ensuring that audit feedback is likely to have maximum impact and timely corrective action.

Standard Number	Standard Documentation Requirement	No of records audited	MEDICAL					NURSING					ALLIED HEALTH				
			YES	NO	NA	0	1	YES	NO	NA	0	1	YES	NO	NA	0	1
PFR.5	General Consent for treatment obtained and documented when a patient is admitted as an inpatient.	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
AOP.1.3	The initial medical assessments conducted prior to admission to inpatient status are no older than 30 days or the medical history has been updated and the physical exam repeated.	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
AOP.1.5	The initial medical assessment is conducted and documented within the first 24 hours of admission.	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
AOP.1.2	The initial nursing assessment is conducted and documented within the first 24 hours of admission.	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
AOP.1.1	The assessment included: * Health history	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
AOP.1.1	* Physical examination	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
AOP.1.1	* Psychological status	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
AOP.1.1	* Social status	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
AOP.1.1	* Economic status	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
MMU.4	List of medications taken prior to admission	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
ASC.3.2	Pre-admission assessment	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
PFR.5.2	Consent is obtained and documented before the induction of anesthesia	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
AOP.1.3	The medical assessment of surgical patients is documented before anesthesia	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
ASC.5	Anesthesia care is planned and documented	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
ASC.4	Patients are re-evaluated immediately before the induction of anesthesia	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
PFR.5.2	Consent is obtained and documented before the induction of anesthesia	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
ASC.5.1	The risk, benefits and alternatives to anesthesia are discussed with the patient, his/her family, or those who make decisions for the patient	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
ASC.6.1	Arrival and discharge times for post anesthesia care	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
AOP.1.3	The medical assessment of surgical patients is documented before surgery	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
PFR.5.2	Consent is obtained and documented before surgical or invasive procedure	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
ASC.7.1	The risk, benefits and alternatives to surgery are discussed with the patient, his/her family, or those who make decisions for the patient	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
ASC.7.2	Written Surgical Report a) Description of the surgical procedure, findings and any surgical specimens	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
ASC.7.2	b) A postoperative diagnosis	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
ASC.7.2	c) The names of the surgeon and surgical assistants	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
ASC.7.2	d) Available before the patient leaves the post-operative recovery area	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
PFR.5.2	Consent is obtained and documented before the use of Blood and Blood Products	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
ASC.9.1B	Consent is obtained and documented before other high-risk procedures and treatment	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
MOI.11.1	Every patient clinical record entry identifies: 1) author and legibility	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
MOI.11.1	2) date	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
MOI.11.1	3) time (when required)	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
	finding of discrepancy resolve on site	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%

Fig 1 Detailed template



Fig 2 Proposed Process

## Outcome

- Tangible improvement of clinical records documentation after the implementation of active clinical records auditing.
- Discrepancy and errors are rectified in-situ thus making care delivery safer.
- Physicians, nurses & other healthcare professionals are better informed & educated on JCI standards related to documentation.
- Additional active audit of 264 cases yearly, without additional manpower, through streamlined auditing & soft expansion of resources.
- Example OBS compliancy increase from 79% to 85% after the implementation of open review audit.

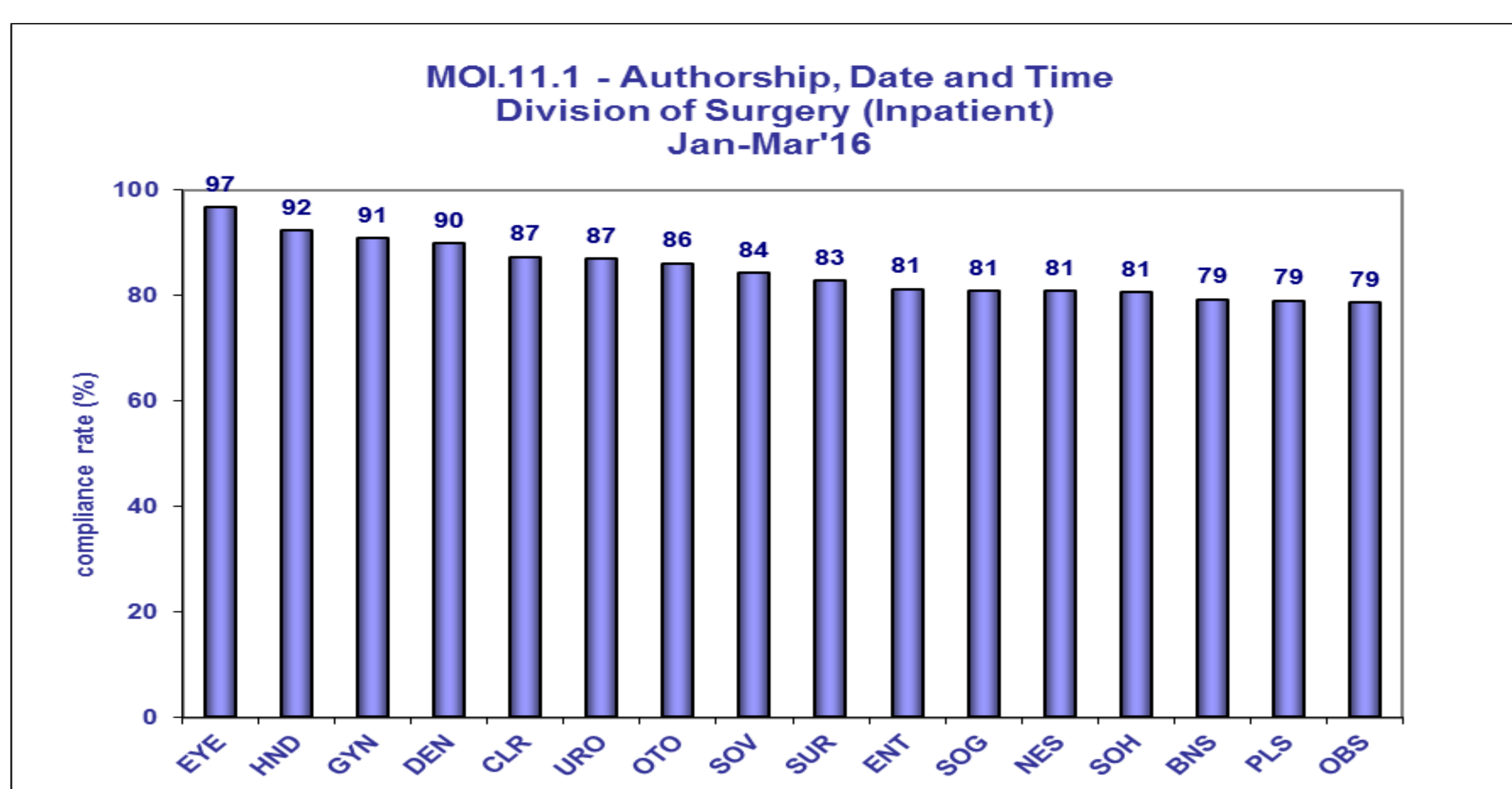


Fig 1 Compliance of Authorship, date and time before implementation of open review audit

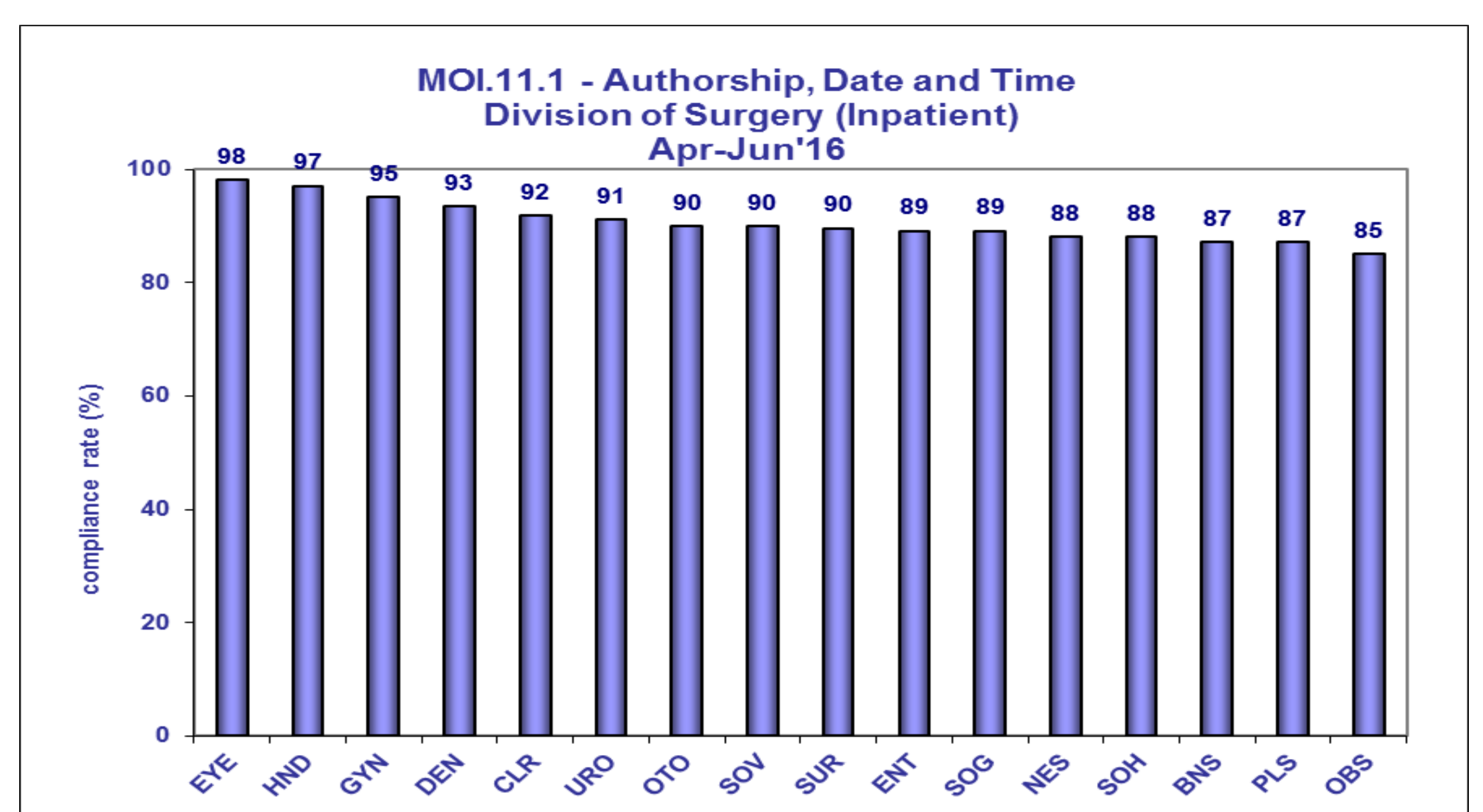


Fig 2 Compliance of Authorship, date and time after the implementation of open review audit