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

Singapore Healthcare Management 2016
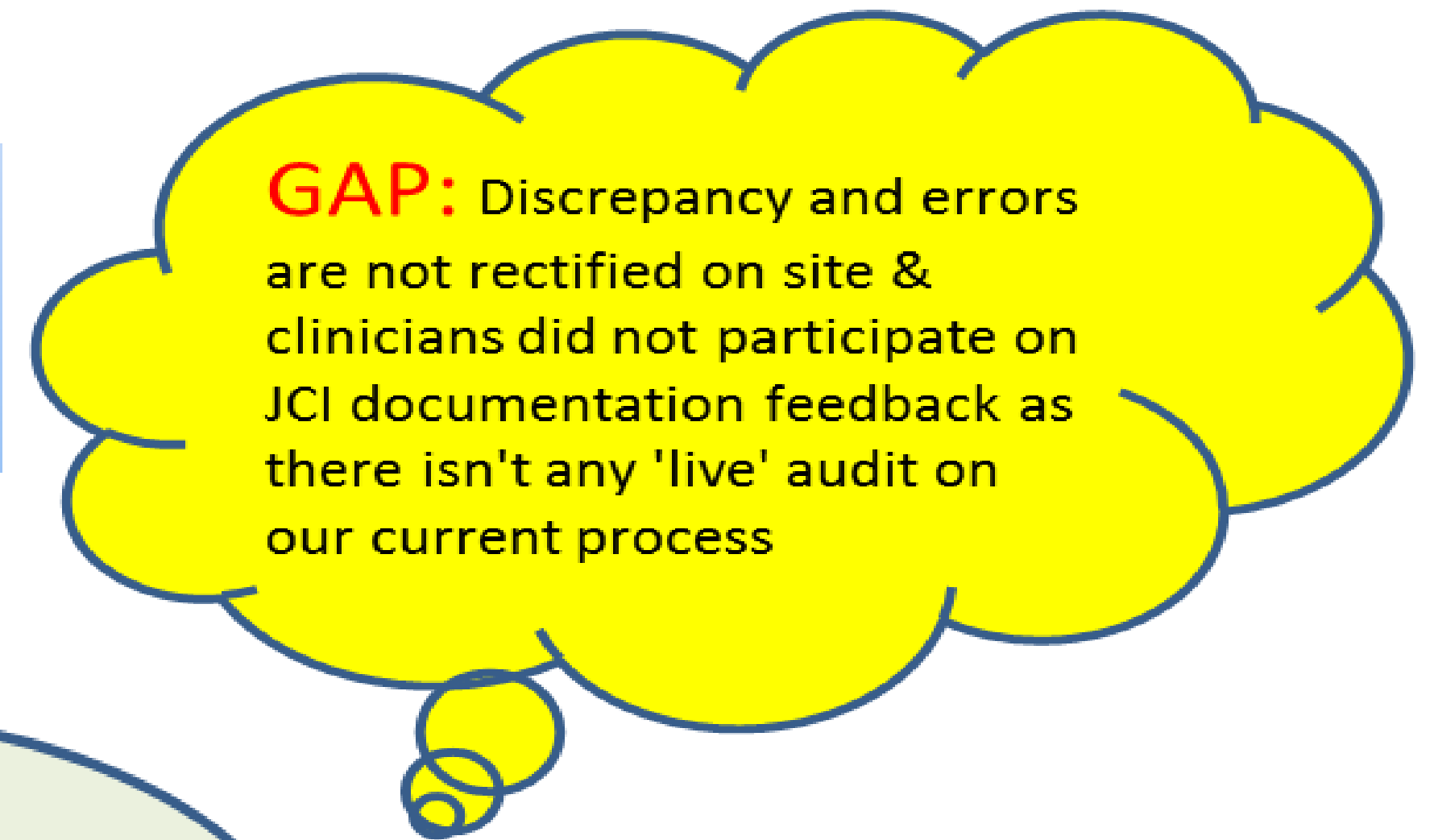
Singapore General Hospital SingHealth

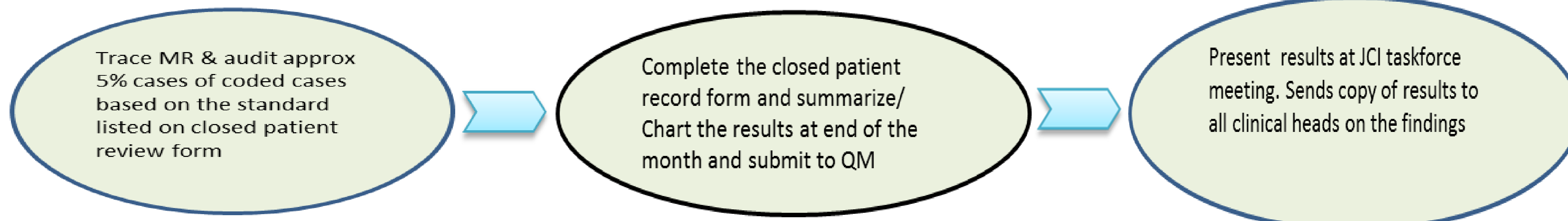Andy Wong, SGH (HIMS)
Anne Goh, SGH (HIMS)

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

GAP: Discrepancy and errors are not rectified on site & clinicians did not participate on JCI documentation feedback as there isn't any 'live' audit on our current process

Process before intervention

Trace MR & audit approx 5% cases of coded cases based on the standard listed on closed patient review form

→ Complete the closed patient record form and summarize/ Chart the results at end of the month and submit to QM

→ Present results at JCI taskforce meeting. Sends copy of results to all clinical heads on the findings

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.

Fig 1 Detailed template

Table Agenda in Mar, June, Sep, Dec Department meeting.

1st agenda (15min), to review active casenotes

Invite Nursing, AHP, HIMS

2 Active Cases* to be bought in by the NM

Using Checklist

Findings will be recorded in Meeting Min

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.
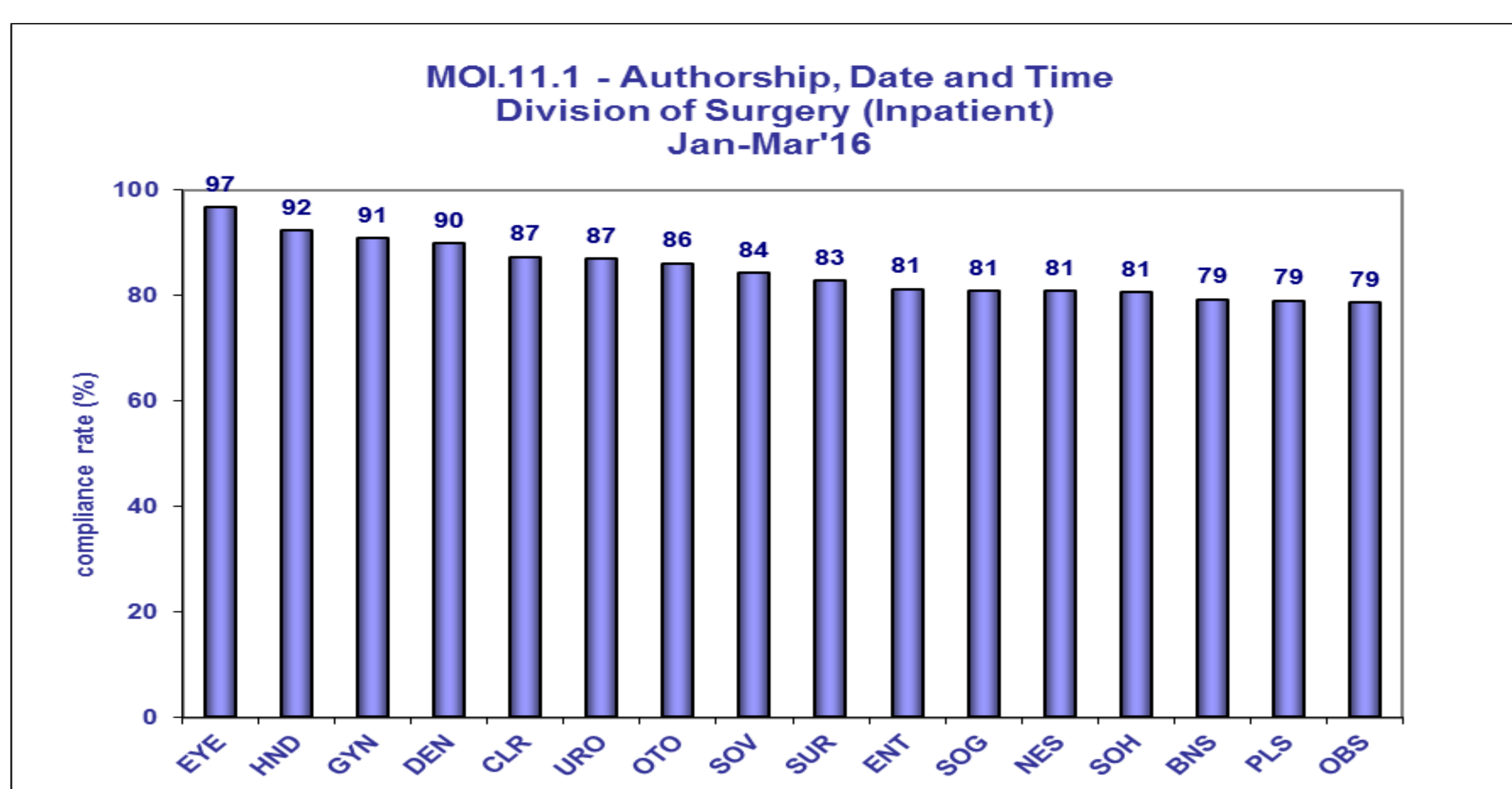- Example OBS compliancy increase from 79% to 85% after the implementation of open review audit.

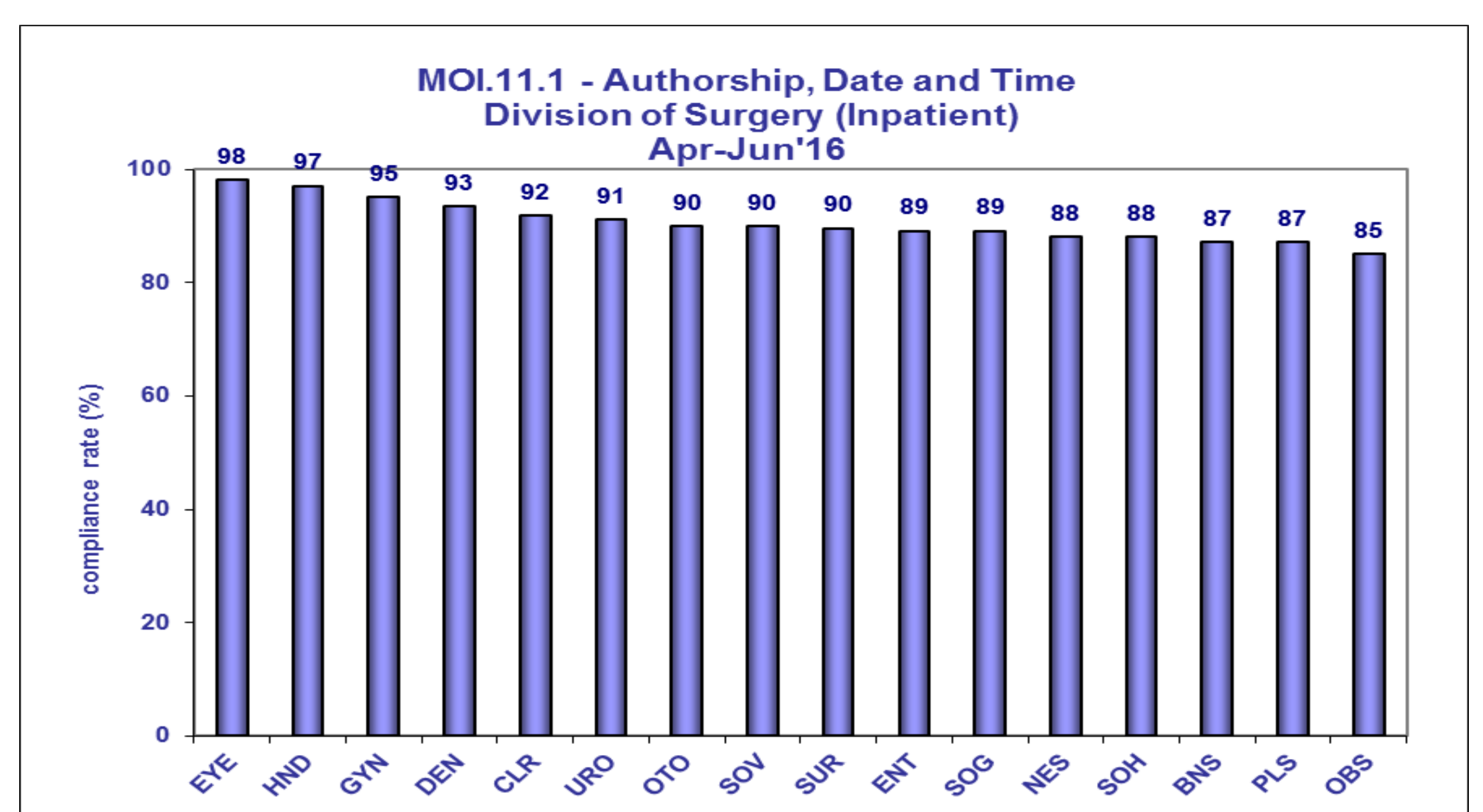Fig 1 Compliance of Authorship, date and time before implementation of open review audit

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