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Locarno Regional Hospital
is an organization Accredited by JCI

Strategies around clinical records

Background

The goal of the project has been to improve the quality of patient records completion in terms of completeness, legibility of clinical and care activities also recording of inpatients and emergency room patients medical records.

Besides being a tool for the assessment and monitoring of patient clinical conditions, patient records play an increasingly important role in clinical risk management. A complete and legible patient record which is readily available and up to date, improves integration among health care professionals, ensures efficient delivery of patient care, and is more likely to reduce errors and patient safety risks.

The patient records of the Ente Ospedaliero Cantonale (EOC) hospitals were consistently monitored in the years from 2000 to 2006 as part of the quality audits run by the quality department. However, although the results of monitoring did highlight some deficiencies in the appropriate utilization of patient clinical records, they did not provide the hospital leaders with any clear direction on the areas to improve. The problem was quantified by means of quality audits and through the reports sent by staff and tracked by the organizational incident reporting system.

Methods

In order to improve recording and entering legibility of clinical and patient care activities, the Locarno Regional Hospital developed a monitoring system based on a retrospective analysis of a random sample of patient records, as part of the wider EOC pilot project on "Accreditation according to the Joint Commission International quality standards". In order to make the system fully operational and to implement the improvement strategies, an interdisciplinary hospital committee was set up at the Locarno Hospital, with the task of supervising and coordinating all the problems concerning patient records. The work done by this Committee was sustained by ongoing and targeted awareness and supervising activities carried out by senior physicians and head nurses on appropriate patient records keeping.

Based on patient record documentation, the Committee has elaborated an evaluation chart (figure 1) containing a list of requirements regarding the entering of clinical documentation, more specifically 40 requirements for ER patients records and 72 requirements for inpatients records.

The requirements are furthermore subdivided according to the documentation typology and applicability criteria have been defined for each of them (eg. patients with surgical procedure). Both "Completeness" and "Legibility" are to be evaluated for each requirement.

The analysis has been retrospectively performed every four months by the committee for medical records reviewed on samples of closed cases. Altogether, from April 2007 till July 2008, 452 inpatient medical records have been analyzed (equally divided in the main 10 medical disciplines of Locarno Hospital) and 200 ER patients medical records.

Ospedale Regionale di Locarno
La Carità
INPATIENT RECORD EVALUATION ACCORDING TO JCI STANDARDS

M-GQ-038/H

Auditor 1: ……………………… Auditor 2: ………………………
Auditor 3: ……………………… Clinical discipline: ………………………
Medical record n.: ……………………… Unit: ………………………
Date of audit: ……………………… Admission type: ❑ Urgent ❑ Planned

Medical record evaluation tool

ID	Ref.	Content requirements	Evaluation criteria					Note
			Completeness				Legibility	
			Complete	Incomplete	Missing	not applicable	not legibile	
General								
1	§ 1.1.4	**Clinical statistics intra-muros, nursing data**						
2	§ 1.2.1 MCI 19.1 EM. 1	**Patient personal data/Patient ID label (patient identification data on each document in the medical record)**						
3		**Critical information for hospitalization**						
3.1	§ 1.3.2	**Name of General practitioner and/or sending physician**						
3.2	§ 1.5	**Sending physician's summary**						
Admission								
4	§ 1.7	**Medical history**						
4.1	MCI 19.3	• Author and date of medical entries						
4.2	AOP 1.5 EM 3	• Initial medical assessment is documneted within 24 h of patient admission						
5		**Initial nursing assessment**						
5.1	MCI 19.3	• The author, date and time of every entry						
5.2	AOP 1.5 EM 1	• Reason of hospitalization						
5.3	AOP 1.5 EM 1	• Social information						
5.4	AOP 1.5 EM 1	• Allergies or sensitiveness to medications or other substances						
5.5	AOP 1.5 EM 1	• Values and beliefs (religion)						
5.6	AOP 1.8.2 EM 3	• Pain assessment at admission						
5.7	AOP 1.8.2 EM 3	• Pain intensity is measured and documented						
5.8	AOP 1.8.2 EM 3	• Pain character, frequency, location, and duration						
5.9	AOP 1.8.2 EM 3	• When found; pain regular reassessment and follow-up (see also pain form)						
5.10	AOP 1.5	• Consciousness and perception						
5.11	AOP 1.6	• Fall-risk assessment						
5.12	AOP 1.6	• Nutritional screening						
5.13	PFE 2	• Education need assessment						
5.14	AOP 1.5 EM 3	• Assessment findings are documented within 24 h of admission						

Figure 1 - Inpatient medical record evaluation chart (page 1 of 4)

In order to analyze the results, an indicator was developed to measure the completeness of surveyed patient records, to be tracked every four months on the basis of the results of audits. In order to accurately assess the effect of every single implemented improvement strategy, the indicator is calculated for the entire patient record as well as for the individual documents comprising the patient record.

Results

Due to ongoing monitoring, improvement actions, and to important awareness and education activity involving medical and nursing staff, a substantial improvement in the quality of patient record completion was obtained over the 15 month period when the patient records review system was in place. In particular, the level of completeness of inpatient records increased from the first data point of 18.75% in April 2007 to the last data point of 97.85% in July 2008 as shown in figure 2.

The completion of single document within the medical record has also improved. In particular, by comparising data from the last audit in July 2008 to those found during the audit in April 2007 (figure 3), almost all documents in the patient record appear to be over 90% complete.

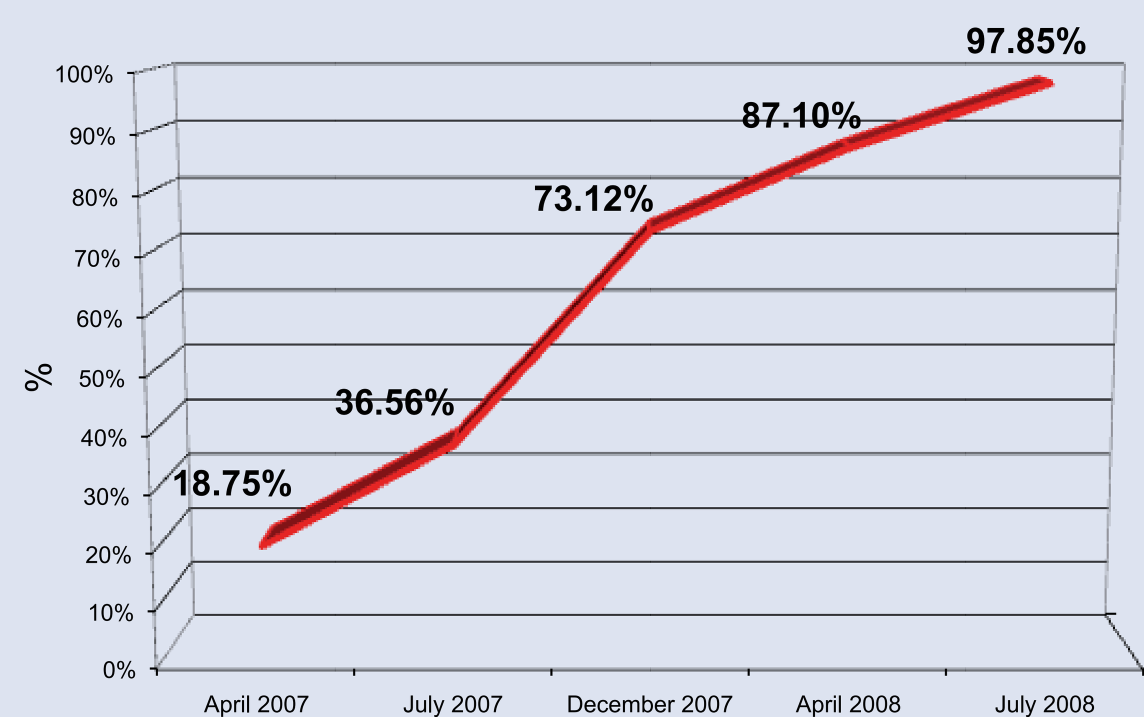

Figure 2 - Level of completeness of inpatient records

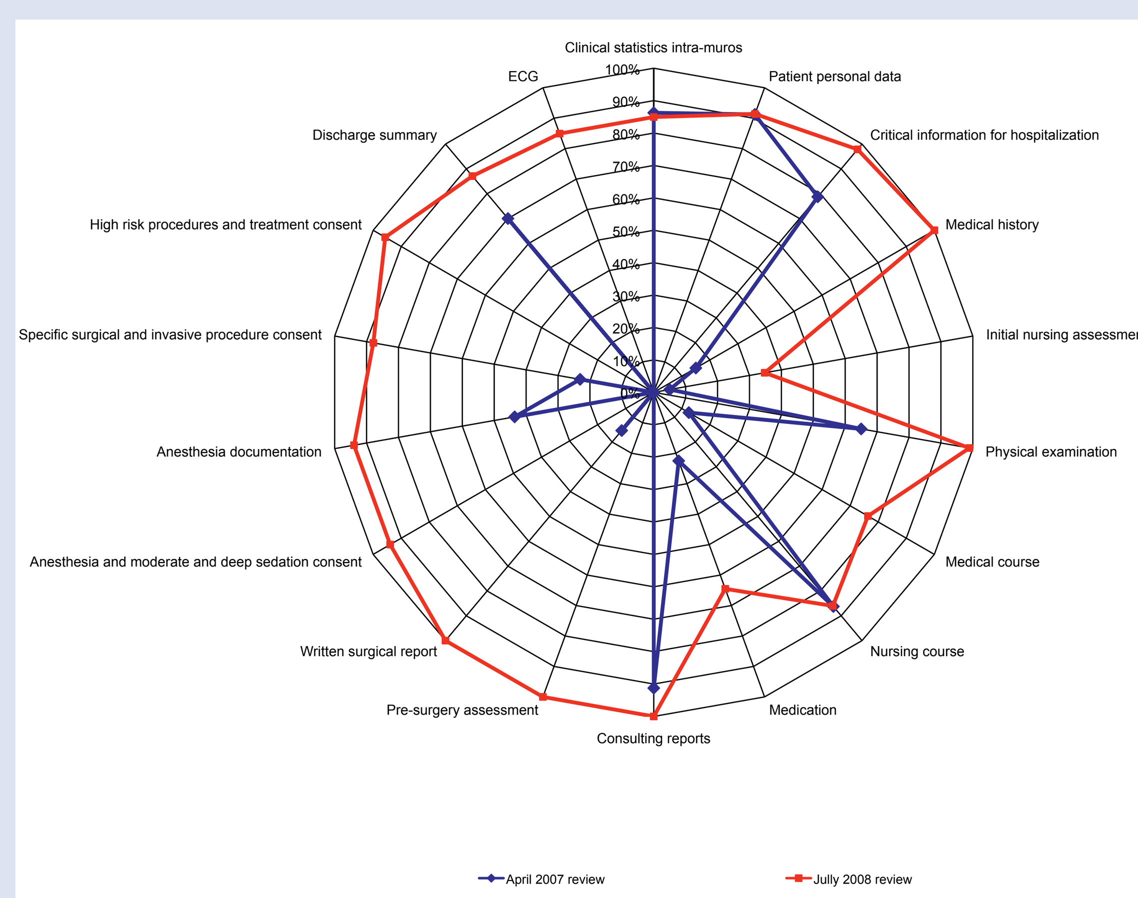

Figure 3 - Medical records general completeness

Figure 4 - Hospital poster campaign

Conclusion and discussion

The lesson that can be learnt from this project is that you need to deploy a set of strategies requiring both top-down and bottom-up interventions in order to improve the completeness and legibility of patient clinical records. The experience was so positive that we will probably repeat it again.

We would like to share the strategies that allowed us to achieve these results:

- ✓ **Clear and precise goals**
- ✓ **Work method and clear standards for reference**
- ✓ **Third-party authority** (JCI) to overcome the institutional self-regarding nature
- ✓ **Incentive** (the will to achieve JCI accreditation)
- ✓ Choice of **charismatic individuals** as part of the patient records review committee
- ✓ Persistent **identification of** new **areas for improvement**
- ✓ **Ongoing staff education**
- ✓ Communication strategy: **poster campaign** on hospital wards
- ✓ **Reassessment of the evaluation tasks assigned to the Various professionals** in order to eliminate redundancies
- ✓ **Adaptation and simplification of patient records**
- ✓ **Intensive supervision** by senior physicians and head nurses

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