Snapshot audit of documentation compliance Ward F10, Royal Oldham Hospital

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Background

High quality documentation in clinical records allows all health professionals involved in management of a patient to work in collaboration. This collaboration means that patient safety and delivery of high quality care can be maximised.

Ward F10 is a general medical ward in a busy district general hospital. There is a high turnover of patients and junior doctors. A snapshot audit of the ward's compliance to documentation standards was carried out in order to assess the current level of compliance and identify areas for improvement.

Methods

Data were collected from all (24) ward patients' notes on a specif c day using a proforma related to the six key areas:

- Venous Thromboembolism prophylaxis
- Antibiotic Prescribing
- DNACPR documents
- Estimated Date of Discharge
- Discharge Summary
- Family Update

Standards were taken from Trust policies which are derived from GMC, NICE and the Royal College of Physicians guidance.

Target compliance for standards was 100%.

Results

Venous Thromboembolism:
Compliance to policy for risk assessment was 100% and 96% were given the appropriate dose.

Antibiotic prescribing:
100% were prescribed according to hospital policy, with an end date documented.

DNACPR documentation:
Compliance with consultant signature and documented discussion were 70%. No information leaf ets were given.

Discharge summary:
96% of discharge summaries were started during admission but only 78% were completed within 24 hours of discharge.

Next of kin update:
71% of patients had a documented NOK update.
Estimated Discharge Date documented:
Compliance 100%.

Key Messages

Trust information booklet for patients/families relating to DNACPR decisions identif ed and encouraged as a resource to use when discussing these.

Teaching of all medical staff to remind importance of starting discharge summaries during admission (ideally on ward round), ensuring that in case of weekend discharge and patient death summaries are still completed within 24 hours.

Trial of “new-patient checklist” on ward as a prompt to ensure all aspects covered for ward round. Re-audit during April-August 2014 placement.

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NHS
The Pennine Acute Hospitals NHS Trust

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