Maintenance of Patient Records in Tallaght University Hospital Psychiatric Unit

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Background:
This audit was conducted in accordance with regulations from the Mental Health Commission in relation to maintenance of patient records in approved centres. These regulations are covered in the 'Judgement Support Framework' under section 27. The Judgement Support Framework was developed as a guidance document to assist approved centres to comply with the Mental Health Act 2001 (Approved Centre) Regulations 2006. The Framework promotes the continuous improvement of the quality of services provided to residents of approved centres.

Aims:
The purpose of this audit was to evaluate how the maintenance of patient records in Tallaght acute psychiatric unit complies with these regulations.

Methods:
- A retrospective review of patient charts on the inpatient unit was conducted in August 2020, analysing each chart for compliance with the regulations as set out by the judgement support framework.
- Charts were chosen at random from the 3 inpatient wards.
- A second retrospective review of patient charts was completed in December 2020 following the implementation of corrective measures identified following the first review.
- The data of the two reviews was compared to evaluate the effectiveness of the corrective measures implemented.

Results:
- 16 charts were reviewed in the first audit cycle and 13 charts in the second audit cycle.
- Graphs were generated to illustrate the percentage compliance for each criteria and compare the findings of the first and second audit cycles.

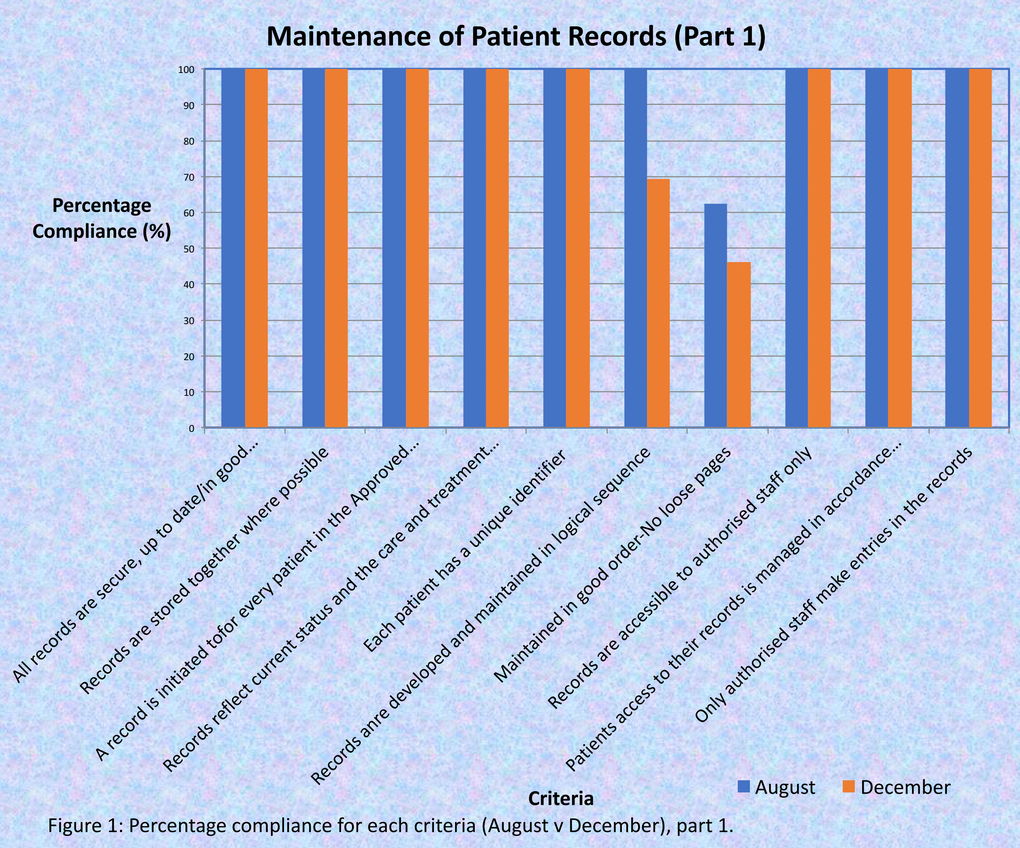

Figure 1: Percentage compliance for each criteria (August v December), part 1.

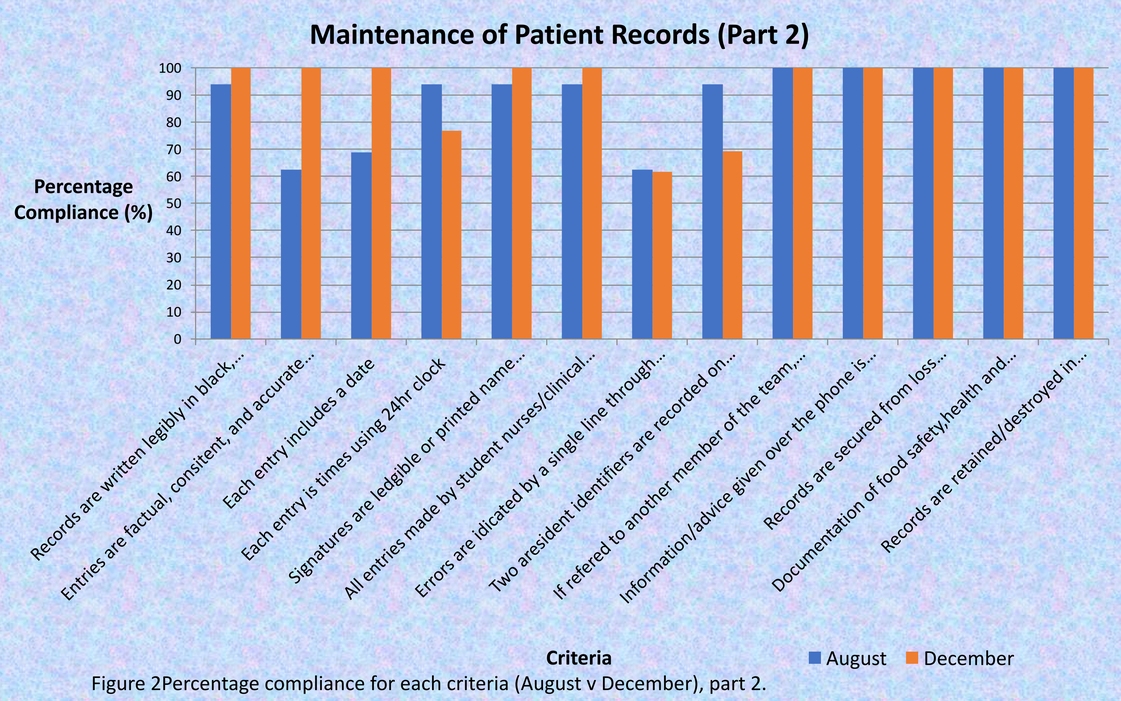

Figure 2Percentage compliance for each criteria (August v December), part 2.
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Discussion:
First Audit Cycle:

Criteria which scored lowest in the first audit cycle included:
- Maintained in good order, No loose pages (Scored 62.5%): 6/16 charts contained loose pages and were not maintained in good order.
- Entries are factual, consistent, and accurate and do not contain jargon, unapproved abbreviations (Scored 62.5%): 6/16 charts contained jargon and unapproved abbreviations. Abbreviations that would be comprehensible to all staff accessing the record were accepted. Examples of unapproved abbreviations included TRS (treatment resistant schizophrenia), FTD (formal thought disorder) etc.
- Each entry includes a date (Scored 68.75%): 5/16 charts contained entries that had no date assigned.

Requirements which did not reach full compliance (Scored 93.75% in all the below requirements):
- Records are written legibly in black, indelible ink.
- Signatures are legible or printed name accompanies illegible signatures.
- All entries made by student nurses/clinical training staff are counter signed by registered nurse/clinical supervisor.
- Two resident identifiers are recorded on all documentation.

Implementing change:

Documentation education was delivered to all members of staff who are involved in the maintenance of patient records or who make clinical entries in patient records. The documentation education focused on the regulations for maintaining patient records as specified in the judgement support framework, the importance of compliance and the audit results, particularly criteria in which, we scored lowest.

2nd Audit Cycle:
Key Findings:

Improvement:
- 100% of charts were compliant with criteria 'Entries are factual, consistent, and accurate and do not contain jargon, unapproved abbreviation' in December compared to 62.5% in September.
- 100% of charts were compliant with 'Each entry includes a date' in December compared to 69% in September.

Disimprovement:
- 69 % of charts were compliant with criteria 'Records are developed and maintained in logical sequence' in December compared to 100% in September.
- 46 % of charts were compliant with criteria 'Maintained in good order-No loose pages' in December compared to 62.5% in September.
- 80 % of charts were compliant with 'Each entry includes a 24hr time' compared to 94% in September.

Consistent Results:
- The results on 'Errors are indicated by a single line through the error and the correction written alongside with date, time and initials' were largely consistent with 62.5% compliance in September and 61.5% compliance in December.

Conclusion:

Despite ongoing monitoring of maintenance of patient records by auditing on a monthly basis and the implementation of corrective measures to make improvements through use of documentation education and circulating audit results to staff, the results of this audit are inconsistent from month to month with some areas improving and others disimproving. These results support the implementation of more robust measures to improve maintenance of patient records and ensure compliance with regulations. Electronic patient records are likely to be a reliable solution to this problem.

Further identified work:

Development of an official list of approved and accepted acronyms for use within the approved centres of the mental health service.

** Clinical audit consent received from the clinical director of the acute psychiatric unit, Tallaght University Hospital.*