Improving Documentation in Acute Medicine

Dr James Goodman, Dr Iona Thorne and Dr Helen Burgess
james.goodman@doctors.org.uk
West Middlesex University Hospital, Twickenham Road, Isleworth, Middlesex, TW7 6AF.

Objective
The documentation of medical admission clerking at the West Middlesex University Hospital (WMUH) was previously recorded on unstructured continuation sheets. There was no standardisation for medical clerking, the post take ward round or prompts to assess important parameters e.g. VTE risk assessment or level of resuscitation for patients admitted under the acute medical take. This lead to wide and often unsatisfactory variations in the quality of documentation, resulting in ineffective handover of care and downstream planning for diagnostic investigations and discharge. Poor compliance with CQUIN targets e.g. VTE assessment on admission resulted in financial penalties for the hospital trust. Our aim therefore, was to improve documentation and thus improve the quality of admission clerking to aid handover and improve patient care.

Methods
The quality of documentation for acute medical admissions was audited in June 2012. Twenty standards for documentation were audited in the initial medical clerking, and twelve standards audited in the documentation for the post take ward round. The standards audited were derived from recommendations from several sources:

- Nice guidance for VTE risk assessment
- The Royal College of Physicians 'Generic Clinical Record: Keeping Standards': and The Acute Medicine Terminal of the Royal College of Physicians
- Diabetes UK specialist foot care report

An audit was conducted over two weeks on the acute medical unit, involving a number of different levels of trainee doctors and consultants. The admitting medical teams were not informed of the ongoing audit.

Data Analysis
Twenty four sets of notes were initially audited; results are shown in red in the above bar chart. These revealed consistently poor documentation, both at clerking and the post take ward round. Problem lists were only documented in 50% of cases and a working diagnosis on the post take ward round was documented in only 18%.

Implementation
Using the results from the audit, key issues around documentation, handover and downstream planning were identified. The need for a standardised 'clerking booklet' (proforma) was therefore identified as recommended by the Royal College of Physician’s Acute Medicine Task Force and other professional organisations.

Conclusion and Further Work
Further audits of the standardised medical admission clerking proforma will be necessary to:-

- Ensure standards are maintained.
- Examine the effect on length of stay.
- Assess patient satisfaction.
- Formally evaluate other suggested standards.
- Assess impact on quality of information communicated to GPs on patient discharge.

In conclusion, the audit has demonstrated that the use of a standardised medical admission clerking proforma:-

- Improves the quality of documentation of admission medical records in nearly all standards assessed.
- Captures important data and increases compliance for three CQUIN targets (dementia screening, delirium screening and VTE assessment) thereby reducing financial penalties for the trust.
- Improves the quality of post take ward rounds.
- Facilitates discharge planning.
- Increases doctor satisfaction in acute medicine.

References

Three pages from the clerking booklet are shown above. This was designed to incorporate current recent recommendations previously described by various medical organisations.