Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	20 October 2020
TEITL YR ADRODDIAD: TITLE OF REPORT:	Royal College of Physicians Medical Records Keeping Standards (Reasonable Assurance) Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr Philip Kloer, Medical Director and Deputy Chief Executive
SWYDDOG ADRODD: REPORTING OFFICER:	John Evans, Assistant Director, Medical Directorate Lisa Davies, Clinical Effectiveness Co-ordinator

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Internal Audit Royal College of Physicians (RCP) Medical Record Standards report was first brought to the Audit & Risk Assurance Committee (ARAC) in December 2018 for discussion, with updates on progress in relation to the report's recommendations provided to ARAC in October 2019 and April 2020.

This report constitutes a further update on progress, as requested at the ARAC meeting held in April 2020.

Cefndir / Background

During discussion at the ARAC meeting in October 2019, assurance was sought on the audit report recommendations. The following proposals were discussed and agreed:

- A yearly audit by specialty, with responsibility for the audit and reporting the outcomes to be held by Clinical Leads.
- Yearly specialty record keeping audits to be included on the clinical audit forward plan and supported by clinical audit.
- Outcomes reported through Directorate Quality and Safety meetings.
- The Clinical Record Keeping Policy should be updated to show reference to the cyclical audit programme, and to highlight accountability for implementation, monitoring improvement and reporting outcomes.

Additionally, a Record Keeping Audit Working Group has been convened to take an oversight of this work. The Group proposed the following additional areas of focus:

- Development of an e-learning module – Good Record Keeping Practice for Clinicians – RCP Standards.
- Provisions for exploring a digitalised system in the future.
- Continuing Professional Development (CPD) record-keeping training course.
- Quality Improvement (QI) Leads at hospital sites to take a lead role, working with Hospital Directors and clinical leads in order to progress the audit.

- Consideration of non-medical staff who contribute to health records

It was acknowledged at the April 2020 meeting of ARAC that progress with the actions agreed had been hampered due to the deployment of key staff to focus on the COVID-19 pandemic response. However, it was noted that this work would resume following the COVID-19 pandemic, when working arrangements return to normal.

It is noted that the ARAC response from October 2019 was concerned that the Medical Records work is considered in conjunction with the ongoing Clinical Coding issues. A collaborative report has been considered; however, owing to the COVID-19 response, elements of this work have progressed separately and due to the number of recommendations relating to the Audit Wales Clinical Coding Follow-up, this is addressed in a separate paper.

National / local objectives involved

- RCP Standards for Clinical Note Keeping
- Health & Care Standards –3.1 Effective Care
- Health & Care Standards – 3.5 Record Keeping
- Health & Care Standards – 4.2 Patient Information
- UHB Strategic Objectives 9 & 10

Asesiad / Assessment

Progress was resumed at a focused meeting of the Record Keeping Audit Working Group on 11th August 2020. The Group discussed the progression of both the original audit report recommendations, and additional actions proposed subsequently.

A summary of progress against the recommendations/actions is outlined below:

Yearly Audit by Specialty

It has been agreed that a yearly record keeping audit by specialty will be undertaken, with Clinical Leads to take responsibility for the audit and reporting of outcomes. The yearly specialty record keeping audits are to be included on the clinical audit forward plan and supported by clinical audit. Progression of the specialty audits has been delayed due to a number of factors, including the pandemic response; a delay to the appointment of Quality Improvement site leads; and a conscious decision to wait until quality improvement activity can be progressed prior to re-audit.

Since this work has resumed, the previously agreed further audit of the Withybush General Hospital results (to be undertaken and reported back via the Effective Clinical Practice Sub-Committee - now dis-established and replaced with a Working Group - and to ARAC) has been progressed. A meeting was held with the Clinical Director for Clinical Audit and the Quality Improvement Lead at Withybush on 21st August 2020 and it was agreed that, in order to inform a quality improvement plan to address the findings of the previous audit, a re-audit would take place during September 2020. Whilst the re-audit would not necessarily be able to demonstrate the impact of quality improvement actions taken, it would identify any change in the previous position, and highlight priority areas for improvement. This approach will be piloted at Withybush with a view to roll out across all sites, with the support of the Quality Improvement Site Leads and Clinical Director for Clinical Audit.

Accordingly, a sub-group has been formed at Withybush, and an action plan has been developed. The Clinical Director for Clinical Audit wrote to the Hospital Director and General Manager requesting permission to audit 10 sets of notes from each Hospital ward, over a

seven day period during mid-September. A number of Junior Doctors were successfully recruited by the Quality Improvement Lead to undertake the audit, and the RCP audit tool was utilised to prospectively audit 92 records. Findings from the audit have been analysed and show an improvement across several of the standards:

RCP Standard audited to: Average % score of all records		**WGH Audit 2020**	**WGH Audit 2019**
Standard 2:	No. of patients first and last name on each page	**57%**	**54%**
	No. of pages with patient's NHS number or other unique identifier	**60%**	**46%**
Standard 3:	Compliance with standardised structure of health record, following the organisational protocol	**80%**	**40%**
Standard 4:	Documentation reflecting continuum of patient care and in chronological order	**87%**	**35%**
Standard 5:	Initial assessment handover recorded on standardised proforma	**50%**	**40%**
	Discharge summary recorded on standardised proforma	**50%**	**30%**
Standard 9:	Record of change of consultant recorded and dated	**86%**	**100%**
	Record of change of consultant time recorded	**66%**	**100%**
Standard 6:	Percentage of written entries that have the date recorded	**97%**	**91.5%**
	Percentage of written entries that have the time recorded	**80%**	**67.5%**
	Percentage of written entries that have a signature	**95%**	**86%**
	Percentage of written entries that have a legible printed name recorded	**79%**	**46.5%**
	Percentage of written entries that have a legible printed designation recorded.	**67%**	**33.5%**
	Percentage of deletions/alterations that are countersigned	**2%**	**33%**
	How many deletions/alterations were dated?	**0%**	review raw data
	How many deletions/alterations had the time recorded?	**0%**	review raw data
Standard 8:	How many written entries indicate the responsible lead professional was present?	**64%**	**47.5%**
Standard 10:	Identified time period gaps between entries in patient's record	**- ***	**20%**
	Where there is an identified gap, an explanation has been provided?	**100%****	**0%**
Standard 12:	Decision of 'DNR' recorded clearly	**67%**	review raw data
	Decision of 'DNR' recorded clearly with decision maker clearly identified	**65%**	review raw data
	No of health records audited	**92**	**c. 20**

** only one entry identified on those wards where identifying a time period gap is essential. All other entries were either compliant or it was not applicable to that ward - 5/10 wards fully compliant, 1/10 wards where there was 1 identified time gap entry in 1 of the 10 notes audited, and 4/10 wards stated this was not applicable.*
*** the one entry had an explanation of why there was a gap in reporting therefore met the standard*

It should be noted that there was a large difference in the number of health records audited as part of the 2019 Withybush audit (circa 20) and the re-audit, which makes comparison difficult. Furthermore, analysis of the re-audit data highlighted queries with how the data was recorded which may potentially skew the analysis by demonstrating lower levels of compliance with some standards. This may be due to a lack of understanding around usage of the audit tool (i.e. recording a 'no' response where an 'n/a' was required). This was rectified when the data was analysed for the 2020 audit, however these issues may have also been present for the 2019 audit, making a comparison more challenging. The raw data from the 2019 audit is being reviewed and will be cleansed accordingly. However this has highlighted the need to provide specific awareness raising and training around usage of the tool, to improve the accuracy of data collection for future audits undertaken. Training resources will be prepared for this purpose.

Whilst there has been marked improvement in compliance with several standards, the following areas remain a concern and require targeted improvement or further investigation:

- Compliance with *Standard 2 - Every page in the medical record should include the patient's name, identification number (NHS number) and location in the hospital* – continues to show lack of improvement;
- Whilst evidence of compliance with *Standard 5 - Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma* has shown some improvement, the compliance remains unacceptably low. Those wards that did use standardised proformas showed full compliance; however, the lack of standardisation requires further investigation;
- Some improvement has been made in relation to *Standard 8 - Every entry in medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made* however, further improvement is required;
- Investigation into lack of compliance with the deletions/alterations aspects of *Standard 6 – Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed*. Whilst there were few deletions/alterations made within the records audited, compliance with the standard was generally low;
- In relation to *Standard 10 - An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why* – further investigation is required to review wards reporting that they did not have a protocol for time period gap reporting and so it was not applicable to that ward, as this is impacting on ability to meet the Standard.

The audit findings will be presented at a number of hospital-wide meetings, including the next Whole Hospital Audit Meeting. This will further raise awareness of the RCP Standards and the importance of good record keeping, in order to generate improvements in compliance.

The audit findings will inform the further quality improvement activity necessary to deliver improvements during the next six months. This was discussed with the local Quality Improvement Team at a meeting on 30th September 2020. Planned activity includes:

- Identifying differences across wards and targeting improvement activity accordingly;
- Identifying whole-hospital trends;
- Awareness raising of good record keeping at ward level/specialty;
- Promotion of a Good Record Keeping Practice for Clinicians – RCP Standards module (see below);
- Aide memoires on good record keeping practices – posters, business cards;
- Roll out of stamps (see below)

A further snap-shot audit will be completed in six months to demonstrate the impact of quality improvement activity on site.

Now appointed, the Quality Improvement Site Leads will work with Hospital Directors and clinical leads in order to progress improvements in Record Keeping, as an identified priority. This will include support for the speciality audits, as previously agreed. This work will be progressed in Withybush initially, with a view to rolling out experiences and lessons learned across all sites, via the Quality Improvement Leads.

Structure for Reporting Audit Outcomes

It has been agreed that the specialty audits will be reported through Directorate Quality and Safety meetings, and that the Quality, Safety & Experience Assurance Committee (QSEAC) will be the forum through which issues will be escalated.

Subsequent discussions have taken place at Executive level regarding quality and safety structures, including the introduction of standardised agendas for directorate/site quality and governance meetings. It is proposed that the standardised agenda will include a requirement to report on local RCP Record Keeping audits at specialty level periodically, under the Effective Clinical Practice agenda item. Issues can be escalated to Operational Quality, Safety and Experience Sub-Committee (OQSESC) and QSEAC where necessary.

Update to the Clinical Record Keeping Policy

The review of the Clinical Record Keeping Policy has been discussed with the Assistant Director of Digital Services and Health Records Manager. Discussion focused on three key areas:

- inclusion of reference to a cyclical record keeping audit programme, which will highlight accountability for implementation, monitoring improvement and reporting outcomes;
- potential inclusion of the RCP Record Keeping Standards within the Clinical Record Keeping Policy;
- potential to align with the Nursing Documentation project. A meeting has taken place with Judith Bowen, Clinical Informatics Lead Nurse, Nursing Practice, regarding opportunities for alignment.

The potential to merge the Clinical Record Keeping Policy with the Record Keeping for Nurses and Midwives Policy has also been discussed, and a working group with representation from medical, nursing and therapies will be established to explore the potential development of a single Clinical Record Keeping policy.

Provisions for exploring a digitalised system in future

An initial meeting has taken place between the AMD for Quality and Safety; the Chief Clinical Information Officer; the Assistant Director of Digital Services and the Clinical Effectiveness Co-ordinator to discuss the digitalisation of records within the Health Board. An update was provided on the overall plan for digitalisation in Wales, which is taking a modular approach. Current action will focus on understanding which aspects of the record can and should be digitised, and identifying priority areas which are already being rolled out in many instances. Further work will take place to identify the benefits of digitisation for case recording, including barriers, with a view to identifying this as a priority to progress further. It was acknowledged that clinical leadership and engagement is a critical factor, with the technology being an enabler. Quality improvement activity is required to deliver the cultural shift required to make digitalisation a success.

Ongoing conversations will take place to progress this further, but it was agreed that the work to address RCP record keeping standards would be incorporated into the wider digitalisation agenda within the Health Board wherever possible.

Development of an e-learning module – Good Record Keeping Practice for Clinicians – RCP Standards.

The content for a Good Record Keeping Practice for Clinicians – RCP Standards training session has been developed. Discussions are ongoing with the Leadership Education Development Department regarding the translation of this course into an e-learning module, to be made available on ESR. However, whilst this is in progress, an alternative solution has been identified to ensure that clinicians are made aware of the RCP Standards, and good record keeping practice in the interim, to coincide with any quality improvement activity taking place in Withybush.

This will involve a recorded presentation of the module, which can be delivered face-to-face and/or made available electronically and shared widely with clinicians to promote the RCP Standards and key messages about why good record keeping is important. This will feature local Health Board examples of impact of poor record keeping and case studies wherever possible.

Discussions regarding the inclusion of the module on ESR will continue, including the possibility of designating this a mandatory e-learning course.

Stamps

A trial implementation of identification stamps with clinician's name, GMC number and space for date/time and initials has taken place previously within Withybush and the recent re-audit may present an opportunity to review evidence of stamp usage within the records. Discussions will take place as part of the Quality Improvement Plan for Withybush General Hospital regarding roll out of the stamps on another ward, to support an assessment of their effectiveness and allow for comparison.

Additionally, stamps have been rolled out to the Obstetrics and Gynaecology service and usage is due to commence. Discussion is ongoing regarding a series of snapshot audits within the service to demonstrate the impact of the stamps on record keeping practice before and after their introduction. This will also support the commencement of the specialty audit for Obstetrics and Gynaecology, as previously agreed.

The following three areas will be addressed by the Record Keeping Audit Working Group as part of the next phase of developments, at a meeting to take place on 27th October 2020:

- Continuing Professional Development (CPD) record-keeping training course
- The need to consider non-medical staff who contribute to health records
- Exploring links to revalidation and appraisal, by designating it a Quality Improvement activity for doctors to use at appraisal.

Argymhelliad / Recommendation

This report is provided to the Audit & Risk Assurance Committee as a source of assurance regarding the progress made in relation to the original audit report recommendations, and subsequent actions agreed by the Record Keeping Audit Working Group, following the previously delayed progress due to the pandemic response.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	Effective Clinical Practice Working Group
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	689
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 3. Effective Care
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. 5. Deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	RCP Record Keeping Standards Internal Audit Report October 2018, RCP Medical Records Standards
Rhestr Termau: Glossary of Terms:	Contained within the body of the report

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	None

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	None
Ansawdd / Gofal Claf: Quality / Patient Care:	This recommendation will improve patient safety and care.
Gweithlu: Workforce:	None
Risg: Risk:	This recommendation is to mitigate risks highlighted in the Internal Audit, RCP Medical Record Keeping Standards report, October 2018, and historical issues with the standard of medical record keeping Medical Directorate Risk reference - 689
Cyfreithiol: Legal:	None
Enw Da: Reputational:	None
Gyfrinachedd: Privacy:	None
Cydraddoldeb: Equality:	No negative impacts. The recommendation will have a positive impact as it has the potential to improve the standard of care for all patients.