Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 October 2019
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 & Director of Clinical Strategy
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mr John Evans, Assistant Director, Medical Directorate Alistair Armitage, Project Support Officer, Medical Directorate

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 brought to the Audit and Risk Assurance Committee (ARAC) in December 2018 for discussion, with an update on progress with the report recommendations to be provided to ARAC in October 2019.

This report is an update on progress to date, with a proposed process for future review of health records that identifies issues with non-compliance, and a reporting structure for assurance of ongoing improvement, which the Committee is asked to approve.

Cefndir / Background

The Internal Audit Royal College of Physicians Medical Record Standards report was brought to ARAC in December 2018 for discussion and to the Quality, Safety & Experience Assurance Committee (QSEAC) in February 2019. Assurance was sought on the report recommendations, namely:

- The Medical Director will write to all medical staff reminding them of the RCP Record Keeping Standards and the Health Board policy.
- The Medical Director will agree with the Hospital Directors, the Clinical Directors and the Clinical Audit Department an appropriate process to review health records and identify and address issues of non-compliance.

It is noted that concerns in regard to record keeping are a national issue and not unique to Hywel Dda UHB.

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

In December 2018, a letter was sent to all clinicians to remind them of the RCP Record Keeping Standards and the Health Board policy on medical record keeping, and also outlining the need for a process for monitoring future compliance with the RCP Standards.

A snapshot audit has been undertaken recently across all 4 sites, with 70 randomised acute inpatient medical records audited to give an overview of current compliance and any improvements that have been made.

The results of the snapshot audit are below:

RCP Standard audited to: Average % score of all records		**BGH**	**GGH**	**PPH**	**WGH**	**Health Board**
Standard 2:	No. of patients first and last name on each page	50%	67%	57.5%	54%	**57%**
	No. of pages with patient's NHS number or other unique identifier	48%	66%	50%	46%	**52.5%**
Standard 3:	Compliance with standardised structure of health record, following the organisational protocol	100%	80%	0%	40%	**55%**
Standard 4:	Documentation reflecting continuum of patient care and in chronological order	100%	80%	65%	35%	**70%**
Standard 5:	Initial assessment handover recorded on standardised proforma	60%	60%	25%	40%	**46%**
	Discharge summary recorded on standardised proforma	100%	90%	0%	30%	**55%**
Standard 9:	Record of change of consultant recorded and dated	100%	100%	100%	100 %	**100%**
	Record of change of consultant time recorded	81%	100%	100%	100 %	**95%**
Standard 6:	Percentage of written entries that have the date recorded	98%	99%	98%	91.5 %	**96.5%**
	Percentage of written entries that have the time recorded	86%	89.5%	76.5%	67.5 %	**80%**
	Percentage of written entries that have a signature	100%	97.5%	91.5%	86%	**94%**
	Percentage of written entries that have a legible printed name recorded	86%	89.5%	83%	46.5 %	**76%**
	Percentage of written entries that have a legible printed designation recorded	31%	80%	75.5%	33.5 %	**55%**
	Number of deletions/alterations.	0	0	1	14	**15**
	How many deletions/alterations were countersigned, timed and dated	n/a	n/a	100%	33%	**66.5%**
Standard 8:	How many written entries indicate the responsible lead professional was present?	54%	19%	86.5%	47.5 %	**51.5%**
Standard 10:	Identified time period gaps between entries in patient's record	0%	29%	0%	20%	**12%**
	Where there is an identified gap, an explanation has been provided?	n/a	100%	n/a	0%	**50%**
Standard 12:	Decision of 'DNR' recorded clearly with decision maker clearly identified	100%	100%	n/a	n/a	**100%**
		No. of health records audited:				**70 records**

Results show:

- little improvement in recording of patient identifiers on each sheet of the patient's medical record (standard 2)
- a lack of standardisation in the documentation used (standard 5)
- room for improvement in clinical oversight of entries by the lead professional responsible for the patient (standard 8)

Discussion with Dr Subhamay Ghosh, AMD for Quality and Safety, and Mr Mark Henwood, Deputy Medical Director, has resulted in an agreed process for continuous review of health records, whereby each speciality undertakes a yearly audit of acute inpatient medical records, to create a culture of accountability and ownership of the content of clinical records by clinicians. This yearly audit of acute medical records by speciality, as a responsibility of the Clinical Lead will comprise:

- 10 random sets of patient notes on each site for each speciality (maximum 40 per speciality)
- Outcomes to be reported through the directorate Quality & Safety meetings to QSEAC through their annual reports to monitor compliance with the standards and to record areas of improvement

It is emphasised that this plan for improvement of compliance with RCP Record Keeping Standards does not include medical records storage, which remains a significant challenge for the Health Board, and is a separate issue.

The RCP generic medical record keeping standards define good practice for medical records and address the broad requirements that apply to all clinical record keeping. Low standards of record keeping presents an organisational risk, as it has the potential to reduce the quality of patient care and safety, does not support professional best practice, and also has an impact on Information Governance and litigation. Errors and omissions in clinical records are frequently related to clinical incidents, in particular those that come to litigation and also to General Medical Council (GMC) fitness to practise panels, and therefore presents a significant challenge and risk to the Health Board.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to take assurance from the process proposed below to evaluate ongoing compliance with and monitoring of medical record keeping standards, to fulfil recommendations in the Internal Audit Record Keeping Report:

- A yearly audit by speciality, with responsibility for the audit and reporting the outcomes to be held by the Clinical Leads;
- Yearly speciality 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.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	5.3 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, Clinical Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	689 Score 16

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 Statement	Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce

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:	None. 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
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.