

AUDIT OF MEDICAL RECORDS KEEPING AT A NIGERIAN GERIATRIC CLINIC

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ABSTRACT

BACKGROUND: A medical record also known as health chart is the written health information about a patient or clients and is always opened whenever a patient or client visits a health facility. There are different types of medical records and it may be problem based or patient based; paper based or electronic. It enhances continuity of care; source of communication between healthcare professionals, as aides de memoire and it is a legal document.

OBJECTIVE: To compare the medical records keeping with reference standards.

METHOD: This is a prospective clinical audit, was conducted in a Nigerian Nursing Home for the elderly. The medical record keeping was compared with the generic standards of medical record keeping of the Health Informatics Unit of the Royal College of Physicians. Two clinical audit cycles were performed.

RESULTS: At the first clinical audit cycle only the third standard was 50%, others were zero. At the second clinical audit cycle there was improvement and 100% increase in standard 1, 3, 4 and 5, with 10% increase in standard 2. Paper based medical records are kept at the nursing home. Most of the residents do not know their age as their birth dates was not recorded. There were 30 residents at the nursing home when the clinical audit was conducted.

CONCLUSION: Initially, the medical record keeping was below standard but with the clinical audit there was improvement. Clinical audit is important in medical practice in comparing the practice with standards.

KEY WORDS: Clinical Audit, Geriatric, Medical Records, Clinical Audit Standards

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INTRODUCTION

Clinical audit is important to improve medical care as it identifies areas for poor practice that will need to be worked on for better and improved practice. Conducting a clinical audit is a prerequisite in some countries by the National Medical and Nursing Licensing regulatory body for the renewal of practicing medical and nursing license. It is also used for appraisal of health care professionals. Carrying out a medical audit which sometimes is called clinical audit is important and serves several functions such as improved medical care and service delivery, maintenance of the healthcare service provided, as an opportunity for training and it identifies areas that need improvement in

the health care delivery system.^{1,2,3} It is used also to improve the standards of medical care as it involves comparing the current practice with established standards.^{4,5,6,7,8} This ensures that what is suppose to be done is done, and it is the best way to demonstrate and improve medical practice² as it helps in identifying areas of the medical practice that would benefit from improvement.⁹ A clinical audit also known as medical audit involves selecting the criterion (plural: criteria), setting targets and standards, comparing the local practice with the standard(s) that are set, implement necessary changes and conducting a re-audit which may be the second or third cycle of the clinical audit.

Medical records kept in health institutions are important documents and are encountered daily by health care professionals as they have several functions.¹ Doctors and nurses use medical records to carry out their duties.¹⁰ A medical record is a collection of information about a patient or client's health, the types of health care

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service they received and it is maintained or kept by the health care provider but released only on request by the patient or by a court of law. This means that it is important that proper medical records are kept, which should be accurate and legible (if paper based medical records are used so that it can be read by anyone).¹¹ Medical records are kept by different departments that are appropriate for the care they provide.¹ This clinical audit shall be on medical records kept at a senior citizens clinic in a Nigerian Nursing Home for the elderly.

There are different types of clinical audit for example prospective and retrospective clinical audit. This audit is a standard based retrospective audit. A standard based audit involves setting standards with which data from the medical practice shall be compared with. It is a retrospective audit because the data that shall be used for the first clinical audit cycle are previous medical records that already exists in the facility.

AUDIT METHODOLOGY

Inclusion Criteria for Clinical Audit

The inclusion criteria for the clinical audit are residents of the Port Harcourt home for the elderly in Nigeria. All medical records of the residents of the nursing home shall comprise the source of data for the clinical audit.

Clinical Audit Methodology and Process

The first clinical audit cycle consisted of analyzing the medical records from March to April 2016 of residents of the geriatric nursing home where the clinical audit is being conducted.

Clinical Audit Criteria

The criteria for this clinical audit shall be the generic medical record keeping standards set by the Health Informatics Unit (HIU). The Health Informatics Unit is part of the Clinical Standards Department of the Royal College of Physicians (RCP), London and the preparation of the generic medical record keeping standards were supported by the NHS (National Health Scheme) Connecting for Health. These criteria have been used as a clinical audit tool in several clinical audits and researches on hospital records.

Clinical Audit Standards

Standards for good record keeping as defined by the Health Informatics Unit (HIU) but those that

shall be used as criteria in this clinical audit are those that are applicable to this geriatric unit where this clinical audit shall be carried out. The generic medical record keeping standards are twelve, only five of these twelve standards shall be used for this clinical audit and these are number 1, 2, 4, 6 and 10 of the standards for record keeping originally stated by the Health Informatics Unit (HIU). These standards have been approved by the Academy of Medical Royal Colleges^{11,12}.

The standards for this clinical audit shall include the criteria and target percentage which shall be 70% of the criteria. The target of 70% will be used because in most clinical audits, it is difficult to achieve 100%. The medical records at the Port Harcourt home for the elderly shall be the source of data. Thirty records shall be incorporated into the clinical audit.

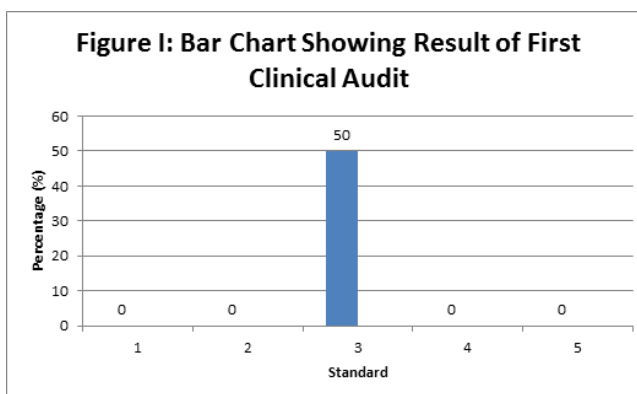
RESULT

Result from the First Clinical Audit Cycle

Paper based medical records are kept at the centre where the clinical audit was carried out. The medical records of thirty residents at the nursing home were examined.

Table 1: Result of First Clinical Audit Cycle

Standard	Target Percentage	Achievement
1	90%	0
2	90%	0
3	90%	50%
4	90%	0
5	90%	0



There were five criteria and standards in the clinical audit. It is only the third standard which says 'documentation within the medical record should show the continuation of patient care and should be done in a chronological order' that was done in 50% (15) of the medical records incorporated into the clinical audit. This was done in all the residents' medical record.

Areas that need improvement after the first clinical audit cycle

A meeting was held at the nursing home and the importance of good medical records was highlighted. This is necessary because at different times different doctors are posted to the nursing home. The paper based medical records kept are in the custody of the doctor and not readily available to any other person. A suggestion was made and single files for each patient were introduced. All the standards of good medical record keeping were highlighted and the second clinical audit which is a prospective clinical audit of all the medical records in the month of June 2016 shall be done.

A cabinet was provided where all medical records of the residents should be kept. It was also agreed that any new resident brought to the home shall be seen immediately by the doctor whether the resident has a medical illness or not, so as to have the background health information about the person. This shall be made into a leaflet that shall be given to anyone bringing the person to know why this is necessary. Also the doctors agreed to research on comprehensive geriatric assessment to design a comprehensive assessment sheet to be used in the nursing home so that every resident shall be assessed on it. It shall be a guide since it is a form of structured medical record; no information shall be left out as there will be columns for all information requested.

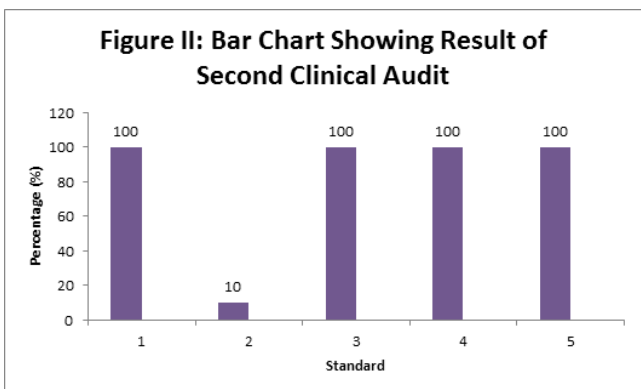
The importance of the comprehensive geriatric assessment shall be pasted on the wall so that any doctor posted to the nursing home shall know its importance, always use it and fill it correctly. It shall serve as a source of data for research.

Result of Second Clinical Audit Cycle

The second clinical audit cycle was conducted after changes were implemented on the areas that need improvement after the first clinical audit cycle.

Table 5: Result of Second Clinical Audit Cycle

Standard	Target Percentage	Achievement
1	90%	100%
2	90%	10%
3	90%	100%
4	90%	100%
5	90%	100%



After the second clinical audit cycle, there was improvement in all the standards and the least improvement was in the second standard (10%). In 10% of the medical records, the name of the resident was written in all the sheets in the medical record while in 90%, the name of the resident was only written on the first sheet. If the sheets fall off and the names of the resident are not written on them, it will be difficult to identify the medical record they belong to.

Table 6: Comparing the Results of the First and Second Clinical Audits Cycles

Standard	First Clinical Audit Cycle	Second Clinical Audit Cycle	Improvement
1	0	100%	100%
2	0	10%	10%
3	50%	100%	100%
4	0	100%	100%
5	0	100%	100%

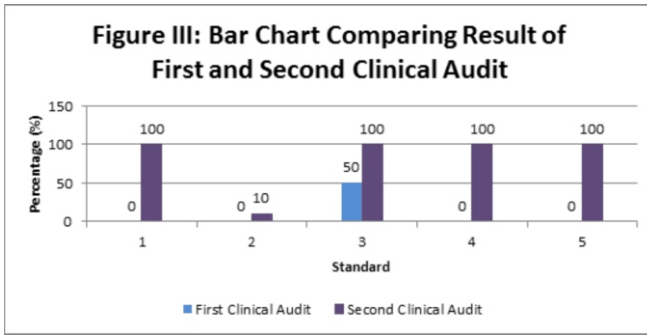


Table 5 and Figure III compares the results of the first and second clinical audit. There was improvement in all the five standards. The least improvement was in the second standard. This will generally improve the healthcare provided to the residents of the nursing home.

CONCLUSION

There were some deficiencies in the medical records at the nursing home as they are not up to the standards of the medical record keeping set by the Health Informatics Unit (HIU) of the Royal College of Physicians. After the second clinical audit cycle, there was improvement in all the five standards used for the clinical audit.

RECOMMENDATIONS

The following recommendations were made after the second clinical audit cycle which is to maintain all the improvements that have been made on medical record keeping at the nursing home and this can only be achieved by conducting regular clinical audits on medical record keeping. There is still need for improvement on the second standard for the clinical audit which had the least improvement after the second clinical audit cycle. Staff at the nursing home should be continuously involved in the health needs of the residents of the nursing home. Design a comprehensive geriatric assessment sheet/form that shall be used at the nursing home (this is ongoing already) utilizing other comprehensive geriatric assessment sheet/form used in other hospitals to adapt it for local use.

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