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Rowcroft Community Specialist Palliative Care Team Documentation Audit

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100% of all case notes will comply with the following standards:-

- Notes written in black ink
- Each Entry should have the date, time and discipline
- Mistakes and alterations should be crossed out with a single line, which enables the original text to be read. The alteration should be then initialled
- People present during each visit should be clearly documented
- All entries should be signed, with the name printed. In new notes names can just be signed as long as the signature is on the contact sheet
- Patient’s name and hospital number should be documented on each sheet
- All pages to be numbered

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Where did the standards come from?

- National Minimum Standards for Regulations for Independent Health Care
- Royal College of Nursing
- Essence of Care Documentation
- British Association of Occupational Therapist
- British Medical Association
- Chartered Society of Physiotherapist

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Method and Timescale

- Four case notes were randomly pulled from each Clinical Nurse Specialist (CNS) caseload. This was carried out retrospectively and looked at all entries in patient notes during the month of October 2007

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Number of Patients Involved

- Four patients notes were audited from each case load – totalling 32 patients in all.
- There were a total of 249 entries

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Proportion of entries made by different members of the multi-disciplinary team

- 23 case notes had annotations exclusively from CNS
- 17 case notes had entries made by between 2 and 4 CNS
- 5 case notes had entries made by OT and/or OT technician
- 2 case notes had entries made by Social Worker

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Results

- **Notes should be written in black ink**

  100% of entries to the patient notes were written in black ink

- **Each entry should have the date, times and discipline stated:**

  61% of entries to the patient notes had the time of entry stated

  48% of entries to the patient notes stated the discipline

  100% of entries were dated

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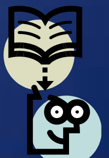
- **Mistakes and alterations should be crossed out with a single line so that the original text can be read and then initialled:**

Of the 32 sets of notes there were only 20 mistakes,
1 mistake had not been noted

8% of mistakes were initialled



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- **People present during each visit should be clearly documented**:

Of the 249 entries 200 entries were for telephone contact.

Of the remaining 49 entries 50% had individuals other than the patient recorded.

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- **All entries should be signed, with the name printed. In new notes names can be just signed as long as the signature is on the contact sheet**

100% had either the professionals signature or name of the professional printed

71% of entries were signed and the name printed where required

29% were signed only

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- **Patients Name and Hospital Number should be documented on each sheet**

  31% of the pages on which entries were made had the patient’s name and hospital number

- **All pages to be numbered**

  25% of pages on which entries were made were numbered

  Inconsistency in numbering of continuation sheets was noted – some people numbering one side - others number both sides

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Summary

- Not all standards being met

Recommendations

- Revision of signing and printing name standard
- Re-design of continuation sheet to make numbering less confusing
- Introduce new patient name and number labels
- Increasing all members of the multi-disciplinary teams awareness to the documentation standards
- Re-audit

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Re-audit

- Same standards as previous audit except for standard relating to signatures and printing of name.
- Revised to all entries should be signed, with the name printed

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Method and timescale

- As in the previous audit – four case notes were randomly pulled from each CNS caseload.
- Carried out retrospectively looking at entries into notes during the month of March 2009
- At the request of the Lead OT an additional 4 sets of notes were taken which had OT involvement

Number of patients involved

- Four patient notes were audited from each caseload and four with OT involvement – totalling 36 patients in all

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Proportion of entries made by different members of the multi-disciplinary team

- 28 case notes had annotations exclusively from CNS
- 5 case notes had entries made by OT and or OT technician
- 3 Case notes had entries made by Social Worker

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Results

- **Notes should be written in black ink**

100% of entries to the patient notes were written in black ink

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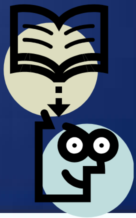
- **Each entry should have the date, time and discipline stated**:

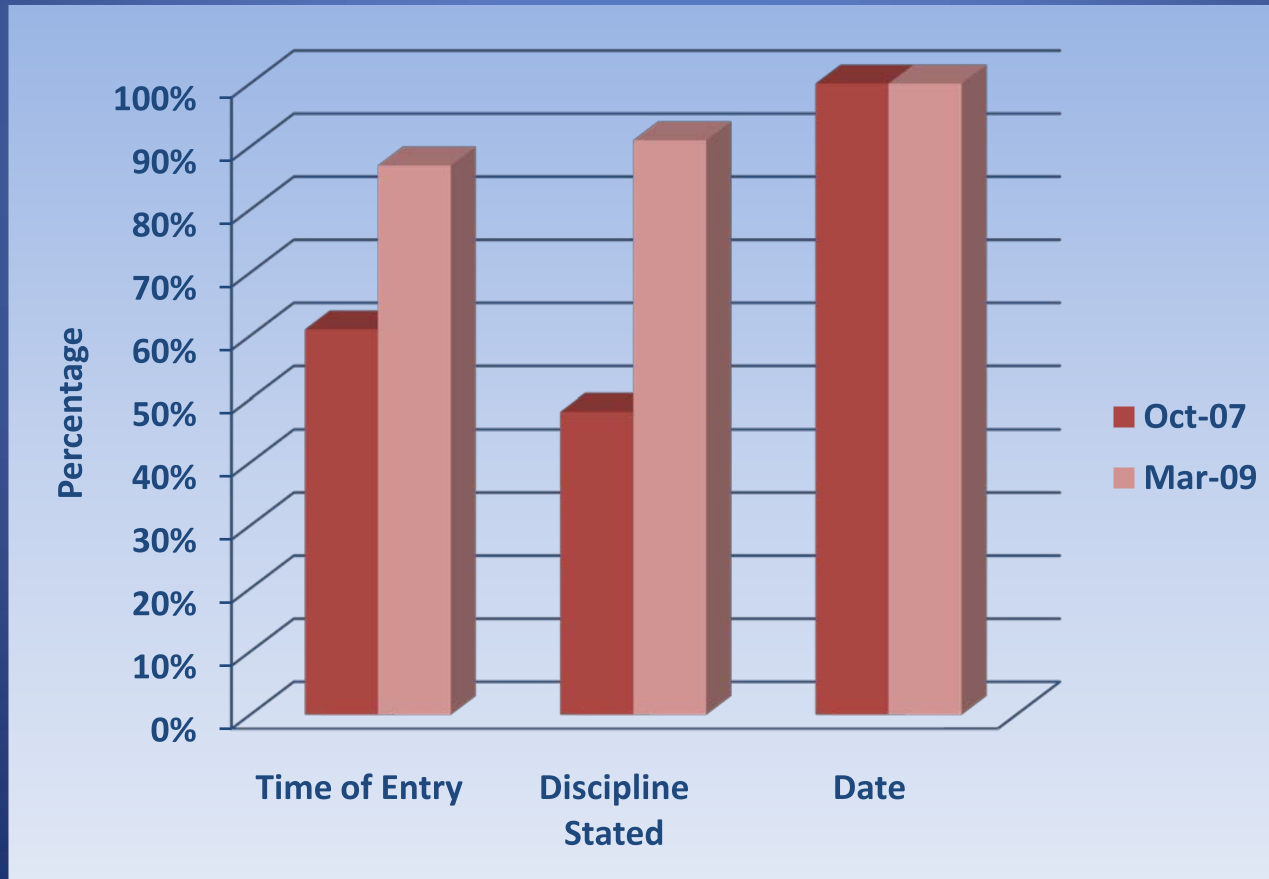
  87% of entries to the patient notes had the time of entry stated

  91% of entries to the patient notes stated the discipline

  100% of entries were dated



Bar chart to show percentages of entries stating time, discipline and date in Oct 2007 and March 2009



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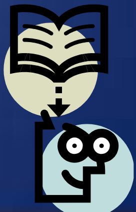
- **Mistakes and alterations should be crossed out with a single line so that the original text can be read and then initialled:**

  Of the 36 sets of notes there were only 19 mistakes

  46% of mistakes were initialled

- **People present during each visit should be clearly documented**

  80% of entries noted the people present where appropriate



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- **Patients Name and Hospital Number should be documented on each sheet**

  97% of the notes had the patients Name and Hospital Number marked on each sheet

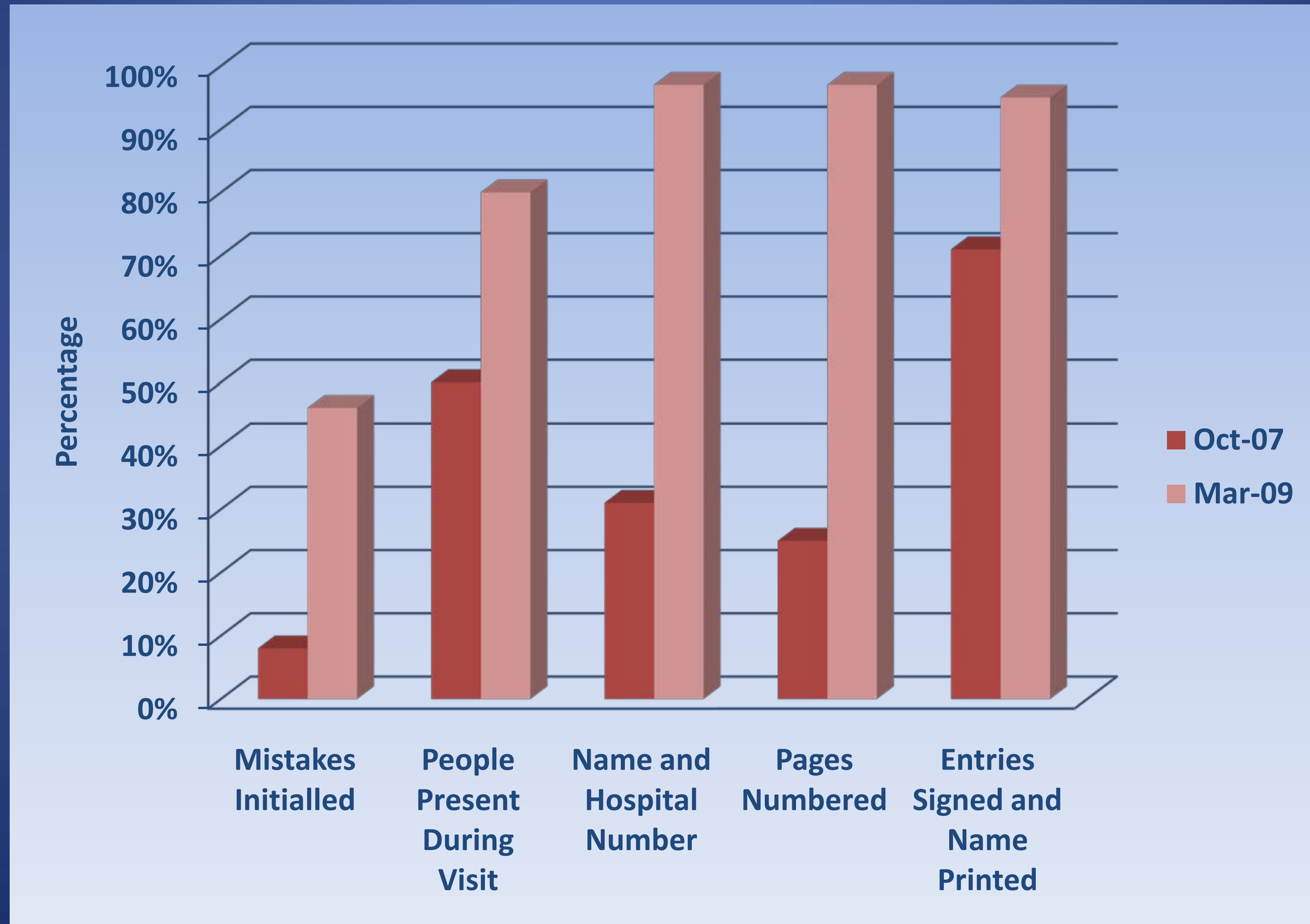
- **All pages to be numbered**

  97% of pages were numbered

- **All entries should be signed, with the name printed**

  95% of entries were signed with name printed

A bar chart to indicate the percentage of time the standards were met in Oct 07 and Mar 09



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Summary

- Marked improvement
- Will require regular monitoring
- Need to continue to provide education to new staff members
- Implementation of Documentation Policy