Audit Report

Improving Standards in Psychiatric Case Notes Recording by Junior Doctors in an Inpatient Setting

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Introduction

Good standard of clinical record keeping and medical case notes are essential in ensuring high quality care of patients as well as aid communication between different team members. It also informs medico legal investigations, clinical audit as well as research.[1] In psychiatric practice, good history, detailed mental state examination and risk assessment as well as relevant physical examination forms the basis for accurate diagnosis, formulation as well as management decisions.

Faculty members as well as nursing staff observed the variability of case notes recording by psychiatry residents and how it impacts the patient care. The study described here comprises of an audit of case notes documentation on patients' admission in an inpatient setting and a subsequent re-audit following an educational intervention. The overall aim of the audit was to examine the standard of recording certain key items of information and mental and physical examination in patients' case notes on admission. Absence of these items implied that these important aspects of patients care has not been considered or done. Therefore, the audit apart from assessing the standards of case notes recording indirectly also assessed the standards of patient care. No previous audit on this topic had been conducted in the department and we were unable to find record of any similar audit in search of Pakistani journals database.

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The Study

The study was undertaken in the inpatient unit of a tertiary care hospital. It may be divided into three distinct phases. An initial baseline audit, an intervention (teaching session by faculty members on notes documentation) and a subsequent re-audit around three months later. Thirty randomly selected inpatient case notes were included in both audit phases.

Methods

In September, a review of thirty medical case notes was carried out of inpatients admitted in the unit. In

Table 1: Results of Review of Case Notes.

Parameter	Initial Audit N = 30	Re-Audit N = 30
Mental state on Admission		
• Appearance and behaviour	23	28
• Speech	19	26
• Mood	20	29
• Thought	18	25
• Perception.	16	25
• Cognition	13	19
• Insight	18	27
Physical examination at the time of admission		
• No record / no reason given	6	1
• Complete documentation	5	17
• Incomplete documentation	19	12
Diagnosis: None documented following admission notes.	16	5
Management plan: None documented	15	4
Risk assessment: Not documented.	20	7

order to define the appropriate standard for the purpose of this study three consultant psychiatrist within the department agreed on a standard that psychiatry residents would be expected to meet at FCPS examination. Records for the current admission were scrutinized with reference to documentation of mental state, physical examination, diagnosis, and management plan and risk assessment. Data was analysed by using a structured proforma. Parameters were recorded as either documented or not compared with the standard.

Findings

The initial audit showed that most of the parameters assessed were poorly documented (Table 1). In mental state appearance and behaviour were mostly documented while cognition was assessed in very few of the cases without any reason given (as it may be because of patient's mental state, sedation because of medicines etc). Physical health was given less emphasis with most of the notes documentation being incomplete. Same trend was observed in documentation of provisional diagnosis, management plan as well as risk assessment.

Action Taken:

The above findings were discussed at a departmental medical audit team meeting with all trainees present. It was agreed that the standard of documentation in admission case notes was unacceptably low and special emphasis needs to be given to it in future.
Mandatory teaching sessions were conducted by the consultants in the department in the following 2 weeks. Various causes of documentation problems including inconsistent faculty expectations, time management issues, lack of residents' education and mis-information about documentation were identified. Residents were taught what information needs to be recorded as well as the clinical importance in doing so. Medico legal importance of documentation of patient refusing to be examined was also highlighted. A follow up session was conducted in 2 months to re emphasise the important points in documentation of patients' notes.

Results of Follow-up Audit: (Closing The Loop)

The whole audit was repeated in three months after the

baseline audit to see if the frequency of documenting different items has improved. There was an overall improvement in the levels of documentation by psychiatric trainees from the initial audit to the second re audit in almost all parameters (Table 1).

Discussion

Accurate and timely documentation is fundamental in reaching a correct diagnosis and deciding upon subsequent management and also being used in assessment of professional competence.[2,3] In general, despite the presence of a definite format for recording mental state examination, physical examination, diagnosis, and management plan in admission folder, several deficiencies were observed during this audit. It appeared that trainees mostly used their own discretion in deciding how and what to record. Inappropriate training in notes documentation, lack of time, fatigue or a perception of certain aspects of examination as being unimportant may be some of the causes of non adherence to the format.

An unacceptably high number of case notes (25/30) had incomplete or no documentation of physical examination, which has also been reported in previous audits on this topic.[4] It may be that examination was performed and not recorded. Patient may have refused examination or been uncooperative but trainees failed to record it or ignored its importance. Similarly although prescriptions were written on medicine cards but overall management plan was not mentioned. Most important of all risk assessment, an inherent part of Psychiatric patient assessment was not given due importance and did not appear to be seen as important by the trainees.

Training and involvement of consultants in checking and supervising the records improved the standards of case notes documentation, thus highlighting the importance of appropriate training.

Accurate record keeping is a basic medicolegal requirement.[5] In the west, Public bodies and enquiries into negligence cases have criticized the poor recording in case notes.[6,7] Medical Defence Union also reported *'At the MDU, we see problems which arise from poor, inadequate or absent notes. We cannot stress enough the importance of clear, concise and contemporaneous notes which serve primarily to enhance patient care but are also useful in protecting a doctor's interests'*.[8] Pakistan is gradually developing into a more litigious society. The importance of clear and complete documentation with date, time and signature in the notes cannot be emphasised enough and needs to be regularly monitored in every speciality.

The audit and subsequent educational intervention was quick, fairly easy and cost effective and brought significant improvement in practice. Improvement in standards of record keeping will eventually lead to improvement in quality of patients care, better communication between members of multidisciplinary team and safer working environment. Audit like this can be used in future too for improving performance in clinical setting.

References

1. Scottish Office. Case Records Good Practice Group – CRAG. Good Practice Statement. Edinburgh: HMSO 1995.
2. Pullen I, Louden J. Improving standards in clinical record – keeping. APT 2006; 12: 280-86.
3. Royal college of Psychiatrists. A competency based curriculum for specialists training in Psychiatry core and General Module. London Royal college of Psychiatrists. http://www.rcpsych.ac.uk/pdf/prov_jan06.pdf.
4. Rigby JC, Oswald AG. An evaluation of the performing and recording of physical examinations by psychiatric trainees. Br J Psychiatry 1986; 150: 533-35.
5. Hoyte, P. Guidelines for Good Records. Can I see the records? Manchester Medical Defence Union Limited 1998.
6. Birchard K. Ombudsman finds medical records 'atrocious'. Lancet 2001; 358: 48.
7. Audit Commission Setting the record straight: A study of Hospital Medical Records. London; Audit Commission 1995.
8. Medical Defence Union. Can I see the records? London MDU 2003.