Ir Med J; October 2023; Vol 116; No. 9; P864
19th October, 2023

Preserving the Path to Excellent Care: An Audit Reveals Gaps in Patient Record-Keeping

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Dear Editor,

Accurate documentation of patient records is essential for ensuring safe and effective patient care. Inadequate documentation has been linked to medical errors and adverse events, resulting in negative patient outcomes and legal action. A study published in the Journal of Patient Safety found that inadequate documentation played a role in 11% of medical malpractice claims and was a factor in 25% of cases where the patient suffered permanent disability or death[1]. Another study in the Journal of Healthcare Risk Management reported that incomplete documentation contributed to 33% of all medical errors[2]. Inaccurate documentation of patient records can result in miscommunication between healthcare providers, leading to incorrect diagnoses, inappropriate treatments, and medication errors[3]. Furthermore, incomplete documentation of informed consent can lead to legal action, as patients have the right to be fully informed about the risks and benefits of medical procedures before giving their consent[4]. These findings underscore the importance of accurate documentation in ensuring patient safety and reducing the risk of legal action.

We are writing to bring attention to the need for improvement in documentation standards, as highlighted by an audit we recently conducted at University Hospital Galway (UHG).

In this closed-loop audit, we reviewed medical documentation in two medical and two surgical wards at UHG against the HSE Standards and Recommended Practices for Healthcare Records Management document. The most recent ten pages and ten medical entries of each active paper record were analysed for the presence of patient and doctor identifiers. Ninety-one records across two medical and two surgical wards were included, encompassing 878 individual pages and 803 separate doctors' notes.

The results were concerning. In cycle one, we found that 274 pages had no patient identifiers, and only 232 of clinical entries had all appropriate doctor identifiers. There was no difference in documentation quality between medical and surgical wards. However, after sharing the data at Surgical Grand Rounds, cycle two of the audit showed an improvement in documentation standards. 221 of pages had no patient identifiers (a 6% improvement), and 382 of notes had all appropriate doctor identifiers (a 21% improvement). There was a

statistically significant difference in documentation quality between medical and surgical wards, with the improvement being more pronounced in the surgical wards. UHG has now instated a mandatory lecture delivered on a bi-annual basis during induction week and changeover, highlighting the results of this audit. We have also disseminated aid memoirs throughout the hospital to remind doctors to try to include all relevant identifiers in their notes.

In conclusion, the findings of this audit demonstrate the need for continued efforts to improve documentation standards. It is crucial that healthcare providers and hospital policymakers work together to implement training programs and technologies that support accurate and consistent patient-record keeping. Doing so will not only improve patient outcomes but also protect healthcare providers from potential legal and financial repercussions.

Declarations of Conflicts of Interest:
None declared.

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