Collaborative Focused Medical Record Review Improves Patient Safety
Yim CW, Tsang SWC, Lau CK, Yeung CK, Wong SPY, TTT Fan, To WC, Cheung L, Leung I, Lai YL, Chung JCF
Department of Medicine Tseung Kwan O Hospital

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Introduction
Patient safety has become a major global concern. Reporting systems for major medical incidents resulting in patient harm are already available. However, there are still potential hazards and variations in practices which remain hidden, if not identified and corrected, may lead to sentinel events

Objectives
To identify hidden health hazards in patient management in acute medical wards through focused medical record review.

Methodology
Health-care workers in the Department of Medicine, including physicians, nursing staffs and ward clerks, jointly reviewed medical records of patients admitted to two acute medical wards from 1st October, 2011 to 31st March 2012. Ten percent of medical records were randomly selected for review each month. Two validated questionnaires based on WHO's recommendation were employed for the detection of harmful incidents in clinical setting. First questionnaire (RF1) was used by the nursing staff to look for triggers for possible adverse events. Cases fulfilling more than one criterion will be reviewed in depth by senior physicians utilizing the second questionnaire (RF2) to describe the harmful incidents in detail, to grade the severity and to ascertain whether the incident was preventable.

Result
A total of 2593 patients were admitted to 2 medical wards (1 male & 1 female), and 250 (10%) cases were initially screened with RF1 questionnaire. Fifty (20%) cases had "triggers" for possible adverse incidents. Eleven (4.4%) harmful incidents were identified: 5 due to adverse drug events, 3 related to delay in diagnosis, 1 developed hospital-acquired infection, 1 developed bed-sore and 1 resulted from lack of service in the hospital. Seven of 11 (64%) incidents were rated as severe by the senior physicians. Among the 7 severe incidents, system-related contributing factors are the most common cause identified, including inadequate reporting or communication, inadequate training or supervision, delay in the provision or scheduling of service and

failure to implement protocol. Four out of 7 (57%) of severe incidents were considered as preventable. None of them resulted in disability. Hidden harmful incidents do occur and the majority of cases are preventable. A systematic review of medical records is useful in identifying these incidents, which would alert senior clinicians to refine existing systems and processes to improve patient safety