



Service Priorities and Programmes
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Healthcare record audit in a family medicine clinic in Hong Kong

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Introduction

To provide effective and safe medical care, it is essential that doctors keeping good healthcare records, documenting relevant clinical findings, investigations ordered, progress of patients, diagnostic impressions and any treatments provided.

Objectives

To evaluate the quality of health care record by doctors in a family medicine clinic through an audit and provide feedback to doctors.

Methodology

Randomly selected 100 health care records of all patients that visited a family medicine clinic from Jan 2012 - Jun 2012 were examined retrospectively by 2 individual auditors who are Family Medicine Specialists. Information that should be included were decided and agreed by the 2 auditors (including reason for consultation, relevant history of chief complaint, progress of previous problems or any prior investigation results, physical examination findings, clinical impression, treatment given and follow up plan). The names of attending doctors in record are blinded before the assessment. Then each health care record was assessed and rated, and the results from 2 auditors were compared to draw conclusion.

Result

Results of 2 auditors were similar and comparable, and the satisfactory rate was >80% for all criteria by both auditors. Drug compliance is one main area of deficiency found in cases with chronic illness, and when doctors encountering patients presenting with multiple complaints, some may not mention relevant clinical history, making the subsequent management to be less justified. An ongoing audit and feedback system can be associated with improvements in keeping good medical record in order to provide safe and effective medical care.