Improving the quality of phlebotomist documentation in North District Hospital
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Introduction
As health care includes multidisciplinary activities, communication about the care given is essential. Documentation is a crucial component for professional practice and providing quality patient care. A complete, accurate, and up-to-date document is legal responsibility of healthcare personnel and phlebotomists no exception. A retrospective chart audit was performed in 2012, the overall compliance for supporting staffs (mainly phlebotomists) is 77.8%. Quality improvement strategies are initiated to improve the compliance and enhance the quality observed in the audit.

Objectives
(1) To improve the quality of phlebotomist documentation record
(2) To increase the compliance rate of audit criteria up to 95% (the critical items up to 100%)

Methodology
(1) Set up documentation standard guideline tailor-made for phlebotomists in NDH
(2) Provide educational program to all phlebotomists, employed interactive teaching and learning activities, like group discussion, sample critique, peer review, pre-test vs. post-test design in evaluating the learner's knowledge.
(3) Audit is employed to ensure the compliance.

Result
Pioneering phlebotomists' proper documentation in Integrated Progress Sheet promotes effective communication between multidisciplinary healthcare provider team, facilitates continuity and individuality of care. Projected satisfactory compliance improvement in the documentation format (55.6% compliance rate in entry with date and signature after entry respectively, 66.7% compliance rate in entry with international time and end with stamp respectively) is inevitably achievable after tailor-made interactive training provided. Approaching next phase in improving the
documentation context is another milestone for phlebotomist's legal recording.