Service Priorities and Programmes

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Quality improvement program on physiotherapy stroke rehabilitation documentation

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Introduction

Complete and accurate clinical documentation is essential, to record the care delivery process of every patient, to ensure the provision of safe and high quality care, and to facilitate an effective and coordinated ongoing care. To ensure the standard of documentation for physiotherapy in-patient stroke rehabilitation in Shatin Hospital, a quality improvement program on clinical documentation were implemented.

Objectives

To (1) evaluate and (2) improve the compliance of therapists on documentation for physiotherapy in-patient stroke rehabilitation in Shatin Hospital.

Methodology

Therapists working in medical wards were recruited in the quality improvement program. Baseline and follow-up audit on documentation for in-patient stroke rehabilitation were performed in June 2012 and June 2013. Documentation of one recently discharged stroke patient was retrieved for each therapist. 37 items were audited with reference to the “Physiotherapy Practice Guideline for Stroke Rehabilitation in Shatin Hospital”, covering assessment, problem identification, goal-specific intervention and preparation for discharge. The compliance rate of each therapist was calculated by the number of complied audit items divided by the total number of audit items with the number of the non-applicable items excluded. In this exercise, 80% to 100% compliance is regarded as excellent, while 60 to 79% is good. After the baseline audit, the neurological assessment form was revised, followed by staff training on the new form. Staff could then familiarize with the new form for half-year before the follow-up audit was conducted.

Result

13 documentations were selected in each audit. In the follow-up audit, there were marked improvements in the compliance rate. The average score of therapist was increased by 11.17% (77.60% to 88.77%). Percentage of staff getting excellent

compliance rate (80-100%) was increased by 38.47% (46.15% to 84.62%). Out of 37 audit items, compliance rate on documentation less than 60% is decreased by 21.62% (10 items to 2 items). Specific audit items also got very promising improvement on assessment, problem identification and goal-specific intervention, including item “post-stroke complications” by 61.54%, 84.62% and 74.62% respectively, item “impaired sensation and perception” by 33.33%, 60.71% and 75% respectively, and item “coordination impairment” by 50.00%, 75.00% and 80.00% respectively. Conclusions: The quality improvement program on documentation is effective to improve the compliance of documentation on stroke rehabilitation and it should be regularly performed to maintain the standard of clinical documentation.