



Service Priorities and Programmes Electronic Presentations

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The Medical Record Documentation Audit Cycle in Physiotherapy: A Continuous Improvement Process for Upholding the Standard of Patient Care and Clinical Handover

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Introduction

Medical record documentation is regarded as an essential element in both the health care and legal system. It serves as an important medium for essential clinical handover among healthcare professionals and to provide objective evidences on quality patient care and litigation defense. In 2014, a first physiotherapy medical record documentation audit was conducted to evaluate the compliance of physiotherapy records to the “Kowloon Central Cluster (KCC) Guidelines on Medical Record Documentation”. Areas for improvement were identified and the audited results were disseminated to physiotherapy colleagues and different stakeholders for sharing. Follow-up action plans on implementation of changes were conducted including updated clinical guidelines, use of pre-printed forms to minimize the use of abbreviation and to include all essential items for clinical handover, cue cards for quick references to cluster approved abbreviation list, and related refresher courses.

Objectives

To re-audit the physiotherapy medical record documentation on evaluating the degree of improvement shown after the first audit and to identify further areas of potential improvement.

Methodology

A retrospective documentation review was conducted. All physiotherapy medical records at KCC in the period of 4 to 10 September 2016 were randomly selected for review and re-auditing. Content analysis on the compliance of physiotherapy record to the “Hospital Authority Manual of Good Practices in Medical Records Management” and the “C-CEBAR” tool from the Australian Commission on Safety and Quality in

Healthcare was evaluated using a custom-made audit form that comprised of 34 explicit criterions.

Result

Four hundred and seventy-five physiotherapy medical records (227 in-patients, 248 out-patients) were reviewed, 332 were collected from Queen Elizabeth Hospital, 97 from Kowloon Hospital and 46 from Hong Kong Buddhist Hospital. A significant improvement was demonstrated as compared with last audit. Overall, the documentation was complete, achieving 100% compliance rate on 22 criterions, and 90-99% compliance rate on 9 criterions. There were 3 criterions with compliance rate below 90% in the out-patient records. It included numbering of each page of physiotherapy record (81.05%), problem identification and goal setting (85.43%), and evaluation of post-treatment patient's response (78.86%).

The present re-auditing completed the full audit cycle. Improvement in the quality on physiotherapy medical record documentation was demonstrated and potential areas that required further improvement were identified. To safeguard a high quality standard in patient care and outcome, further actions plans should be developed and implemented for the continuous upholding of the patient service provision.