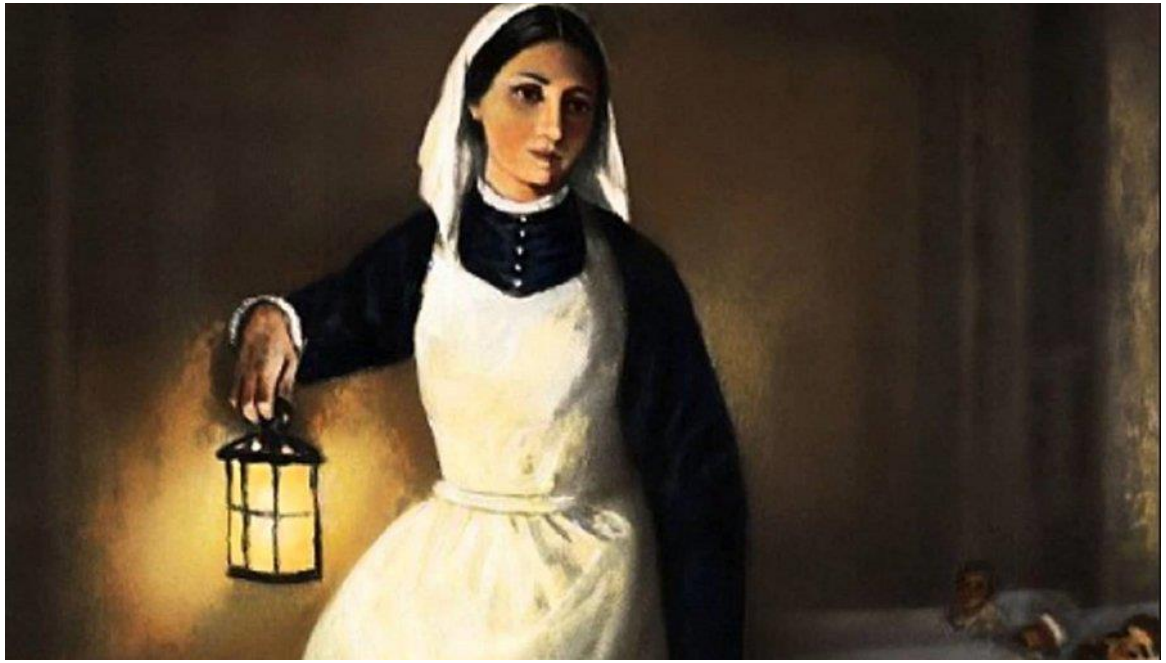
ROYAL COLLEGE *of* PODIATRY

Clinical professional standards: Record Keeping: Best practice for undertaking an audit on your patient records

Marie Laurent and Robin Hull, Professional Support Officers



Not new! Has been attributed to Hippocrates, King Hammurabi and Florence Nightingale

Statistical work carried out by Florence Nightingale, click during the Crimean War 1853-55 which improved sanitary conditions and resulted in decreasing the mortality rates from 40% to 2%.

Audit was formally introduced into the NHS in 1989 via the *Working for Patients* White Paper. It should be noted that at this stage audit was referred to as ‘medical audit’

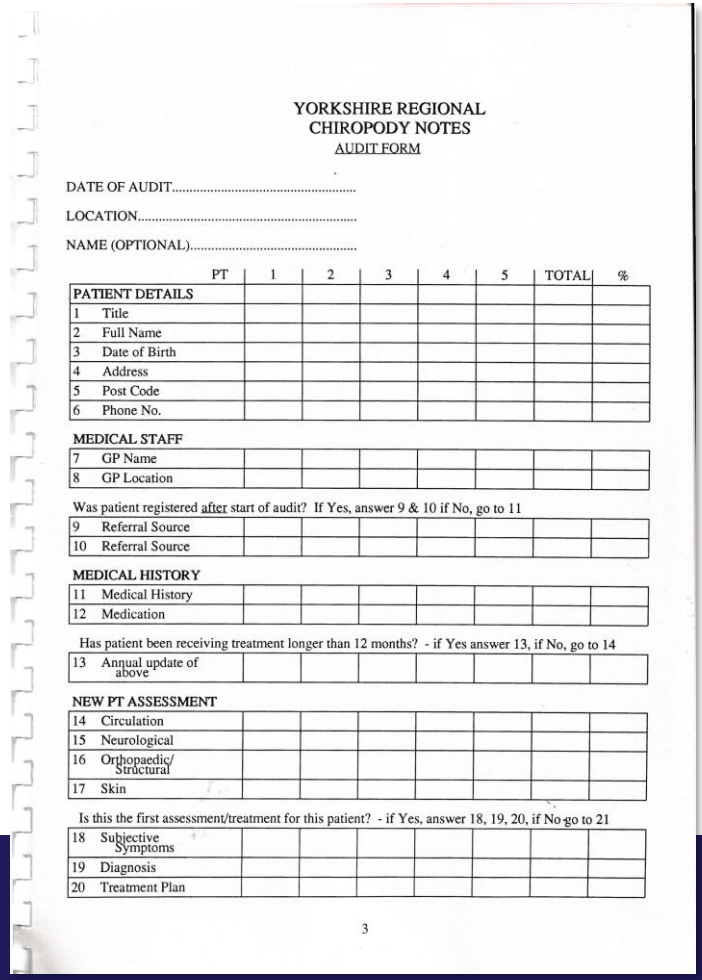
In the early 1990s, audit rapidly evolved and within approximately five years of the *Working for Patients* White Paper, the term ‘clinical audit’ started to gain momentum as nursing staff and other healthcare professionals began participating in audit alongside medics.

Audit is one part of Clinical Governance
Overall aim to improve standard of patient care

ROYAL COLLEGE of PODIATRY

1992/93 First “Chiropody” Note Audit tool developed in Yorkshire region with funding from Regional Nursing and Therapy Audit fund. Was promoted national and adopted or adapted to suit individual services.

- Electronic notes were unheard off
- Some Health Authorities had A4 notes, many on still cards
- Emphasis was on clear legible notes with all sections completed
- Remains the minimum basic requirement to this day



YORKSHIRE REGIONAL
CHIROPODY NOTES
AUDIT FORM

DATE OF AUDIT.....

LOCATION.....

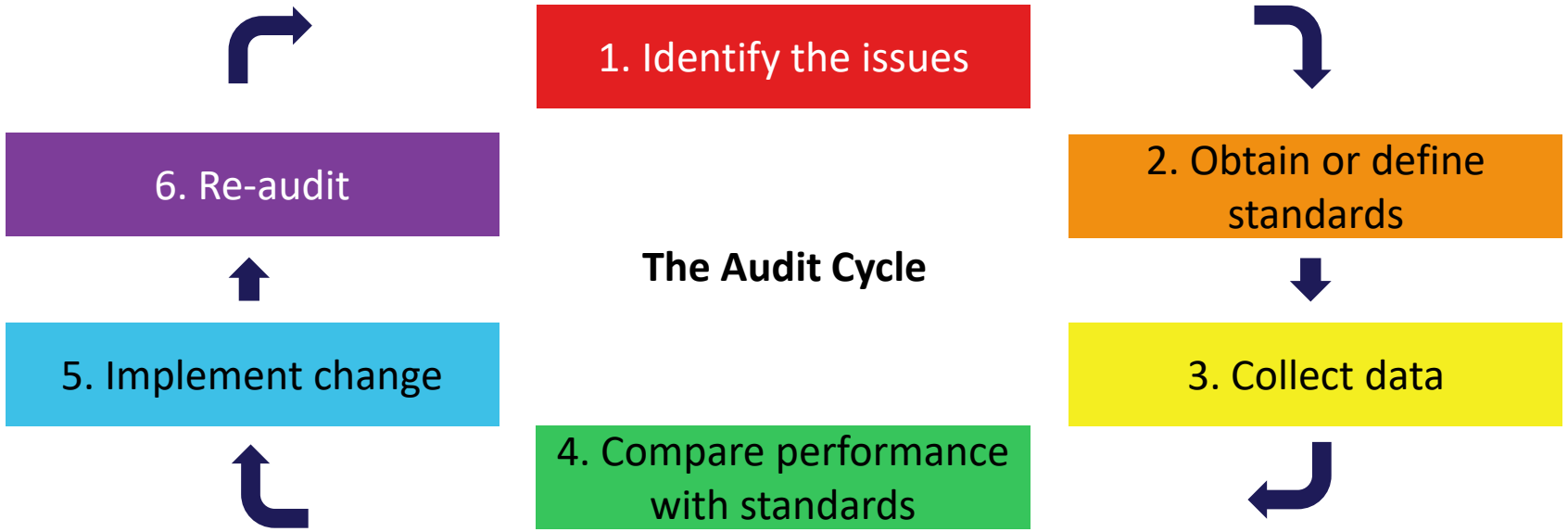
NAME (OPTIONAL).....

PT	1	2	3	4	5	TOTAL	%
PATIENT DETAILS							
1 Title							
2 Full Name							
3 Date of Birth							
4 Address							
5 Post Code							
6 Phone No.							
MEDICAL STAFF							
7 GP Name							
8 GP Location							
Was patient registered after start of audit? If Yes, answer 9 & 10 if No, go to 11							
9 Referral Source							
10 Referral Source							
MEDICAL HISTORY							
11 Medical History							
12 Medication							
Has patient been receiving treatment longer than 12 months? - if Yes answer 13, if No, go to 14							
13 Annual update of above							
NEW PT ASSESSMENT							
14 Circulation							
15 Neurological							
16 Orthopaedic/ Structural							
17 Skin							
Is this the first assessment/treatment for this patient? - if Yes, answer 18, 19, 20, if No go to 21							
18 Subjective Symptoms							
19 Diagnosis							
20 Treatment Plan							

3

ROYAL COLLEGE of PODIATRY

The Audit Cycle applied to podiatry notes



Poor record keeping

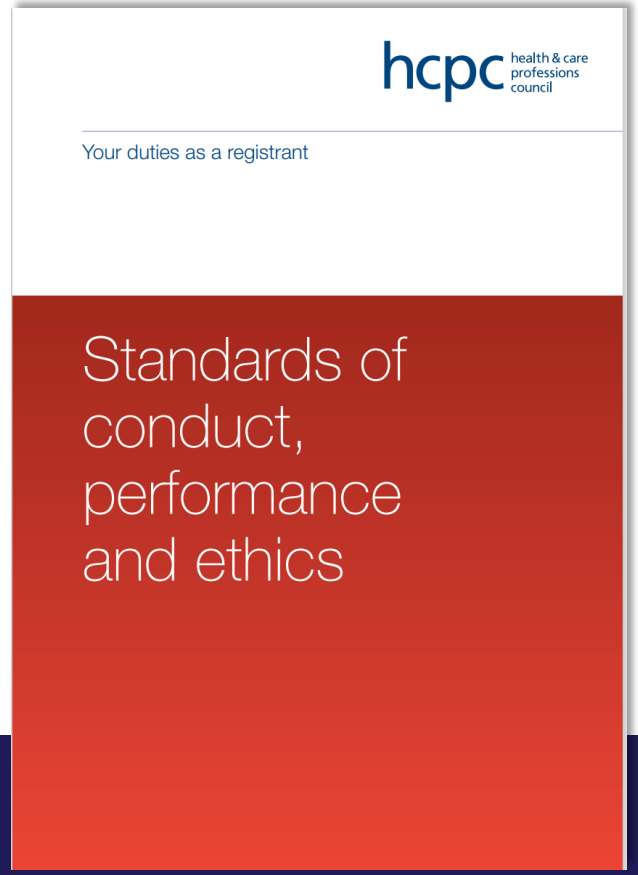
- makes it harder to deliver continuity of care for patients
- is regularly identified as a concern during patient complaints, litigation and HCPC FtP concerns
- makes it harder to defend clinical decision making and your case
- means increased costs for defending cases as need greater use of expert witness and time of lawyers – increased cost to all members fees

Poor record keeping (hcpc-uk.org)

Full, clear and accurate record keeping is vital to the delivery of **safe and effective healthcare**

HCPC Standards of Conduct, performance and Ethics state:

10.1 You must keep full, clear, and accurate records for everyone you care for, treat, or provide other services to.
10.2 You must complete all records promptly and as soon as possible after providing care, treatment or other services.

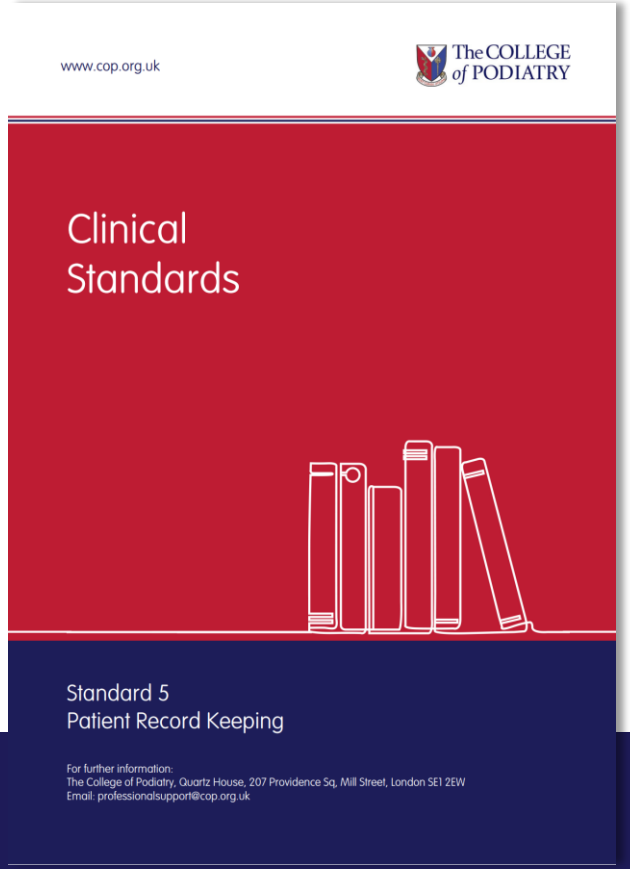


2. Obtain or define standards

Clinical Standards (rcpod.org.uk)

RCPod Clinical standard 5 – Record keeping
Records should:

- be relevant, factual, consistent, and accurate
- be signed and dated and written as soon as possible after the event
- not contain information which would surprise the patient
- relevant information (e.g. leaflets) should be provided to the patient directly during the consultation.

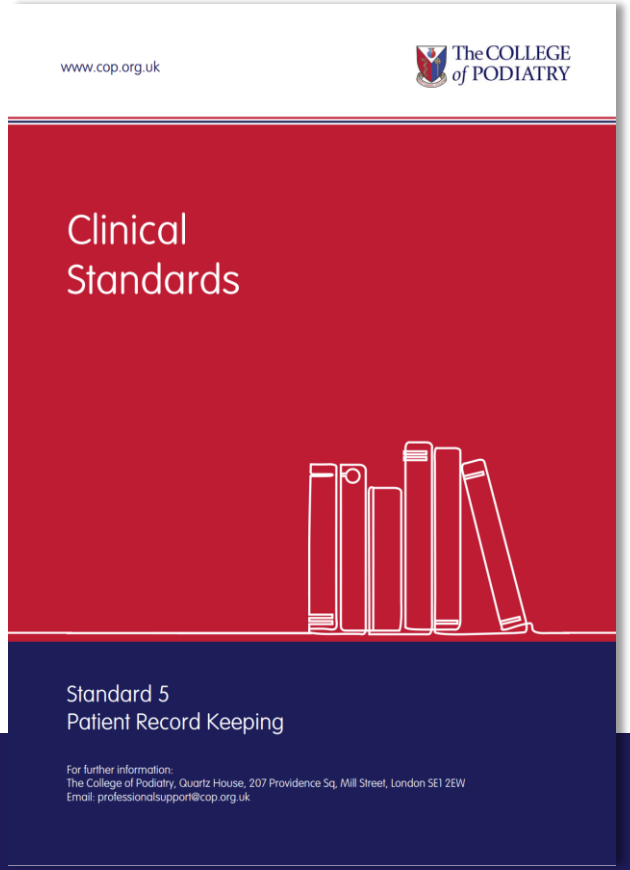


2. Obtain or define standards

Clinical Standards (rcpod.org.uk)

RCPod Clinical standard 5 – Record keeping

Practitioners who are employed should have regard to any relevant local guidance issued by their employer, and these should be included within your standards for auditing



ROYAL COLLEGE of PODIATRY

3. Collect data

Consider

- Consider the sample size and the number of standards you are checking against, and whether this is reasonable to indicate if the standard is met
- Consider the time it will potentially take – it is likely to take longer than you anticipate
- Consider enlarging sample size if the results are poor

- Data needs to be collected retrospectively
- e.g. retrospectively checking one days' worth of patient records per podiatrist
- whether you need to check 10 sets of patient records per podiatrist and whether you need to retrospectively choose a date range

✓ Create your audit tool, or use the example in Annex A of the RK Standard

ROYAL COLLEGE of PODIATRY

3. Collect data

Audit of Patient Records

	Set of patient notes: 1	2	3	4	5	6	7	8	9	10	Total of Y's
1. Do the clinical notes clearly state the following in a logical format:											
a. Patient's Name and dates of each appointment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
b. Why the patient has attended the clinic	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
c. Description of examination and its findings including relevant negative findings	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
d. Diagnosis or differential diagnosis with reasons											
e. The treatment carried out including site and details of technique used	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
f. Plan including follow-up arrangements and any 'safety netting' advice	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Is the patient's medical history complete with no blank gaps and showing that it has been updated prior to any treatment and no less than every 12 months?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

ROYAL COLLEGE of PODIATRY

3. Collect data

3.	Are the patient notes legible?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	Is there a record of the patient's consent, including details of the discussion underpinning that consent i.e Goals, options, risks and benefits	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	Is the patient note signed after each entry or can the podiatrist be identified on computerised notes?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	Are abbreviations kept to a minimum and only College approved abbreviations used?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	Are the records written in dark ink or able to be printed?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

ROYAL COLLEGE of PODIATRY

3. Collect data

8.	Is each of the pages numbered or can the record be printed in chronological order?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	Are any errors crossed out with one line and signed so that they are still legible; or are errors on computerised records clearly mark as such and still visible?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	For patients with diabetes is there evidence of an annual diabetic check present?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11.	Is there a record of any advice given, including advice in respect of after-care or self-management, with details of any advice leaflet issued to the patient including the title of the leaflet?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12.	No payment information is included on the patient record?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

ROYAL COLLEGE of PODIATRY

3. Collect data

13. Are records kept securely when not in use (paper or electronic)?

Y or N

We would expect question 13 to be answered 'Y' in all cases.

Podatrists Name..... Signed ..... Date .....

ROYAL COLLEGE of PODIATRY

4. Compare performance with standards

The Gold standard would be that you answered "yes" to all 13 questions in the Audit tool for all the patients audited

If not, analyse why:

- How many people collected the data, is there so interpretation error present?
- Is there a common error of missing data amongst your practice/practitioners?

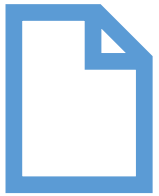
Discuss the results amongst the team

- Discuss RCPod RK Standard and what should be included in every set of notes
- Sharing of outcomes can be done in anonymous way if required, but transparency should be encouraged
- How could record keeping be improved?
- Set a date for a retrospective re-audit

5. Implement change

Any change will depend upon the areas identified in your audit

Do your forms need changing to remind you to include certain information – e.g. medical history form to ensure no gaps, page numbers (paper records)



Do you need to consider switching from paper notes to electronic?

Is it a time-constraint issue? Do you need to consider incorporating further time into the appointment slot, or more time at the end of session?

6. Re-audit

Timing of a re-audit depends upon your results

- Consider annual audit if all audit standards were met (‘gold standard’)
- Consider an audit in, say, three months if many standards are not met
- It is vital to achieve ‘gold standard’ for record keeping
- However, if your audit results reflect ‘gold standard’ then you could consider exploring audits in other areas of your practice

ROYAL COLLEGE of PODIATRY

Moving forward

Reflect upon other areas of concern within your practice, or areas where you feel you could improve upon

e.g.

- Outcomes of orthotic treatment
- Pain scores for before and after treatment
- Nail regrowth
- NDFA (NHS)
- Change in condition – ie new assessment when new ulcer
- Conversation rate of initial appt to rebookings

Using electronic tools to assist audit

If using electronic notes then you can use coding or treatment type, to identify specific conditions, diagnosis, treatment or outcomes to identify which patient notes you want to audit

Coding could be Read codes (comprehensive codes used mainly in NHS)

Local Codes (With Cliniko you can set “treatment type” to suit your practice)

With SystmOne in a large NHS department there could be 1000-2000 patient contacts per week.

- SystmOne report would be huge
- Can export data to Excel spreadsheet and eliminate all those where appointment date and date notes written up are the same.
- Then have the data for discussion
- Could be genuine reasons for late recording of data

Event date (appointment date)	Event day	Event entered date (date notes written up)	Event recorded by	Days different	NHS no	Patient Surname
12-Jun-23	Monday	19-Jun-23	GRAY, Sharon (Mrs)	7	9876543210	Fawcett
12-Jun-23	Monday	19-Jun-23	GRAY, Sharon (Mrs)	7	9876543211	Chapman
12-Jun-23	Monday	13-Jun-23	GRAY, Sharon (Mrs)	1	9876543212	Windsor
12-Jun-23	Monday	14-Jun-23	AMBROSE, Lawrence (Mr)	2	9876543213	Maxted
12-Jun-23	Monday	13-Jun-23	AMBROSE, Lawrence (Mr)	1	9876543214	Mullenger
12-Jun-23	Monday	16-Jun-23	LAURENT, Marie (Mrs)	4	9876543215	Linley
13-Jun-23	Tuesday	14-Jun-23	LAURENT, Marie (Mrs)	1	9876543216	Elsworth
13-Jun-23	Tuesday	16-Jun-23	Hull, Robin (Mr)	3	9876543217	Murry
13-Jun-23	Tuesday	16-Jun-23	Hull, Robin (Mr)	3	9876543218	Lawton
13-Jun-23	Tuesday	16-Jun-23	Hull, Robin (Mr)	3	9876543219	Skelton
13-Jun-23	Tuesday	16-Jun-23	Hull, Robin (Mr)	3	9876543220	Carr
13-Jun-23	Tuesday	16-Jun-23	Hull, Robin (Mr)	3	9876543221	Lange
13-Jun-23	Tuesday	14-Jun-23	AMBROSE, Lawrence (Mr)	1	9876543222	Burleigh
14-Jun-23	Wednesday	15-Jun-23	AMBROSE, Lawrence (Mr)	1	9876543223	Hodgson
14-Jun-23	Wednesday	16-Jun-23	GRAY, Sharon (Mrs)	2	9876543224	Blakeley
14-Jun-23	Wednesday	16-Jun-23	GRAY, Sharon (Mrs)	2	9876543225	Walker
15-Jun-23	Thursday	16-Jun-23	LAURENT, Marie (Mrs)	1	9876543226	Tapply
15-Jun-23	Thursday	16-Jun-23	LAURENT, Marie (Mrs)	1	9876543227	Welburn
16-Jun-23	Friday	20-Jun-23	Hull, Robin (Mr)	4	9876543228	Ridley
16-Jun-23	Friday	20-Jun-23	Hull, Robin (Mr)	4	9876543229	Jackson
16-Jun-23	Friday	20-Jun-23	Hull, Robin (Mr)	4	9876543230	Bairstow
16-Jun-23	Friday	20-Jun-23	Hull, Robin (Mr)	4	9876543231	Dutton

Electronic audit used to identify which patients notes need manual audit.

NHS systems such as SystmOne tend to use clinical coding known as Read Codes for assessments and diagnosis

In this example looking at Diabetes risk assessment.

Report shared with department using assignment number so individuals only know their own data

Assignment number	(XaleL) O/E - Left diabetic foot at low risk	(XaleR) O/E - Left diabetic foot at moderate risk	(XaleM) O/E - Left diabetic foot at high risk	Grand Total	% Coded low	% Coded Moderate	% Coded High
11671542		4	3	**7**	0.00	57.14	42.86
22706959	10	9	2	**21**	47.62	42.86	9.52
22817981	8	11	2	**21**	38.10	52.38	9.52
22818116	1	20	2	**23**	4.35	86.96	8.70
22818147	8	3		**11**	72.73	27.27	0.00
22818206	2	3		**5**	40.00	60.00	0.00
22818249	9	4		**13**	69.23	30.77	0.00
22818375	4	1		**5**	80.00	20.00	0.00
22818411	3	1		**4**	75.00	25.00	0.00
	366	**433**	**229**	**1028**	**35.60**	**42.12**	**22.28**

Reminder on Record Keeping

- Records should be relevant, factual, consistent and accurate
- Include the date and time on each entry
- SOAP Format
  - *Subjective:* What the patient is complaining of
  - *Objective:* Your observations including any relevant assessment results
  - *Action*: Treatment
  - *Plan*

- Each entry should be signed at the end – with no further lines added without a signature

- In paper notes – your name should be written under your first signature

- If it is not recorded it has not been done!

ROYAL COLLEGE of PODIATRY

Reminder on Record Keeping

What else constitutes treatment notes:

- New patient consent form
- New patient assessment inc fully completed medical history forms – e.g. all tick box questions must have a response
- Consent for specific treatments – e.g NS / VP
- Photos
- Any telephone conversations and correspondence with the patient including emails

ROYAL COLLEGE of PODIATRY

Reminder on Record Keeping

Also includes…

- Correspondence to and from other HCPs
- Blank spaces should be struck through, to prevent subsequent amendments
- Any alteration needs to be dated and signed in such a manner that the original entry can still be read
- Software must have an audit trail function that will show any alterations and reliably attribute them to an identified use
- Computerised notes need to be able to identify the practitioner by a password, ideally 2FA – do not have a generic profile or share passwords

ROYAL COLLEGE of PODIATRY

Reminder on Record Keeping

To note…..text messaging and social media conversations, and use of own phone

Text messaging and social media conversations are informal and are therefore considered to be an inappropriate way to communicate with patients regarding their individual medical issues.

It is advised to have these conversations via phone or email (recording the content in the notes). Use of own phone for email/photos/messages is not advised due to the potential risk of unauthorised use. A business mobile phone / business camera is preferred.

ROYAL COLLEGE of PODIATRY

Signed Consent

- A signed consent form is only one part of the overall evidence that informed consent has been obtained.
- Where procedures are invasive and/or carry significant risks, patients must be asked to sign a further consent form. This includes the following:
  - All invasive procedures
  - Any treatment requiring local anaesthesia
  - Any treatments involving caustics, cryotherapy, dry needling and alternative therapies
  - All verrucae treatments
  - All injections of medicines
  - Acupuncture
  - Where a student, or someone in training situation, is to undertake the procedure
  - Photography and video recordings

Any Questions

Professional Support Officers

professionalsupport@rcpod.org.uk

020 7234 8652