1. Introduction

This report is the first attempt by the hospital at an inpatient record review. The aim for the review was to assess the current position of the hospital with regard to the state of our inpatient records across several wards. The data presented here will act as a baseline for us to build upon.

2. Methods

The methodology for the review was taken from the document produced by Dr P Ramdas and Dr C Reddy “A methodology to conduct inpatient record reviews” KZN DOH 2004.

Basically we randomly selected 40 sets of case notes, 10 from the paediatric ward, 10 from the female surgical ward, 10 from the female medical ward and 10 from the male ward (surgical and medical). Each chart was assessed and scored on indicators for medical, pharmacotherapy, nursing and administration as shown in the results.

The results are presented as a whole and not separated by ward.

3. Results

Medical indicators (Target 100%)

1. History of presenting complaint 40/40 (100%)
2. Basic examination 40/40 (100%)
3. Assessment 28/40 (70%)
4. Plan 37/40 (92.5%)
5. Investigations 40/40 (100%)
6. Progress notes with time and date 0/40 (0%)
7. All entries signed 40/40 (100%)
8. Charts with all medical indicators 0%
Pharmacotherapy indicators (Target 80%)

1. EDL followed / rational prescribing 32/38 (84%)
2. Medicine in stock 38/38 (100%)
3. Medicines administered correctly 35/38 (92%)
4. Acceptable time lag before medicines given 35/38 (92%)
5. Prescribers signature 38/38 (100%)
6. Charts with all indicators 29/38 (76%)

Nursing indicators (Target 100%)

1. Vital signs recorded as prescribed 40/40 (100%)
2. Admission entry and assessment completed 40/40 (100%)
3. Plan of action in line with needs 40/40 (100%)
4. Progress notes six hourly 26/40 (65%)
5. All entries dated, timed and signed 37/40 (92.5%)
6. Charts with all indicators 23/40 (57.5%)

Administration indicators (Target 100%)

1. Admission form filled 40/40 (100%)
2. Classification according to income 31/40 (77.5%)
3. Charts with all indicators 31/40 (77.5%)

4. Discussion

This is a first round audit of the hospitals inpatient notes. Several problems are immediately obvious. Firstly the medical staff are not recording the time patients are seen in the notes either on admission or at review although the date was always recorded and all entries were signed. This problem is fairly easy to rectify. Other problems with the medical note entries are that in 30% of cases an assessment or diagnosis was not included in the clerking. Following the SOAP style of note taking will address this.

Pharmacy indicators were generally very good. In 16% of cases the EDL had not been followed and no justification given.

The nursing indicators were very good apart from lack of progress notes in 35% of cases. These notes were all from a single very busy ward and the patients had only been on the ward for a day or so. Strategies will need looked at to see the nurses have time to complete their paperwork.
The only problem with the clerical indicators was that the level of income had not been recorded in 22.5% of cases.

Overall the standard of notes was felt to be good. There are several areas of weakness outlined above that will need to be addressed and will hopefully show some improvement before the next audit is carried out.