Audit of documentation at St James's Hospital Memory Clinic: a Quality Improvement Initiative

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Background

Good quality case notes and assessments facilitate 1) Diagnostic decision making 2) inter-disciplinary communication 3)are a useful asset for research
4) Provide a fundamental safeguard should a medico-legal issue arise

Aims & Objectives

Aim: To improve the quality and standards of the patient case notes recording the *assessment process*, *diagnosis disclosure and communication* attending St. James's Hospital Memory Clinic

Objectives: To ensure 1) All case notes include the information outlined in NICE guidelines (2018) and Royal College of Psychiatrists MSNAP standards (2020) for assessment and diagnosis
2) The content of all the case notes follows the HSE Standards and Recommended Practices for Healthcare Records Management (2011)

Methods

Audit tool designed based on above mentioned standards

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Case notes of patients assessed at the Memory Clinic from 1st July 2020 to 31st Aug 2020 were appraised

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Results presented to the team and recommendations sought

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Change:New documentation templates, separate for initial and follow up assessments

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Time allowed to embed the templates fully in clinic

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Re-audit: appraise notes of consecutively assessed pts from 1st April 2021 to 13th May 2021

Results

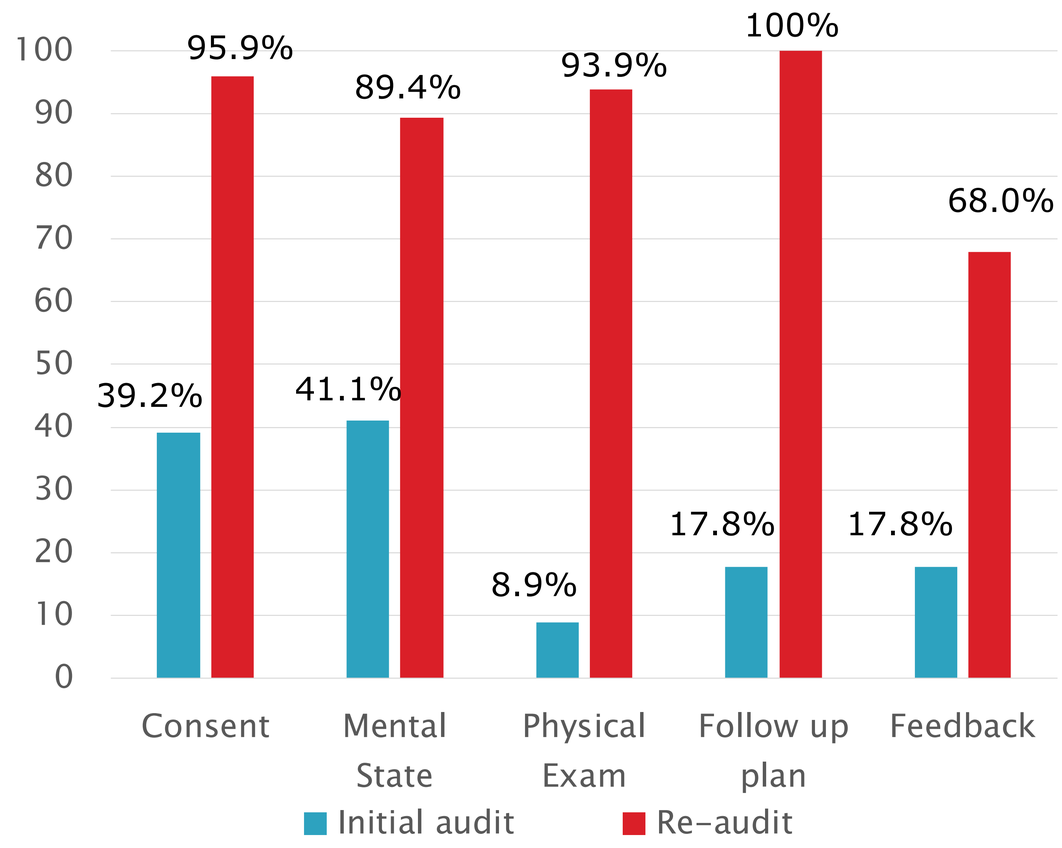
Re-audit demonstrated improvement in documentation, particularly for:

- Consent for participation in research
- Preferences for diagnosis disclosure
- Recording of sensory deficits-hearing vision and sense of smell
- Mobility and falls
- Alerts and allergies
- Over the counter medications
- *Anticholinergic Cognitive Burden Score*
- All aspects of history: personal history, smoking, alcohol, driving, regular activities, Will, EPOA
- Others as shown in the chart

New documentation template **feedback section comprehensively designed** to adopt a brain health approach at feedback meetings and clearly record discussions of risks and risk management

Areas for further improvement highlighted by the re-audit:

- Low rates of recoding two patient identifiers on each page of case notes
- Calculating Anticholinergic Cognitive Burden score of medications
- Recording dementia screen blood results
- Fully completing the feedback section at disclosure
- Completing a personalized feedback form for the patient



Conclusions

This was a useful process which has improved the standards of assessments and documentation.

The re-audit has identified some areas which need further work. These issues have been discussed within the team, recommendations incorporated into practice and will be re-audited in 4 months.

References & Declaration

Clinical audit consent sought from Research & Innovation Department of St. James Hospital

1. National Institute for Health and Care Excellence (NICE) *Dementia: assessment, management and support for people living with dementia and their carers* 2018 (NG97) Avilable at: https://www.nice.org.uk/guidance/ng97 (Accessed 9 November 2020)
2. Royal College of Psychiatrists *Memory Services National Accreditation Programme (MSNAP) Standards for Memory Services, 7th edn, 2020* (CCQI 335) Available at: http://www.rcpsych.ac.uk/msnap (Accessed 9 November 2020)
3. HSE *HSE Standards and Recommended Practices for Healthcare Records Management 2011* (QPSD-D-006-3) Available at: https://www.hse.ie/eng/about/who/qid/quality-and-patient-safety-documents/v3.pdf (Accessed 9 November 2020)