



## *9th Toulon-Verona Conference*

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# PATIENT RECORDS AND HOSPITAL ACCREDITATION. THE EXPERIENCE OF THE HOSPITAL OF TRENTO-ITALY

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## ABSTRACT

*Accreditation in rude is a risk reduction process and medical records (more appropriately patient records) are powerful tools to improve communication among the members of the hospital teams in the process of care. The authors describe the experience of the hospital of Trento-Italy in complying with Joint Commission International (JCI) standards on management of information (MOI).*

*Policies and procedures on documentation of care processes have been reengineered across the entire hospital, and a monitoring process has been established. A sample of 982 patient records has been assessed with a check list of 60 items: initial assessment of patient (17 items), management of patient: plan of care, therapy, plan of surgical care, clinical notes (10 items), surgical or anaesthesia procedure (22 items), discharge (11 items).*

*Items in the check list were scored: met (1), partly met (0,5), not met (0), not applicable. Ad hoc Indicators for the monitoring process were: percentage of complete patient records, level of completeness of a single patient record, mean level of completeness of patient records. Mean completeness of initial assessment of patients (17 items) was 79,32%; mean level of completeness of patient management (10 items) was 78, 01%; mean level of completeness for surgical procedure (22 items) was 80,36%; mean level of completeness for discharge was 88,68%*

*The core of the health information system in the hospital lies in the patient records, which should contain all the data concerning the who, what, when and how of medical care. The myth of completeness of patient record (the theory) is often disrupted by the plain observation of what is done in practice. Our baseline in the first assessment was very unsatisfactory, but through a wide organizational effort we involved many professionals in the reengineering and use of patient records according to JCI standards. The indicators used to assess the sample of patient records monitored showed a somehow encouraging compliance. JCI survey in June 2005 was passed and all the standards involved with patient records proved to be an important asset in achieving this goal*

## INTRODUCTION

Accreditation<sup>1</sup> is a process in which an entity, separate and distinct from the health care organization, usually nongovernmental, assesses the health care organization to determine if it meets a set of requirements designed to improve quality of care. Accreditation is usually voluntary and provides a visible commitment by an organization to improve the quality of

patient care, ensure a safe environment, and continually work to reduce risks to patients and staff.

According to the Joint Commission International (JCI), standards are requirements that define performance expectations with respect to structure, process and outcomes that must be substantially in place in an organization to enhance the safety and quality for patient care.

On the other side, the medical record (more appropriately the patient record) can be defined, as *the who, what, why, when and how of patient care during hospitalization*<sup>2</sup>.

The primary purpose of maintaining patient records is to facilitate planning and continuing patient care and treatment<sup>3</sup>, and patient records serve as one of the main communication tools between all members of a health care provider team; there is no doubt that a well documented patient record is essential to good medical care. Therefore, accreditation standards, as the ones in the JCI model of hospital accreditation, take into account the quality of patient records. Under JCI perspective, patient records are documents consisting in pieces of written or printed matter that provide records of evidence of events and care related processes. Documentation is the accumulation, classification, and dissemination of information relating to those processes or events. The objective of any document, like any conversation, is communication; therefore a patient's record is intended to communicate clinical information in a language understandable to everyone who has access to it, including the patient and his or her family, and it must be written simply and clearly<sup>4</sup>.

In a more comprehensive perspective, the practice of medicine is an information-dependent industry in which hospitals, health care providers, and administrators face the formidable task of gathering and exchanging massive amounts of patient information fully, accurately and quickly<sup>5</sup>.

Medicine is an information dependent field in which data are collected, analyzed, and disseminated at each point in the patient-care process, from the doctor-patient level to the senior management levels of hospital and oversight groups.

Patient records provide a history of each patient's medical condition and treatment; they constitute a vital link between patients, doctors, nurses and units/departments within an hospital.

Because physicians need to be aware of an abundance of medical data in order to provide the most informed patient care, these data need to be timely, accurate, complete, and accessible.

Since patient records are central to the health care process, the way in which this information is managed is subject of immediate and ongoing concern both to the medical profession and the public. Documentation can no longer be considered an intrusion in managerial or clinical time, and indeed external pressure in the form of public demands for accountability have increased exponentially over the past decade.

In addition to providing a chronology of patient care, patient records are now used for a number of other purposes. The record is used for billing and third party reimbursement, medical research, and in peer review and quality assurance process. Also, the record provides defence against claims of medical negligence<sup>6</sup>. Whether the matter involves health and accident insurance, administrative benefits, claims for damages through workers' compensation, personal injury investigations, or professional liability lawsuits, frivolous or not, the patient record provides the evidence and basis for any action. The importance of good record keeping cannot be overemphasized. A complete, accurate record suggests that due care was exercised in diagnosis and treatment. While, on the other side, incomplete or vague records may force the settlement of a claim. Good patient records can be considered as *witnesses whose memories never fade*<sup>7</sup>. No matter how much a physician may insist that a certain action was taken or that a discussion (i.e. about informed consent) took place, the absence of appropriate documentation renders an oral statement weak and ineffectual<sup>8</sup>. Plaintiffs' attorneys often argue that, *in it wasn't written down ... it didn't happen*<sup>9</sup>. Nothing

new under the sun, since the Romans used to say the same, as in the following aphorism *quod non est in actis, non est in mundo*<sup>10</sup>.

More than that, there is an old saying that doctors go to school to learn how to write illegibly, while pharmacists (and nurses too) go to school to learn how to read what doctors write<sup>11</sup>

Therefore the assertion that doctors have bad handwriting<sup>12</sup> holds an honoured place in traditional lore. The question of doctors' handwriting<sup>13</sup> – a self righteous chicken scratch that is decipherable only by experienced pharmacists – has a serious side with far reaching implication on the effectiveness of communication between members of health care teams and it's implication in patient safety<sup>14</sup>.

Automation<sup>15</sup> may help reduce some of the problems we have outlined, however while several health care organizations have made steps in automating portions of patient records to better manage the patient care process, these efforts remain piecemeal (i.e. information systems that automate a set of functions in ancillary departments such as radiology, laboratory or pharmacy)<sup>16</sup>. To date hospitals in general still rely on paper patient records for a variety of reasons, including physician's reluctance to change their ways of practicing medicine; technology that is unavailable, not fully developed, or costly; concerns with data privacy and security; concern with the legal and regulatory acceptability of automated data; and a lack of widely accepted guidelines for standardizing data<sup>17</sup>.

## OBJECTIVE

Describe the process undertaken in Santa Chiara Hospital of Trento (HT) to meet JCI standards on patient records as an effort to improve the quality of communication between members of healthcare teams, and therefore patient's safety

## SETTING

HT is part of the Health Care Trust-APSS, a very complex organization of the National Health System, with a workforce of 7.000 employees, 11 primary care districts and 2 hub and 5 spoke acute hospitals. HT is the main health care facility of the APSS and has the following characteristics: 874 beds (of which 110 Day Hospital beds), ≈ 37.000 admissions in 2005, ≈ 2.000 employees (335 physicians) and cost of production up to € 170.000.000.

During 2005, after a *journey* of more that 2 years, HT has been accredited by JCI which has evaluated the hospital and found it to meet the international health care quality standards for patient care and organization management (effective 25 June 2005 through 24 June 2008)

## METHODS

As outlined in the Management of Information standards (MOI) in the *Joint Commission International Accreditation Standards for Hospitals*, the patient records must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course of care and results, and promote continuity of care among health care providers.

Each patient record must contain documentation of at least the following:

- *The patient's name, address, and date of birth* and the name of any legally authorized representative
- *The patient's legal status*, as appropriate
- *Emergency care provided to the patient before arrival*, if any
- *The record and findings of patient assessment*, performed within a specific time frame based on patient's conditions, identifying the patient's physical, emotional, social, nutritional, and other needs which are used to develop a plan of care. The standards require that a medical history and physical examination, a nursing assessment, and

other screening assessments (as needed) be performed for all patients within 24 hours of admission

- *A statement of conclusions or impressions drawn from the medical history and physical examination (i.e. a tentative diagnosis)*
- *The reasons for admission or treatment*
- *The treatment plan and goals of treatment, that are documented blueprints or strategies that identify the patient's unique clinical needs and problems, and should be flexible, realistic, useful, informative, individualized and supportive*
- *Evidence of informed consent for procedures and treatments for which hospital policy requires informed consent*
- *All diagnostic and therapeutic procedures performed and the results*
- *Tests results relevant to managing patient's condition*
- *Records of all operative and other invasive procedures performed such as preoperative diagnosis and an operative report with the post operative diagnosis*
- *Progress notes made by the medical staff and other authorized individuals*
- *All reassessments and any revision to the treatment plan*
- *Clinical observations*
- *The patient's response to care*
- *Consultation reports*
- *Every medication ordered or prescribed for inpatients*
- *Every dose of medication administered and any adverse drug reaction*
- *All relevant diagnosis established during the course of care*
- *Any referrals or communications made to external or internal care providers and to community agencies*
- *Conclusions at the end of the hospitalization (outcomes of care are documented and conclusions or prognosis at the termination of the hospitalization are provided)*
- *Discharge instruction to the patient and family. Documentation is critical when a patient is discharged or transferred to another health care organization. Information that should have a place in a discharge summary include: the reason for hospitalization, significant findings, procedures performed and treatment provided during the patient's stay, the patient's condition at discharge, and any necessary instructions to the patient and family (including instructions regarding medications, physical activity, diet, and follow-up) Patient/family education includes assessment of barriers and readiness to learn, and a record of implementation and evaluation of knowledge gained by the patient/family member<sup>18</sup>*
- *Clinical résumés and discharge summaries, or a final progress note or transfer summary*

Documentation provided by all hospital staff should be timely, accurate and consistent. All entries should be signed, dated, and legible, with abbreviations and corrections conforming to HT's policy<sup>19</sup>.

The characteristics of good patient records are the following:

- *Good records are accurate* and must be kept up-to-date at all times
- *Good records are comprehensive* with complete details of the notable findings
- *Good records are legible, clear and concise*
- *Good records are objective* in the way that they should provide insight into the physician's thought process in treating the patient
- *Good records are timely* and events should be recorded as they occur or become known, since delay only exaggerates the risk of confusion or neglect of important facts or observations

- *Good records are unaltered* and any addition, clarification or deletion of anything in the chart should not be made without labelling, dating and initialling the correction

According to the above requirements and characteristics, the JCI manual on accreditation has 50 standards, out of a total of 368, dealing with patient records: 6 standards are related to the function access and continuity of care (ACC), 9 to assessment of patient (AOP), 18 to care of patient (COP), 2 to patient and family education (PFE), 4 to patient and family rights (PFR), 10 to management of information (MOI). 1 to quality and patient safety (QPS).

During the process leading to the accreditation HT has established an appropriate policy on patient records (MOI\_PO\_01), a policy on the use of abbreviations (MOI\_PO\_02), a procedure for the management of documents (MOI\_PR\_01), and a procedure for the evaluation of completeness of patient records (MOI\_PR\_02).

Policies and procedures have been released as the results of an intensive work on the subjects by specific groups made of professionals (doctors, nurses, managers).

The assessment of patient records was conducted as self evaluation in 22 units/departments, with a sample of 5 patient records each month per unit/department since April 2005. The results are supervised quarterly by HT quality committee, and feed-back is given to the units/departments both as written reports and with meetings.

The assessment was performed using a grid of 60 items, split into four sections:

1. first assessment (17 items)
2. management of patient: plan of care, therapy, surgical plan, progress notes (10 items)
3. surgical procedure and anaesthesia procedure (22 items)
4. discharge (11 items)

Items in the check list were scored: met (1), partly met (0,5), not met (0), not applicable.

## RESULTS

A sample of 982 patient records was assessed using the 60 items grid.

Indicators of choice were: percentage of complete patient records, level of completeness of a single patient record, mean level of completeness of patient records. Overall results were the following:

- mean completeness of initial assessment of patients (17 items) 79,32%
- mean level of completeness of patient management (10 items) 78,01%
- mean level of completeness for surgical procedure (22 items) 80,36%
- mean level of completeness for discharge (11 items) 88,68%
- mean level of completeness for the whole patient record (60 items) 81,86%

Table 1 and Graph 1 show the trend and improvement in the time frame close to JCI survey, when meetings and wards inspections were more frequent. but consistency in giving feed-backs to units/departments is very useful.

Self evaluation by units/departments is an established process of monitoring, and it is linked to part of the result salary for doctors (5 points out of 100), which is negotiated every year in the so called *Budget*, or programme of activities.

## CONCLUSIONS

The core of the health information system in the hospital lies in the patient records, which should contain all the data concerning the complex process of medical care. The myth of completeness of patient record (the theory) is often disrupted by the plain observation of what is done in practice (the reality). Our baseline in the first assessment was very unsatisfactory, but through a wide organizational effort we involved many professionals in the reengineering and use of patient records according to JCI standards. The indicators used to assess the sample of patient records monitored show a somehow encouraging compliance that as to be kept in place, and more awareness on the implications of good patient record in the quality of care.



After a full immersion survey performed by JCI for an entire week, we fulfilled our goal to achieve accreditation in June 2005, and our effort in improving the completeness of patient records proved to be an important asset in achieving this goal.

But more important is the fact that patient's records are not just for the individual doctor, but they are a way of communication with other doctors and health care professionals. If they can't be read or are incomplete and lacking information, then doctors are failing in their duty to communicate effectively and this raises the probability of errors of commission or of omission.

Achieving completeness, timeliness and accuracy of patient records is, in itself, an effective risk reduction strategy and we believe that any health care professional has the moral duty to perform accordingly in his/her daily practice, with no excuse such as *lack of time* or the *many things to do* that seem to be a common soundtrack in many hospitals worldwide.

As most doctors dislike paper work and many treat document details in the record as a painful chore which they would rather not do, we like to make a closing remark through the words of one of the founding fathers of modern medicine, Sir William Osler (1849 – 1919), *record what you have seen; make a note at the time; do not wait*<sup>20</sup>.

Table 1

Month of admission (2005)	Section							
	Initial Assessment		Patient Management		Surgical Procedure		Disch	
	Number of records	Mean Level of Completeness	Number of records	Mean Level of Completeness	Number of records	Mean Level of Completeness	Number of records	Number of records
april	73	71,41%	73	70,20%	37	69,93%	61	
may	121	78,41%	121	75,24%	48	77,63%	114	
june	116	80,55%	116	81,38%	54	87,49%	112	
july	124	80,11%	124	81,64%	53	84,57%	114	
august	124	80,63%	124	76,22%	56	80,03%	116	
september	113	77,87%	113	76,14%	50	83,11%	108	
october	104	81,80%	104	80,89%	55	84,37%	101	
november	125	80,82%	125	79,61%	70	77,72%	123	
december	82	82,65%	82	80,50%	42	77,05%	81	
Total	982	79,32%	982	78,01%	465	80,36%	930	

Figure 1: Medication error reporting form]

<b>STAGE DURING WHICH THE ERROR OCCURRED</b>			
<b>PRESCRIPTION</b>	<input type="checkbox"/> Incomprehensible writing <input type="checkbox"/> transcription <input type="checkbox"/> verbal/telephone order not written out or taken down incorrectly	<input type="checkbox"/> incomplete prescription (dose, administration route, etc.) <input type="checkbox"/> the decision to stop the drug administration was not recorded <input type="checkbox"/> other..... ....	
<b>PREPARATION</b>	<input type="checkbox"/> drug exchange	<input type="checkbox"/> incorrect dosage <input type="checkbox"/> other..... ....	
<b>ADMINISTRATION</b>	<input type="checkbox"/> wrong patient <input type="checkbox"/> drug prescribed and not administered <input type="checkbox"/> administration of a drug no longer included in the therapy <input type="checkbox"/> drug over-dose <input type="checkbox"/> drug underdose <input type="checkbox"/> failure to follow the administration timetable	<input type="checkbox"/> incorrect infusion speed <input type="checkbox"/> incorrect administration route <input type="checkbox"/> no monitoring before or after the administration (if specifically required) <input type="checkbox"/> other..... ....	
<b>PERSONS INVOLVED</b>			
<b>WHO MADE THE ERROR?</b>	<input type="checkbox"/> doctor	<input type="checkbox"/> PN	<input type="checkbox"/> other.....
<b>WHO DETECTED THE ERROR?</b>	<input type="checkbox"/> doctor	<input type="checkbox"/> PN	<input type="checkbox"/> Head Nurse <input type="checkbox"/> other
<b>WAS THE ERROR MADE AND DETECTED BY THE SAME PERSON?</b>	<input type="checkbox"/> yes	<input type="checkbox"/> no	
<b>TYPE OF ERROR</b>			
IF POSSIBLE CLASSIFY THE ERROR ACCORDING TO THE ENCLOSED TABLE			
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input checked="" type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> I			
<b>ORGANIZATIONAL CONDITIONS</b>			
<b>WHERE DID THE ERROR OCCUR</b>	<input type="checkbox"/> corridor	<input type="checkbox"/> ambulatory	<input type="checkbox"/> room
<b>SHIFT</b>	<input type="checkbox"/> morning	<input type="checkbox"/> afternoon	<input type="checkbox"/> night
	<input type="checkbox"/> shift change	<input type="checkbox"/> doctor on duty	<input type="checkbox"/> on call
<b>DAY</b>	<input type="checkbox"/> week day	<input type="checkbox"/> before a holiday	<input type="checkbox"/> non-working days
<b>DISTURBING FACTORS (ex.: presence of people, telephone noise, interruptions)</b>	<input type="checkbox"/> no	<input type="checkbox"/> yes	specify .....
NUMBER OF PATIENTS HOSPITALISED .....			
NUMBER OF PATIENTS FOR WHOM THE OPERATOR THAT MADE THE ERROR WAS RESPONSIBLE .....			
REMARKS, NOTES, SUGGESTIONS .....			
<b>OPERATIVE UNIT</b>			
<b>HEAD NURSE SIGNATURE FOR APPROVAL</b>			
<b>UNIT DIRECTOR SIGNATURE FOR APPROVAL</b> .....			