Continuing Professional Development for Osteopaths

OBJECTIVE ACTIVITY

Clinical audit

Worked up example

Case study – clinical audit

A worked example of a case note audit. (Please note that this is a summary of the information provided in the NCOR Clinical Audit Handbook).

Audit Report Template

Title: *Case note clinical audit*

Name of Osteopath: *A. Osteopath (Adapted from the NCOR Clinical Audit Handbook)*

1. Introduction

- Summarise the aims of the audit, the area investigated and what it intended to look at.
- Describe what evidence was identified and the intended benefits to current patients, potential new patients and any staff working in practice.

The aims of the audit are to ensure that:
> Information is recorded about every patient.
> Notes will act as a high-quality record concerning: -
- *why the patient is attending for treatment.*
- *the questions the patient has been asked.*
- *examinations conducted.*
- *other clinical information collected both within and external to the practice.*
- *the treatment plan and the treatment delivered.*
- *the patient's progress and how this compares with the treatment plan.*
- *the need for referral.*

> Notes will be more accessible and a more useful asset for audit and research purposes.

2. Criteria/objectives

Describe specifically the criteria you identified, why and how they were identified. Describe what benefits the selected criteria represent for patients, the practice and the clinicians in the practice.

> All case notes should include the information listed in the GOsC Osteopathic Practice Standards.

> All case notes should include standards of good practice from identified NHS guidelines.

These criteria were selected following a simple search on PUBMED for Patient AND Record Keeping and on google using patient + record keeping and patient + record keeping + NHS and a review of the Osteopathic Practice Standards. Relevant articles were read to ensure awareness of the most up to date guidelines.

Good quality case notes ensure that they are a helpful resource for practice audit and give indications for areas of CPD as well as research questions.

In the event of requests for information concerning patients, good case notes allow any enquiries to be easily answered.

3. Standards set

Describe specifically the standards set for the audit and how they were identified and agreed on.

An initial sample of 10 case notes identified that existing notes were of good quality and a high standard threshold should be set.

The standards selected were:
> 100% of all case notes should include the information listed in the GOsC Osteopathic Practice Standards.
> 100% of all case notes should include standards of good practice from NHS guidelines.

Reasons the standards were chosen:
> The aim is to make case notes reach as high a standard as possible.
> Clear notes with key criteria to be met avoid recording unnecessary information.

4. Method

Question	**Response**
Where did the audit take place?	*In my single handed practice.*
When did it begin?	*January 2010 following design of the data collection tool.= informed by the GOsC Osteopathic Standards and other guidelines.*
How long did it last?	*Selecting the case notes and reviewing against the tool took 2 hours.*
Who was involved?	*Case notes of 50 patients over the previous year were examined.*
What population / item was being audited?	*See the annex.*
How was the population selected	*50 consecutive patients dating back over the past year was used to ensure that the notes were not 'cherry picked.'*

The size of the population	*As above.*
Attach the data collection tool and describe what data was collected and any other outcome measures used	*See the data collection tool attached below.*

5. Summary of results

Describe the main findings of the first part of the audit, including the population, each standard and the degree to which it was met.

As the standard was 100%, the number of 'nos' were calculated for each item. High numbers of nos included:

Black ink – 51% of records recorded a no for this item.
Family history – 74%
Non-prescribed medication – 20%
Alcohol consumption – 66%
Consent to treatment – 10%

Entering the data into excel provided an opportunity to represent the data as bar charts. (Examples of the full results are outlined in the full report in the NCOR Clinical Handbook)

6. Evaluation of the findings and future action

Question	**Response**
Describe what problems were identified / what could be improved	*Evaluation of the audit findings identified that the 100% standard was reached for 15 of the 43 (35%) items on the data collection sheet relating to standards set for osteopathic case notes. This meant that there was room for improvement in the record keeping.*
Identify what changes will be introduced and how they will be implemented.	*> A new case note sheet was devised specifically listing the headings given above.* *> All pens other than black ones were removed from the practice.* *The new case note sheet took one week to develop and was introduced at the beginning of February 2010.*
State how long you will allow the changes to take effect.	*A span of three months was allowed for the new case note sheet to become fully embedded in the practice before a planned re-audit in May*

Plans for reauditing	*At the conclusion of the three month period.*

7. Findings of the re-audit

Describe briefly when the re-audit took place and what the principal findings were.

Fifty case notes for patients with the new-style notes were audited. The audit data was collected on the data collection grid (figure 6) as described in the first stage and data were entered onto an Excel spreadsheet.

There is considerable difference in the percentage of items not recorded compared with the first stage. Fifty-eight per cent of items reached the 100% standard; although 42% did not fully reach the 100% standard, they reached 90% or above

8. Conclusions

Describe when another audit is likely to take place and what plans are in place to monitor standards.

Describe what has been learned from the audit process. What would you do differently next time? This is an important step and will help consolidate the learning process.

The audit highlighted the clear need to redesign my case notes to meet the current standards of osteopathic practice set in the Osteopathic Practice Standards.

This was not a difficult audit to undertake, but it highlighted the need for some basic planning, reflection on the number of case notes needed, the best time of year to undertake the audit and the time taken to complete all stages thoroughly. The period after Christmas is often quieter in practice, so it represented a good opportunity to undertake the first stage of the audit and implement any changes.

Three months was adequate time for a sufficient number of new patients to be seen to be able to have at least 50 new sets of case notes for audit. It clearly showed that despite considerable change in the number of case notes improving in standard, there was still room for further improvement at the end of the process. The case note will be repeated annually to ensure standards do not slide.

Themes of the *Osteopathic Practice Standards*

My clinical audit helped me to review all themes of the *Osteopathic Practice Standards* as outlined below.

Theme from the OPS	**Reflection**
Communication and patient partnership	*I reviewed the Osteopathic Practice Standards to ensure that the requirements of my recorded consent incorporated the main elements as outlined in Theme A.*
Knowledge, skills and performance	*In order to undertake the clinical audit, I had to research and learn about clinical audit and also reviewing literature around patient notes. This was a significant amount of reading and reviewing of material which gave me the knowledge and skills that I needed in order to undertake a specific clinical audit in this area.*
Safety and Quality	*As part of my clinical audit, I reviewed the GOsC OPS requirements in relation to clinical records.*
Professionalism	*I needed to be able to collect, analyse and reflect on the data that I recorded as part of the audit. Therefore I reviewed the Osteopathic Practice Standard requirements in relation to the analysis of data under Professionalism.*