Medical Records Chart Audits: Effectiveness of Peer Medical Record Audit to Improve Accurate Documentation & Provide Educational Experience to Staff Nurses

THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
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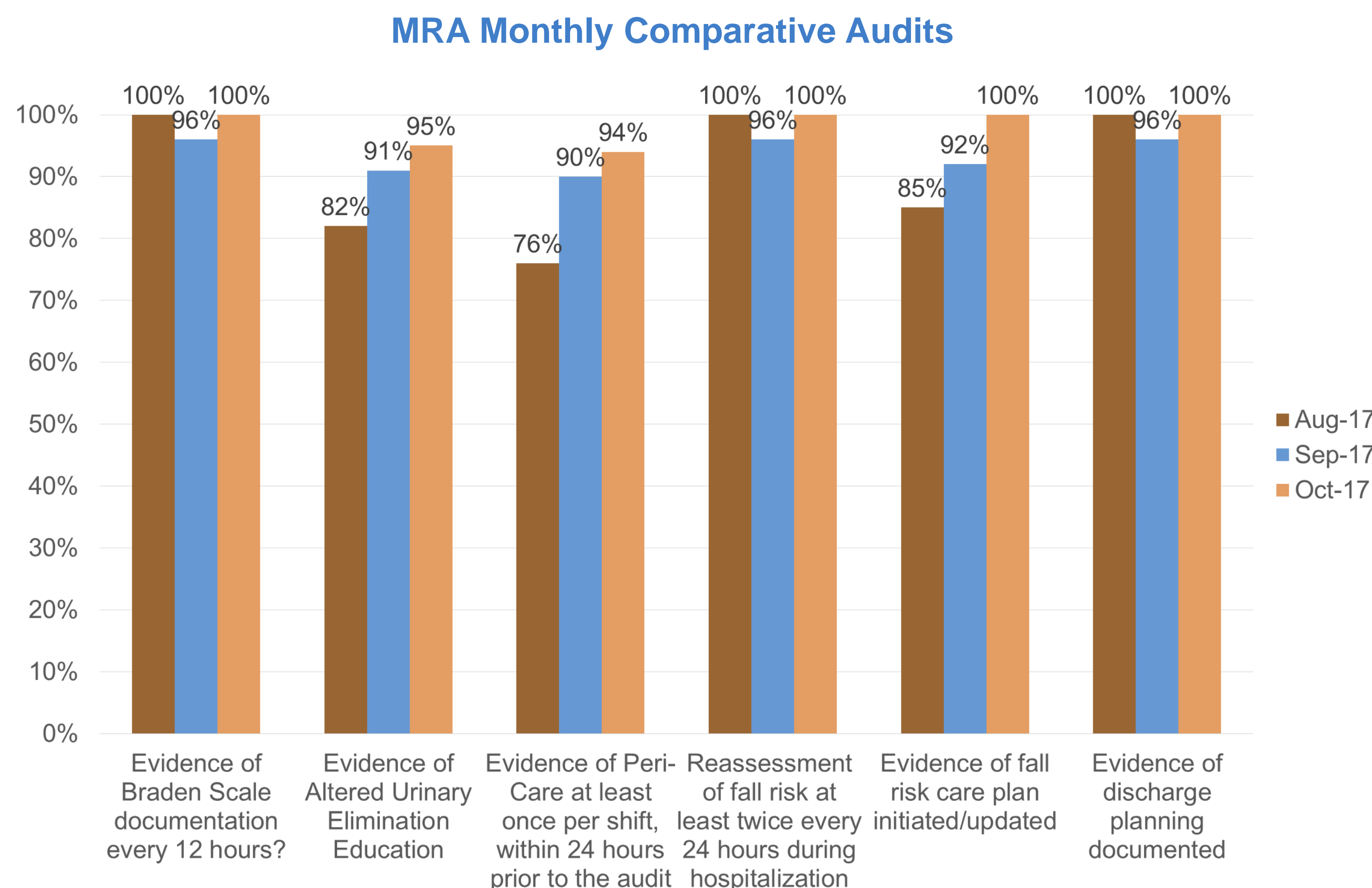
Background

An electronic health record (EHR) can be a powerful tool to healthcare providers to coordinate processes and plan of care. The process of documentation and charting requires accurate, specific, and timely data entry. Oftentimes, there are lapses in nurse charting and vital information can be missed. The process of peer medical record auditing identifies missing information and acts as an education tool for nurses for completing accurate documentation and institutional compliance.

Objectives

The objectives of this quality improvement project were to identify deficiencies in medical records documentation of nurses in Transition Post Anesthesia Care Unit (TPACU). Using peer medical record audits would also give the auditors a first-hand look at the deficiencies and provide opportunities to educate staff about proper documentation.

Design Interventions

The team consisted of 12 RNs in TPACU, with each auditor tasked to audit three different peer nurses' charts per month. Charting was comprised of documentation from a 12 hour shift. Auditors received education and instructions regarding the process and key areas to audit, including admission assessment, SBAR, pain assessment and reassessment, skin assessment scores, and catheter associated urinary tract infections (CAUTI). Data reports were generated monthly to identify individual and group deficiencies. A goal of 90% compliance was set for all elements audited within a 3 month period. Reeducation was conducted on a monthly basis and consisted of team huddles, one on one education and email reminders.

MRA Monthly Comparative Audits (Aug-17, Sep-17, Oct-17)

Was SBAR Permanent Handoff Communication Completed?

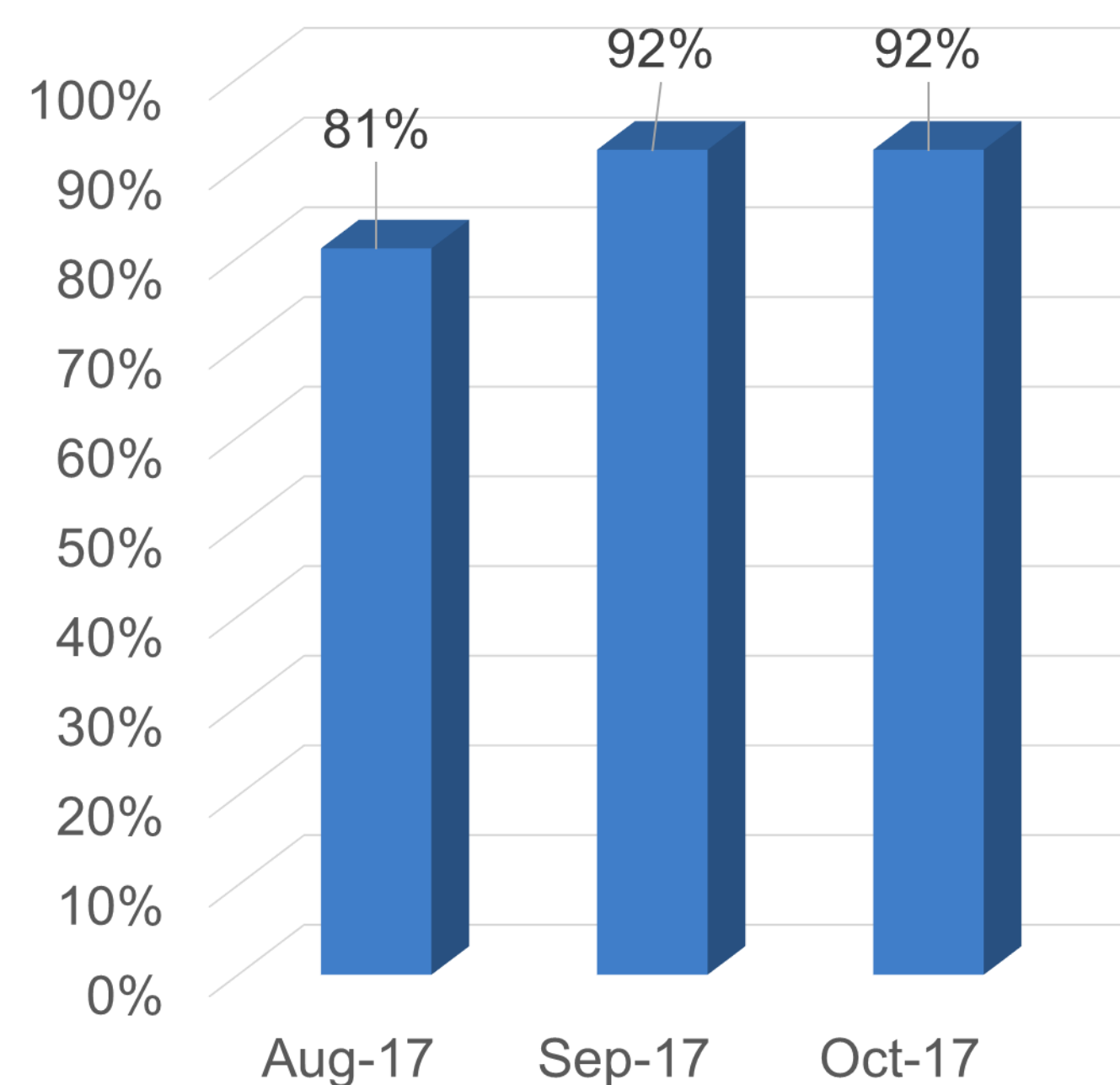**Admission Pain Assessment** (Aug-17, Sep-17, Oct-17)

Results

A monthly comparative report showed gradual but consistent improvement in the medical record documentation by both the auditors and staff nurses. An average compliance score of greater than 95% on all categories showed improvement from an initial average of 90% during the first month of audits. Ongoing education has been provided to educate all nursing staff on how to complete the monthly audits. In collaboration with the nursing staff and leadership team, a heightened awareness was created to ensure documentation compliance and patient safety.
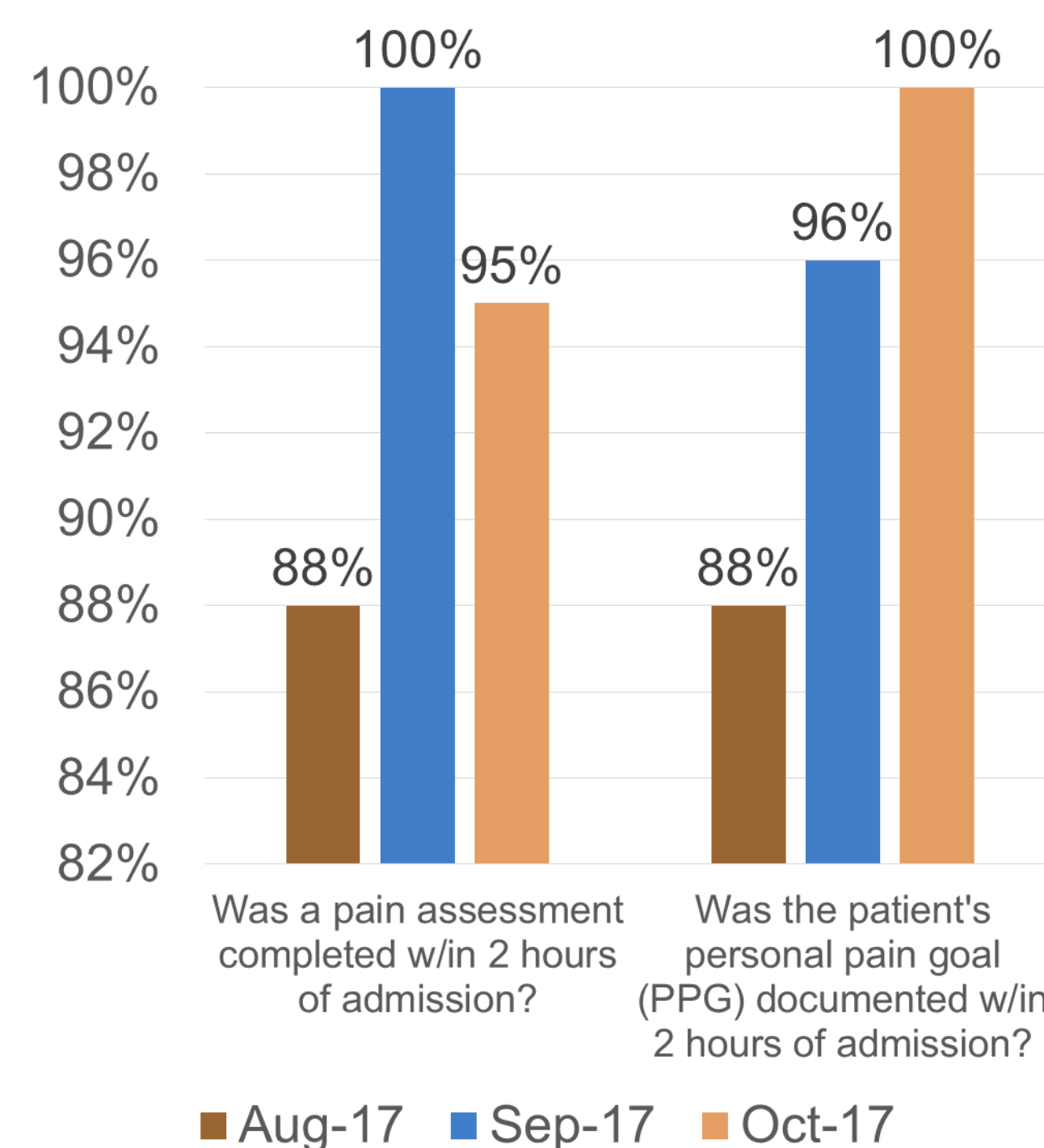
Implications for Nursing Practice

EHR systems have allowed for collection of significant data in a manner that has helped improve patient care and research. Complete and accurate documentation of information by nurses and other healthcare workers is critical to its success. This quality improvement project provided a means of involving clinical nurses in examining documentation of others, learning more about requirements themselves, and assuring accuracy of documentation in the electronic health record.

Team Members

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