Original Article

Highlighting The Flaws In Admitted Patients Treatment Sheets In Cardiology Ward Of Federal Government Polyclinic Hospital: A Clinical Audit Report

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Abstract

Objective
The objective was to bring attention to the deficiencies identified by nurses, registrars, and consultants in the treatment documentation of the admitted patient. Our intervention had a positive impact on the medication administration record of in-patients, leading to improved patient care and better treatment outcomes. Negative reactions to medications or other consequences are experienced by hundreds of thousands of patients every year, yet many of them do not seek medical attention. Apart from the financial implications, medication errors inflict psychological and physical distress upon patients. A significant outcome of medication errors is the reduction in patient satisfaction and a consequent deterioration of trust in the healthcare system.

Keywords: Negligence, records, errors, audit, risk.

Introduction

Why was this change Important?
Errors and mistakes were being made on regular basis because of 2 different treatment sheets (one for nursing team and one for doctors) being used for a single patient, vaguely written medications on treatment sheet and lack of following of standard guidelines with proper documentation and signatures (6,10). This was effecting patient care with delayed and/or improper dosing and both medical staff and patient experience. Maintenance of professional records plays a crucial role in treatment outcome and patient satisfaction, as patient records must travel with the patient throughout the course of care (7). Monitoring of antimicrobial therapy reduces the likelihood of overdosing and the potential for antibiotic resistance to develop in the population (3).

Method

The first audit was done on 31st May 2022. We carried out a cross-sectional snap shot audit of all patients' treatment sheets admitted in cardiology ward. These were compared with standard guidelines which included:

- A dedicated Medication Administration Record (MAR)/ Chart for the patient
- Properly written drug treatment chart in the line with standard practice with doctor signature
- Complete consultant notes and documentation

- Orders being followed by doctor in charge
- Drugs written clearly with proper doses
- Implementation of the change timely as ordered in the daily round with complete documentation by the nurses

Data in the first audit was collected from 7 patients in the Cardiology ward. The audit was repeated after one month. Data in the second audit was collected from 14 patients in the Cardiology ward

Table 1: Results (percentage present) first Audit – 31st May 2022

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Is it a dedicated Medication administration record (MAR) /chart for the patient?	0%	0%	0%	0%	100%
Is the drug treatment chart being properly written in the line with standard practice with doctor signature?	14.3%	0%	14.3%	28.5%	42.85%
Are consultant notes and documentation complete in the current treatment sheet?	0%	14.3%	42.8%	14.3%	28.6%
Are the orders being followed by the doctor in charge (trainee, house officer, medical officer)?	0%	42.85 %	42.85 %	14.3%	0%
Are the Drugs written clearly with proper doses?	0%	28.5%	14.3%	42.8%	14.3%
Have the nurses implemented the change timely as ordered in the daily round with complete documentation?	0%	28.5%	42.8%	14.3%	14.3%
How often omissions/mistakes occur in the current drug treatment chart?	Very frequent 42.8%	Often 28.5%	Neutral 14.3%	Infrequent 14.3%	Rare 0%

Table 2: Results (percentage present) Re - Audit – 7th July 2022

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Is it a dedicated Medication administration record (MAR)/ chart for the patient?	100%	0%	0%	0%	0%
Is the drug treatment chart being properly written in the line with standard practice with doctor signature?	28.5%	21.4%	14.3%	7.2%	28.5%
Are consultant notes and documentation complete in the current treatment sheet?	35.7%	50%	14.3%	0%	0%
Are the orders being followed by the doctor in charge (trainee, house officer, medical officer)?	50%	50%	0%	0%	0%
Are the Drugs written clearly with proper doses?	14.3%	0%	50%	35.7%	0%
Have the nurses implemented the change timely as ordered in the daily round with complete documentation?	50%	50%	0%	0%	0%
How often omissions/mistakes occur in the current drug treatment chart?	Very Frequent 0%	Often 21.4%	Neutral 0%	Infrequent 35.7%	Rare 42.85%

Discussions

Our audit's objective was to identify and call attention to the errors being made daily on the treatment records of admitted patients, which are resulting in poor patient treatment outcomes and negatively impacting patient quality of life. As a result, we audited patients admitted to the cardiology ward of the polyclinic hospital. Our study employed a cross-sectional snapshot methodology. Initially, the records of seven patients were reviewed (Fig 2). After the first audit's results were analyzed, they were presented to the hospital administration, and adjustments were made to the medication administration record, nursing staff training, and doctor education. Both the hospital administration and the medical and nursing teams embraced the changes. After one month, a re-audit (Fig. 3) was conducted to assess the influence of changes and the efficacy of the quality improvement project. Medication Administration Record / Drug Treatment Charts are essential components of the patient record and patient care. Keeping accurate records of a patient's care by the attending physician , nurses and complete staff is of the uttermost importance (2). Medication errors can also result in morbidity and even death, which reflects negatively on the healthcare organisation and damages its reputation. (1,4,5). When it comes to maintaining medical paperwork in order in a professional manner, there is something to be learned for everyone concerned, from nurses and trainees to medical students. (3)

Conclusions

We highlighted the deficiencies in the treatment charts and the need to introduce a dedicated medication administration record (MAR) to be followed by both the doctors and the nurses to reduce errors and mistakes in patient management. This is forwarded to the hospital administration for required change to improve nurses and doctors training, time utilization, and patient care. The re-audit showed, after introduction of a dedicated Medication Administration Record along with doctors and nurses training, there was significant improvement in documentation, orders being followed and significant reduction in errors and mistakes.

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