Quality Assurance and Verification

Healthcare Audit Summary Report

Audit of Compliance with Standard 3 of the HSE Standards and Recommended Practices for Healthcare Records Management (V3.0) in Intellectual Disability Services and Maternity Services.

Audit Reference Number: QAV007/2017

Title	***Audit of compliance with Standard 3 of the HSE Standards and Recommended Practices for Healthcare Records Management (V3.0) in Intellectual Disability Services and Maternity Services.***	
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Timeframe	November 2017 – May 2018	
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Source of Evidence	**Type**	**Date**
	Request for Evidence *(all Sites) requested and returned between -*	13/12/2017 - 19/02/2018
	Site Visits: Portiuncula University Hospital, Ballinasloe 14/12/2017 Midlands Regional Hospital, Portlaoise 09/01/2018 St. Luke's General Hospital, Kilkenny 16/01/2018 Áras Attracta, Swinford, Co Mayo 23/01/2018 Mayo University Hospital, Castlebar 24/01/2018 Ard Na Gaoithe, Cope Foundation, Co Cork 30/01/2018 Brothers of Charity Services Ireland, Waterford 07/02/2018 Rosanna Gardens, Sunbeam House Services, Co. Wicklow 21/02/2018	

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ABBREVIATIONS

AND	Assistant National Director
BOCSI	Brothers of Charity Services, Ireland
CEO	Chief Executive Officer
CO	Chief Officer
CTG	Cardiotacograph
HCR	Healthcare Record
HSE	Health Service Executive
ID	Intellectual Disability
MRHP	Midlands Regional Hospital, Portlaoise
MUH	Mayo University Hospital
ND	National Director
NKDA	No known drug allergies
PPPG	Policy, Procedure, Protocol or Guidelines
PUH	Portiuncula University Hospital
QAV	Quality Assurance and Verification
QPSD	Quality Patient Safety Division
SHS	Sunbeam House Services

1. BACKGROUND/RATIONALE

In 2011 the Health Service Executive (HSE) published *Standards and Recommended Practices for Healthcare Records (HCRs) Management V 3.0* (herein named the *National Standard*), which includes the National Maternity Healthcare Record. The aim is to provide a framework for consistent and coherent HCRs in the HSE, which in turn will support high quality services and patient safety. Section 1.3 of the National Standard states *'The Standards and recommended practices apply to healthcare records of all types (including records of service users treated on behalf of the Health Service Executive in the private healthcare service where the Health Service Executive healthcare record is used) regardless of the medium on which they are held'.*

Prior to the publication of the *HSE HCRs Standards V3.0, a HSE Code of Practice for Healthcare Records Management Abbreviations booklet (2010)* was developed (herein titled the abbreviations document). This booklet provides staff with an agreed list of abbreviations for use in HCRs approved by the then Quality and Patient Safety Division.

This audit was requested by the National Director (ND), Quality Assurance and Verification (QAV) to obtain assurance that HCR management complies with the National Standard.

2. AIM AND OBJECTIVES

The aim of the audit was to provide assurance to the ND, QAV, that the selected sites were compliant with Standard 3 for the criteria audited.

The objectives of this audit were to determine:

1) The level of compliance with specific criteria selected from Standard 3 of the *HSE Standards and Recommended Practices for Healthcare Records Management Version 3.0* in four maternity units within acute hospital sites and four Intellectual Disability service providers.
2) The communication, training and induction strategies adopted and implemented by the sites audited following publication of *HSE Standards and Recommended Practices for Healthcare Records Management Version 3.0* as per sections 1.6.1, 1.6.2 and section 14 respectively of the National Standard.

The eleven criteria selected for audit from Standard 3: Content of the HCR are listed below:

3.3.1	The Service User's name is on each side of each page where service user information is documented and each side of each page has the correct unique service user identification number and/or identification label.
3.3.4	All documentation is clear and legible.
3.3.7	It is always clear from the healthcare record the date (day/month/year) that an entry was made.
3.3.8	The time (24 hour clock) is noted against each healthcare entry.
3.3.15	All entries in the record by healthcare professionals are made as soon as possible after each intervention and at least once every 24 hours (medical/nursing/midwifery) during the working week for acute in-patient episodes.
3.3.17	The name of the primary clinician who is assuming overall responsibility for the service user's care is clearly identifiable in the healthcare record at all times.

3.3.22	Retrospective documentation is (a) dated, (b) timed, and (c) signed (and counter-signed as appropriate.
3.3.23	The reason why the retrospective entry is being made is clearly stated.
3.3.25	Abbreviations used in the healthcare record are on the list of HSE approved abbreviations. If not on this list the term is written in full followed by the abbreviation in brackets and this procedure is followed on every page where the abbreviation is used.
3.3.32	There is a note in the healthcare record* of any significant abnormal results found and communicated to the relevant healthcare professional. Where appropriate, the resulting action to be taken is recorded in the healthcare record.
3.3.45	The healthcare organisation's procedure regarding alerts and allergies is adhered to.

*3.3.32: In maternity services, the audit focus was on the filing of cardiotacograph (CTG) scans in the appropriate place, evidence of communication of abnormal results and recording of resulting action.

3. METHODOLOGY

The audit was conducted across two services, namely maternity services in acute operations and adult intellectual disability (ID) services in community operations. Audit sites were selected to give a national geographical spread.

- The four maternity units selected were approximately similar in size and activity to allow for appropriate comparison.
- For the ID services, the audit team selected two larger residential settings where audit sampling was utilised and two smaller residential sites (numbering 12 and 13 residents) where all residents' HCRs were audited.

The audit sites selected were as follows:

Maternity units within scope	ID sites within scope
St. Luke's General Hospital, Kilkenny	Áras Attracta, Swinford, Co. Mayo
Mayo University Hospital, Castlebar	Ard Na Gaoithe, Cope Foundation, Cork City
Midland Regional Hospital, Portlaoise	Brothers of Charity Services Ireland, Belmont Park, Waterford
Portiuncula University Hospital, Ballinasloe	Rosanna Gardens, Sunbeam House Service, Ashford, Co Wicklow

For the purposes of the audit, the audit team used the definition of a HCR as set out in the National Standard, namely: *all information collected, processed and held in both manual and electronic formats pertaining to the service user and their care.*

HCRs in ID services differ from those in the maternity services, and include medical information and person-centred plans. The person-centred plans include a range of health, social and recreational activities.

Evidence of compliance was determined by the following:

1) A random sample of 15 HCRs was chosen from each site (where such a sample size was possible) based on the following criteria:
   - For maternity units, a list of HCR numbers was sought for service users who:
     (i) were discharged from the unit during the months of either September or October 2017 and had a length of stay between two and five days (this time

period was selected to capture recent HCR entries, whilst allowing sufficient time for the patient to be discharged from the maternity service)

(ii) had received a cardiotacograph (CTG) tracing during their stay.

- For the ID service sites, a list of HCR numbers was sought for all service users resident on the site. For two ID service sites there were less than 15 residents, and all HCRs for those sites were reviewed.

2) The following documentation was requested prior to site visits:
   - Copies of local policies/procedures/protocols/guidelines (PPPGs) related to HCR management.
   - HCR management communication, training and induction programmes to include attendance records for training, induction and refresher courses attended by staff.
3) Site visits were undertaken over a period of one day, and included:
   - A review of HCRs
   - A review of any other relevant documentation as provided by the audit liaison
   - Semi-structured interviews with relevant staff
   - An exit meeting with relevant staff to outline preliminary findings of the audit.
4) An audit report was circulated to each audited site. Before finalising the report it was also forwarded, in draft form, to the site for review of factual accuracy, comment and management response to the recommendations made.

4. FINDINGS

This audit was the fourth HCR management audit undertaken by the Healthcare Audit (HCA) function. It was also the most extensive, covering eight sites, four in acute hospital maternity units and four in ID sites. In addition, this was the first time that community-based services were audited by HCA with regard to HCR management.

Audit findings showed there was a lack of clarity within all audited sites regarding the precise application of the National Standard. This was particularly the case in ID sites, wherein all sites audited were moving away from a medical model of care, towards a social model[1]. One consequence of this shift is that the healthcare records maintained in the ID sites audited were not limited to medical or clinical information, and contained a range of information including the social activities of the service user, their person-centred plans, future individualised goal planning, amongst much more.

As stated in section 1, the Standard applies to healthcare records of all types, so the auditors tested compliance against the criteria in the same way regardless of the site-type. In each ID site audited however, the site liaison questioned whether the standard should also be applicable to non-medical information being recorded for residents, and pointed to

[1] The medical model describes disability as a consequence of a health condition, or disease, or caused by a trauma that can disrupt the functioning of a person in a physiological or cognitive way. This model regards disability as a condition a person has, and focuses on the prevention, treatment or curing of the disabling condition. Conversely, the social model of care focuses on barriers facing people with disabilities, instead of concentrating on impairments. In this model, a person's activities are limited not by the impairment or condition but by the environment and barriers they face.

the difficulties inherent in attempting to do that. One site, Rosanna Gardens, Sunbeam Houses Services (SHS), questioned, and continue to question, at the time of this report, the auditors' site-specific findings and recommendations. Rosanna Gardens, SHS is a section 38 organisation. However, other section 38 organisations audited did accept the findings and recommendations for their sites.

The auditors note that this policy is not listed in the current Service Level Agreements between the Heath Service Executive and Section 38 service providers in the ID sector.

Overall, the audit demonstrated that the National Standard and its associated abbreviations booklet need urgent review having not been amended since their inception in 2011 and 2010 respectively.

The findings herein were tabulated where possible for comparison purposes between sites and service type.

Objective 1: The level of compliance with specific criteria selected from Standard 3 of the HSE Standards and Recommended Practices for Healthcare Records Management Version 3.0.
In total 11 criteria were selected from the National Standard. Evidence from the review of HCRs demonstrated that all 8 sites were fully compliant with criteria 3.3.15 (a documented entry at least once every 24 hrs) and 3.3.32 (evidence documented in HCRs of action taken following abnormal results). Compliance rates varied considerably for the other nine criteria, in some cases at a community/acute operations level, and in other cases on a site-by-site basis.

Criterion 3.3.1

Criterion 3.3.1 required that the service user's name was recorded on each side of each page where service user information was documented.

Six of the eight sites audited were either fully or substantially compliant with criterion 3.3.1 including all acute service sites. Two ID sites were entirely non-compliant. Management at both of these sites (BOCSI Belmont Park and Rosanna Gardens, SHS) stated during the audit that it was not the policy locally to put the service user's name on both sides of each page of the HCR, despite the requirements of the National Standard, and consequently the auditors found all records reviewed at both sites to be non-compliant with this criterion.

The auditors were of the opinion that while both sites were non-compliant with the *current* National Standard, this criterion and its application within ID services should be reviewed as part of a review of the national standard.

Criterion 3.3.4

Criterion 3.3.4 required that all documentation was clear and legible.

The auditors reviewed 113 HCRs across 8 sites, and found passages of illegible text on 10 HCRs, i.e., an occurrence rate of 8.8%. Of the 8 sites reviewed, 7 were either fully compliant or substantially compliant with criterion 3.3.4, i.e., for those sites, there were very few instances (or no instances) noted of illegible entries in the HCRs. There were, however, 4 instances of illegible text noted on the HCRs reviewed at Midlands Regional Hospital Portlaoise, representing 40% of the total non-compliances noted across all sites.

Criterion 3.3.9

Although this was not one of the criteria initially selected for audit, it was noted by the auditors that there were multiple instances at seven sites where clinical staff signatures did not comply with 3.3.9 '*All entries are signed with a clear signature, PRINTED NAME, job title and bleep number/identification number*'. The auditors made a separate recommendation about criterion 3.3.9 to these seven sites.

Criterion 3.3.7 (Date of entry)

Criterion 3.3.7 required that the date an entry was made on the HCR is recorded.

The auditors reviewed 113 HCRs and found 13 instances of non-compliance, i.e., where a date either was not recorded or was recorded incorrectly, giving an overall compliance rate of 88.5%.

All four maternity units were compliant or substantially compliant with criterion 3.3.7, as were three of the ID service sites. In the remaining site (Ard na Gaoithe, COPE Foundation), a compliance rate of 27% was achieved, as in 11 of the 15 HCRs the entry date in the night community notes (nursing/healthcare assistant documentation) recorded the opening shift date and closing shift date only, e.g., 24/25-01-2018. The auditors were of the opinion that the recommended review of the National Standard should include a review of this criterion, to establish what precisely was necessary in ID sites given that most entries on HCRs in that service were not clinical and/or medical notes (see Recommendations section).

Criterion 3.3 8 (24-hour clock)

Criterion 3.3.8 required that the time of entry was recorded against each entry, and recorded in 24-hour clock format.

Table 1 (below) shows the compliance rates obtained at each site:

Table 1

3.3.8	*The time (24 hour clock) is noted against each healthcare entry.*			
Site	Compliant	Non-Compliant	Not Applicable	Compliance Rate (%)
Portiuncula University Hospital, Ballinasloe	14	1	0	93
Mayo University Hospital, Castlebar	11	4	0	73
Midlands Regional Hospital, Portlaoise	14	1	0	93
St. Luke's Hospital, Kilkenny	13	1	0	92
Acute Service Total	**52**	**7**	**0**	88
Áras Attracta, Swinford, Co. Mayo	0	15	0	0
Rosanna Gardens, Sunbeam House Services (Wicklow)	1	11	0	8
Ard na Gaoithe, COPE Foundation, Co. Cork	0	15	0	0
BOCSI, Belmont Park, Waterford	0	12	0	0

3.3.8	*The time (24 hour clock) is noted against each healthcare entry.*			
Site	Compliant	Non-Compliant	Not Applicable	Compliance Rate (%)
ID Service Total	**1**	**53**	**0**	2
Overall Total	**53**	**60**	**0**	47

There was a noticeable difference in compliance rates between acute maternity sites, which had an overall compliance rate of 88.1%, and ID sites, where the overall compliance rate was 1.9%.

Of the 54 HCRs audited within ID sites, only one was compliant with this criterion. The nature of many entries was that they were made at the end of a shift, and recorded the activities of the resident for the day together with the care given. On some HCRs, the 24-hour clock was employed when an entry was made recording clinical or nursing support or intervention.

Within BOCSI, Belmont Park however, the auditors noted that the manner in which times of entries were recorded had recently changed to the 24-hour clock format. This was discussed during the exit interview, and the site liaison clarified that it was now policy within BOCSI, Belmont Park to use the 24-hour format for all entries. Within Rosanna Gardens, many HCR entries were recorded electronically on an information system, and the time of those entries was recorded automatically in the 24-hour format (the compliance figures in Table 1 above refer to entries on the hard-copy HCRs only.)

Criterion 3.3.17 (Primary Clinician Name)

Criterion 3.3.17 required that the name of the primary clinician who was responsible for the overall care of the service user is clearly identifiable in the HCRs.

Substantial or full compliance was noted at seven sites, with no noticeable difference between the site-types.

In Áras Attracta, three general practitioner (GP) practices delivered medical care as required on a rota basis, and all service users were under the care of the same team, leaving the auditors to conclude that criterion 3.3.17 did not apply.

The auditors are of the opinion that the recommended review of the National Standard should include this criterion, as it is understood differently at different sites and found not to be applicable at one site (see Recommendations section).

Criterion 3.3.22 (Details of retrospective entries)

Criteria 3.3.22 requires that all retrospective entries are (a) dated, (b) timed and (c) signed (and countersigned as appropriate). There was a noticeable variation in occurrence levels between the maternity and ID services in relation to this criterion, as shown in Table 2 below:

Table 2

3.3.22	*Retrospective documentation is: (a) dated, (b) timed, and (c) signed (and countersigned as appropriate).*			
Site	Compliant	Non-Compliant	Not Applicable	Compliance Rate (%)
Portiuncula University Hospital, Ballinasloe	2	2	11	50
Mayo University Hospital, Castlebar	5	1	9	83
Midlands Regional Hospital, Portlaoise	2	1	12	67
St. Luke's Hospital, Kilkenny	3	1	10	75
Acute Service Total	**12**	**5**	**42**	71
Áras Attracta, Swinford, Co. Mayo	0	0	15	n/a
Rosanna Gardens, Sunbeam House Services (Wicklow)	1	0	11	100
Ard na Gaoithe, COPE Foundation, Co. Cork	0	0	15	n/a
BOCSI, Belmont Park, Waterford	1	0	11	100
ID Service Total	**2**	**0**	**52**	100
Overall Total	**14**	**5**	**94**	74

Of the 17 retrospective entries noted in maternity services HCRs reviewed, 5 were not compliant with criterion 3.3.22 because (i) the entry was not identified as being a retrospective entry, or (ii) the entry was unsigned or not countersigned, or (iii) other details were omitted. Compliance with the criterion was noted as 70.6% for acute services.

Within ID sites, the nature of the setting and the type of care delivered meant that many entries in the HCRs were inherently retrospective, i.e., they gave a summary of the activities of the resident and care given over the preceding hours, often covering the period of the shift of the care-giver making the entry. The audit team did not consider that this type of entry fell within the scope of criterion 3.3.22 (Details of retrospective entry) or 3.3.23 (Reason for retrospective entry), and found only two retrospective entries on ID site HCRs reviewed, both of which were considered compliant with criterion 3.3.22.

Criterion 3.3.23 (Reason for retrospective entry)

Criteria 3.3.23 was a companion to 3.3.22, and required that in all cases of retrospective entries, a reason for the entry should be provided. The number of instances recorded was too small for meaningful comparison of compliance rates, but the manner of the non-compliance was the same; 19 instances of a retrospective entry were noted, and in only 5 of those instances was the reason for the retrospective nature of the entry provided (giving an overall compliance rate of 26.3%).

Criterion 3.3.25 (Abbreviations)

Criteria 3.3.25 required that all abbreviations used in the HCR were on the list of HSE approved abbreviations, and sets out a process to be followed if the abbreviation proposed to be used is not recorded in the booklet.

In maternity sites, 3 of the 4 were fully compliant, and the fourth (Mayo University Hospital) achieved a compliance rate of 80%, giving an overall compliance rate of 95%. In ID sites, an

overall compliance rate of 74% was noted, but 11 of the 14 instances where non-approved abbreviations were used were noted in the same site (BOCSI Belmont Park). Management at BOCSI Belmont Park stated during exit interview that ID sites commonly used abbreviations (both in research papers and documented by professionals within HCRs) that were not currently recognised within the abbreviations booklet, but this issue did not occur with the same frequency in the other ID sites reviewed.

The issue of abbreviations had been raised by the auditors in three previous healthcare audits (QPSA005/2013, QPSA002/2014 and QAV005/2015 *"Audit of compliance with Standard 3 of HSE Standards and Recommended Practices for Healthcare Records Management (HCRs) V3.0"*). Specific recommendations made on foot of those audits requiring that the abbreviations booklet (2010) be updated to include commonly used abbreviations in *all* HSE services have not been implemented.

Criterion 3.3.45 (allergies and alerts)

Criterion 3.3.45 required that the healthcare organisation's procedure regarding alerts and allergies was adhered to. Compliance rates observed in the sites reviewed are shown in Table 3 hereunder:

Table 3

3.3.45	*The healthcare organisation's procedure regarding alerts and allergies is adhered to.*			
Site	Compliant	Non-Compliant	Not Applicable	Compliance Rate (%)
Portiuncula University Hospital, Ballinasloe	15	0	0	100
Mayo University Hospital, Castlebar	14	1	0	93
Midlands Regional Hospital, Portlaoise	15	0	0	100
St. Luke's Hospital, Kilkenny	13	1	0	93
Acute Service Total	**57**	**2**	**0**	97
Áras Attracta, Swinford, Co. Mayo	6	9	0	40
Rosanna Gardens, Sunbeam House Services (Wicklow)	10	2	0	83
Ard na Gaoithe, COPE Foundation, Co. Cork	13	2	0	87
BOCSI, Belmont Park, Waterford	11	1	0	92
ID Service Total	**40**	**14**	**0**	74
Overall Total	**97**	**16**	**0**	86

Compliance rates for this criterion varied widely, particularly between ID sites. In maternity services, while two instances were noted where 'NKDA' (No Known Drug Allergies) was not documented in the patient profile or the antenatal section assessment record, it was however recorded clearly on the medicines sections of the HCR, and a services compliance rate of 96.6% was noted.

None of the ID sites reviewed were fully compliant, and within two sites (Ard Na Gaoithe, Cope Foundation and Rosanna Gardens, SHS) a potential risk of significant harm to residents was highlighted.

Within Ard Na Gaoithe, Cope Foundation, two HCRs documented allergies on the nursing assessment section which were also documented on the front page of the medical notes, but 'NKDA' was printed on the residents' medication chart. This oversight could potentially have led to significant harm to the residents involved.

In Rosanna Gardens, SHS, there were three instances of alerts and allergies in two HCRs that did not comply with the criterion. In one HCR, the auditors noted that the allergy was recorded on the client passport (their identification and needs when attending other facilities) and annual medical form, but not on the medication prescription chart. For the other HCR, two allergies were identified in the medical section and in the client passport, but not recorded on the medication prescription chart.

In both of the above sites, the patient safety concerns were highlighted during the exit meeting, and followed by a letter from the auditors to the relevant CEOs highlighting these concerns and making recommendations for remedial action. A positive response was received from the CEO of Ard Na Gaoithe who laid down an initial plan to rectify this patient safety issue (see appendix 1, site recommendations and management response). However as stated earlier, the CEO of SHS (Rosanna Gardens) did not agree to implement the auditors' recommendations. It is the auditors' opinion that this recommendation must be implemented, or that alternative controls are developed to address this risk.

In Áras Attracta, instances of non-compliance with this criteria were also noted, wherein 'NKDA' or wording to that effect was not recorded on the front cover of the HCR for service users without a known allergy. In all such cases, however, it was recorded on the drug prescription kardex, and as none of the service users concerned had a drug allergy, the risk of an adverse event was reduced. In the cases where a service user had a 'Known drug allergies and/or alerts', this was documented in line with local policy.

Other non-compliance issues:

Where other significant departures from the standard were noted by the auditors, they were brought to the attention of management.

In St Luke's Hospital, a detailed entry was made in a HCR on 20 September, 2017, in pencil, contravening criterion 3.3.6 which states that all entries on a HCR must be made in permanent black ink. This entry was shown to and discussed with the site liaison and those in attendance at the exit meeting.

In SHS (Rosanna Gardens,) another issue was highlighted in writing by the auditors to the CEO regarding concerns for patient safety (as well as HCR management) arising from a lack of use of contemporaneous notes in relation to GP/psychiatrist findings and recommendations. There was an inherent risk that clinical interventions and/or clinical recommendations could be misinterpreted or omitted in relation to service user's clinical care.

Objective 2: The communication, training and induction strategies adopted and implemented by the above audit sites following publication of HSE Standards and Recommended Practices for Healthcare Records Management Version 3.0.
Of the eight sites audited, two sites were found to be substantially compliant in terms of communication and governance as per sections 1.6.1 and 1.6.2 of the National Standard, a

further four demonstrated limited compliance and two sites showed no compliance.

Of the eight sites audited, two sites were found to be substantially compliant in terms of HCR management training delivered and recorded as per section 14 of the National Standard, a further three sites demonstrated limited compliance and three sites demonstrated no compliance.

Of the eight sites audited, seven sites demonstrated limited compliance in terms of local audit of HCR management and one site showed no compliance.

Communication and Governance

The auditors found there was a more structured approach to governance of HCR management in maternity sites (for example, all hospitals had dedicated HCR management committees). Two of the four maternity units were substantially compliant, one showed limited compliance and one was non-compliant.

In the ID sites, HCR management was principally seen as the remit of the supervisory staff in the residences, and, for medical notes, as the responsibility of the visiting general practitioners and/or mental health professionals. Three ID residences demonstrated limited compliance and one was non-compliant.

Training

Substantial compliance was found in two maternity units where specific (and on-going) HCR training had taken place. One of these maternity units utilised the 'HSEland' online training package. Of the other two maternity sites, one achieved limited compliance and one was non-compliant.

HCR training in ID sites centred on induction courses and on-the-job training. Two ID sites showed limited compliance with the training requirements in the National Standard and two sites were non-compliant.

Audit

There was evidence of audit of HCRs at seven of the eight sites audited, but little documentary evidence of implementation of recommendations or other follow-up work on audits that had been undertaken. Seven sites were found to have limited compliance, and one site was non-compliant as there was no evidence of audit being performed.

Table 4 below outlines the compliance levels found at each site for the three areas audited in relation to objective 2.

Table 4: Compliance Levels for HCR Management

Audit Site	Governance/Communication *(Compliance level* with sections 1.6.1 and 1.6.2 of the National Standard)*	Training/Induction Strategies *(Compliance level with section 14 of the National Standard)*	Audit of Healthcare Record Management (Local) *(Compliance level with National Standard)*
St. Luke's General Hospital	**Finding: No compliance** **Comment:** Governance and communication of HCR management did not comply with the National Standard. All	**Finding: Limited compliance** **Comment:** Training and induction strategies for HCR management did not comply fully with the National Standard.	**Finding: Limited compliance** **Comment:** There was evidence of HCR management audit and monthly midwifery care metrics took place however there was

Audit Site	Governance/Communication *(Compliance level* with sections 1.6.1 and 1.6.2 of the National Standard)*	Training/Induction Strategies *(Compliance level with section 14 of the National Standard)*	Audit of Healthcare Record Management (Local) *(Compliance level with National Standard)*
	HCR management PPPGs provided were either not dated or the review date had expired.	There was little documented evidence on HCR management training and induction.	little documented evidence of implementation of audit findings.
Midland Regional Hospital Portlaoise	**Finding: Substantial compliance** **Comment:** Governance and communication of HCR management complied with the National Standard.	**Finding: Substantial compliance** **Comment:** Training and induction strategies of HCR management complied with the National Standard.	**Finding: Limited compliance** **Comment:** There was evidence of HCR management audit taking place however there was little documented evidence of implementation of audit findings.
Portiuncula University Hospital	**Finding: Substantial compliance** **Comment:** HCR management and the governance complied with the National Standard.	**Finding: Substantial compliance** **Comment:** HCR training and induction processes complied with the National Standard.	**Finding: Limited compliance** **Comment:** There was evidence of HCR management audit and monthly midwifery care metrics taking place however there was little documented evidence of implementation of audit findings.
Mayo University Hospital	**Finding: No compliance** **Comment:** Governance and communication of HCR management did not comply with the National Standard. All HCR management PPPG's provided were either not dated or the review date had expired.	**Finding: No compliance** **Comment:** Training and induction strategies in relation to HCR management did not comply with the National Standard. There was little documented evidence on HCR management training and induction.	**Finding: Limited compliance** **Comment:** There was evidence of HCR management audit through monthly midwifery care metrics, however there was little documented evidence of implementation of audit findings.
Áras Attracta	**Finding: No compliance** **Comment:** Governance and communication of HCR management did not comply with the National Standard. There was little documented evidence of governance and communication around HCR management.	**Finding: No compliance** **Comment:** HCR training and induction processes did not comply with the National Standard. There was little documented evidence of HCR management training or induction provided.	**Finding: Limited compliance** **Comment:** There was evidence of HCR management audit taking place however there was little documented evidence of implementation of audit findings.
BOCSI, Belmont Park	**Finding: Limited compliance** **Comment:** Governance and communication of HCR management did not fully comply with the National Standard. A core HCR PPPG was not in date.	**Finding: Limited compliance** **Comment:** Training and induction processes of HCR management did not fully comply with the National Standard. There was little evidence of HCR management training.	**Finding: No compliance** **Comment:** There was no evidence of routine local audits specific to HCRs management.
Rosanna Gardens, SHS	**Finding: Limited compliance** **Comment:** Governance and communication of HCR management did not fully comply with the National Standard. PPPGs did not reflect the National Standard.	**Finding: No compliance** **Comment:** There was no documented evidence of HCR management training provided.	**Finding: Limited compliance** **Comment:** A documented HCR management audit process was evident, though there was limited evidence of implementation of findings.

Audit Site	Governance/Communication *(Compliance level* with sections 1.6.1 and 1.6.2 of the National Standard)*	Training/Induction Strategies *(Compliance level with section 14 of the National Standard)*	Audit of Healthcare Record Management (Local) *(Compliance level with National Standard)*
Ard Na Gaoithe Cope Foundation	**Finding: Limited compliance** **Comment:** Governance and communication of HCR management did not comply with the National Standard. PPPGs relating to HCR management did not reflect the National Standard.	**Finding: Limited compliance** **Comment:** Training and induction strategies for HCR management did not comply fully with the National Standard. There was little documented evidence on HCR management training.	**Finding: Limited compliance** **Comment:** A documented HCR management audit process was evident, however there was no evidence of implementation of audit findings.

***Key to compliance level: Compliant:** No action required as the evidence demonstrates that the standard under audit was met in full. **Substantially compliant:** Minor action is required to meet the standard under audit within a reasonable timeframe. **Limited compliance:** Moderate or substantial action is required to meet the standard under audit within a reasonable timeframe. **No compliance:** Major action is required to meet the standard under audit as a priority.

5. CONCLUSION

Audit reports containing specific findings and recommendations were issued to each site (see Appendix A for recommendations made and management response).

Difficulties were inherent in this audit from the outset, as the *HSE Standards and Recommended Practices for Healthcare Records Management (HCRs) V3.0 (2011),* the standard for this audit, has not been updated since 2011 (it was due for review in May 2014). Further, its companion document the *HSE Code of Practice for Healthcare Records Management Abbreviations booklet (2010)* was due for review in June 2012, but this had not been undertaken.

In addition, although the audit team worked to the letter of the National Standard, the current and future applicability of this National Standard to community operations that are moving to a social care model needs to be considered, particularly regarding the specific definition of a 'healthcare record' within that model.

The CEO of SHS did not agree to implement the recommendations of the audit but instead challenged the validity of the audit within their service. It is the auditors' opinion that the report's recommendations must be implemented or that alternative controls are developed to address the identified risks.

Objective 1: Based on the overall findings on objective 1, over the eight sites, the auditors can give limited assurance that there was compliance with the National Standard.

In total 11 criteria were selected from the national standard. Evidence from the review of HCRs demonstrated that all eight sites were fully compliant with criteria 3.3.15 (a documented entry at least once every 24 hours) and 3.3.32 (evidence documented in HCRs of action taken following abnormal results). Compliance rates varied considerably for the other nine criteria, in some cases at a community/acute operations level, and in other cases on a site-by-site basis.

Objective 2: Based on our overall findings on objective 2, over the eight sites, the auditors can give no assurance that there was compliance with the National Standard.

Of the eight sites audited, two sites were found to be substantially compliant in terms of communication and governance as per sections 1.6.1 and 1.6.2 of the National Standard, a further four demonstrated limited compliance and two sites showed no compliance.

Of the eight sites audited, two sites were found to be substantially compliant in terms of HCR management training delivered and recorded as per section 14 of the National Standard, a further three sites demonstrated limited compliance and three sites demonstrated no compliance.

Of the eight sites audited, seven sites demonstrated limited compliance in terms of local audit of HCR management and one site showed no compliance.

Recommendations made in this report identify actions that the senior most accountable person nationally must implement in order meet the requirements of the *HSE Standards and Recommended Practices for Healthcare Records Management (HCRs) V3.0 (2011),* and, *the HSE Code of Practice for Healthcare Records Management Abbreviations booklet (2010).*

6. RECOMMENDATIONS

The *audit request form* was the document that initiated this audit and provided a rationale for it. This document was developed by the National Director for QAV. Within the rationale was the statement *"Healthcare audits were conducted previously related to Healthcare Records and it is important to determine whether there has been an improvement in compliance with the Healthcare Records Standards in the intervening period".* The findings in this audit suggest there has not been a marked improvement in compliance since the previous audits were carried out, and the auditors identified three key areas that require consideration at national level as follows:

a) The national document *HSE Standards and Recommended Practices for Healthcare Records Management (HCRs) V3.0 (2011)* which was the standard for this audit has not been updated since 2011. It was due for review in May 2014. Further, its companion document the *HSE Code of Practice for Healthcare Records Management Abbreviations booklet (2010)* was due for review in June 2012. This has also not been undertaken. With regards to the abbreviations booklet, this has led to omissions within ID services where the auditors were constrained to find sites non-compliant for using abbreviations such as SIB (Self-Injurious Behaviour) which is an everyday abbreviation in this service.

b) The Office of the National Programme for Healthcare Records Management, which the auditors understand is the lead office for HCR management nationally, was not able to appoint a national audit liaison. This made it difficult for the audit team to determine who was directly accountable and responsible as the 'lead person' for HCR management nationally.

c) Some key recommendations made in the three previous healthcare audits on HCR management (2013, 2014, 2015) have not been implemented including:
   - *The Office of the National Programme for Healthcare Records should immediately update the HSE Code of Practice for Healthcare Records Management Abbreviations (2010) booklet to include clinical terms that are now in common use (audit QAV005/2015).* This same recommendation was made in all three of the above audits and has never been implemented.
   - *QPSD to reinforce in new versions of the HSE HCRs Standards document that all hospitals (users) are to implement training and induction strategies in respect of HSE*

HCRs Standards documentation. Only one out of the eight sites audited in this 2018 audit had used the HSELand on line training module on HCR management.

The audit team therefore make the following recommendations:

Recommendation 1:

The Deputy Director General, Chief Operations Officer must ensure an immediate review and update of the *HSE Standards and Recommended Practices for Healthcare Records Management (HCRs) V3.0 (2011),* utilising the guidance set out in *HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs) (2016)* including scheduled reviews every three years or more frequently as required.

Recommendation 2:

The Deputy Director General, Chief Operations Officer must ensure an immediate review and update of the *HSE Code of Practice for Healthcare Records Management Abbreviations booklet (2010),* utilising the guidance set out in *HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs) (2016)*, including scheduled reviews every three years or more frequently as required.

Recommendation 3:

The Deputy Director General, Chief Operations Officer must ensure the implementation of healthcare record management training and induction strategies for all relevant HSE staff, in all HSE services, and in particular, communicate the existence of the HSELand online training module for staff.

Recommendation 4:

The Deputy Director General, Chief Operations Officer must ensure that all healthcare providers review and update all local PPPGs on healthcare record management in line with the updated National Standard and utilise the guidance set out in the *HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (PPPGs) (2016).*

Recommendation 5:

The Deputy Director General, Chief Operations Officer must ensure that all healthcare providers apply a structured audit programme to healthcare records management. The HCR management audit programme must include outcomes, recommendations and implementation of audit findings through quality improvement plans to ensure compliance with the updated national standard.

Acknowledgements:

The audit team wish to acknowledge the co-operation and goodwill afforded to them by the management and staff at all (hospital groups and community healthcare organisations) selected for inclusion in this audit.

Lead Auditor	Mr. Alfie Bradley
Signature	
Date	18 June 2018
AND QAV	Ms. Cora McCaughan
Signature	
Date	18 June 2018

APPENDIX 1 SITE RECOMMENDATIONS AND MANAGEMENT RESPONSE

Management response should be completed by the senior most accountable person with the authority to effect the actions outlined by the recommendations listed.

Audit Site	Recommendation	Management response	Agreed implementation date	Person responsible
Portiuncula University Hospital (PUH)	1. The senior most accountable person in PUH must ensure that a receipted communication is issued to all relevant staff reinforcing the need to adhere to the national standard in relation to the recording of retrospective entries in the maternity HCR and, to ensure that all relevant staff are aware of what a retrospective entry is as per criteria 3.3.22 and 3.3.23 of the national standard.	Memo to issue to all staff regarding finding of Audit and the implementation of requiremts	March 2018	James Keane (GM)
	2. The senior most accountable person in PUH must ensure that a receipted communication is issued to all relevant staff reinforcing the need to adhere to criteria 3.3.9 of the national standard that is, all HCR entries are legible, clearly signed, have a printed name, job title and identification number.	As above	March 2018	James Keane (GM), Marita Forarty (DON) & Siobhan Canney (DOM)
	3. The senior most accountable person in PUH must ensure the development and delivery of a structured maternity HCR management training programme to all relevant staff to ensure compliance with the national standard.	Training programe to be revamped taking on board Audit findings	Immediate and ongoing	Lisa Walsh (Quality & Safety)
	4. The senior most accountable manager in PUH must ensure the development of a documented approach to recording training undertaken on the maternity HCR by relevant staff to include records of attendance.	All training to be recorded in PPARS	Immediate and ongoing	Pauline McEvoy (HR), Lisa Walsh (Qualiy & Safety), Siobhan Canney (DOM), Marity Fogarty (DON)

	5. The senior most accountable person in PUH must ensure the development and delivery of a structured audit programme around maternity HCR management. The HCR management audit programme must include outcomes, recommendations and implementation of audit findings through quality improvement plans to ensure compliance with the Standards and Recommended Practices for Healthcare Records Management V3.0.	Audit of HCR to be included on audit cycle	Second quarter 2018	Siobhan Canney (DOM), Dr De Tavernie (ACD), Lisa Walsh (Quality & Safety), Fergus Hannon (Patient Services)
Midlands Regional Hospital Portlaoise (MRHP)	1. The senior most accountable person in MRHP must ensure a receipted communication is issued to all relevant staff reinforcing the need to adhere to the national standard in relation to the recording of retrospective entries in the maternity HCR and, to ensure that all relevant staff are aware of what a retrospective entry is as per criteria 3.3.22 and 3.3.23 of the national standard.	Accepted	30th April 2018	General Manager
	2. The senior most accountable person in MRHP must ensure that a receipted communication is issued to all relevant staff reinforcing the need to adhere to criteria 3.3.4 and 3.3.9 of the national standard that is, all HCR entries are legible, clearly signed, have a printed name, job title and identification number.	Accepted	30th April 2018	General Manager
	3. The senior most accountable person in MRHP must ensure the development and delivery of structured maternity HCR management training to all relevant staff to ensure compliance with the national standard.	Accepted	30th June 2018	General Manager
	4. The senior most accountable person in MRHP must ensure the development of a documented approach to recording training undertaken on the maternity HCR by relevant staff	Accepted	30th April 2018	General Manager

	to include records of attendance. 5. The senior most accountable person in PUH must ensure the development and delivery of a structured audit programme around maternity HCR management. The HCR management audit programme must include outcomes, recommendations and implementation of audit findings through quality improvement plans to ensure compliance with the Standards and Recommended Practices for Healthcare Records Management V3.0.	Accepted	30th June 2018	General Manager
St. Luke's Hospital, Kilkenny	1. The senior most accountable person in St. Luke's Hospital must ensure that the entry in pencil, a non-compliance issue under criterion 3.3.6 of the Standards and Recommended Practices for Healthcare Records Management V3.0, is dealt with as a matter of urgency and that a receipted communication is issued to all relevant staff to include the statement that any such entry noted on a healthcare record should immediately be brought to the attention of the relevant line manager.	The issue of an entry in pencil made in the Healthcare Record of an individual service user has been highlighted to the author of the entry. A formal written communication will issue in respect of same. All medical and midwifery staff will be reminded by way of written communication that in the event of them coming across a similar issue of non-compliance that they highlight same to the relevant line manager/department head.	8/04/2018	Concepta McDonagh, Director of Midwifery
	2. The senior most accountable person in St. Luke's Hospital must ensure that a receipted communication is issued to all relevant staff reinforcing the need to adhere to the Standards and Recommended Practices for Healthcare Records Management V3.0 in relation to the recording of retrospective entries and to ensure that all relevant staff are aware of what a retrospective entry is as per criteria 3.3.22 and 3.3.23.	Formal communication will be issued to all medical and midwifery personnel reminding them of the need for compliance with retrospective entries as set out in the national standards	8/04/2018	Concepta McDonagh, Director of Midwifery
	3. The senior most accountable person in St. Luke's Hospital must ensure that a receipted communication is issued to all relevant staff reinforcing the need to adhere to criteria 3.3.9 of the *Standards and Recommended Practices for*	Formal Notification will be sent to all medical personnel and midwifery staff to remind them to ensure that all entries they make in individual healthcare records is	8/04/2018	Concepta McDonagh, Director of

	Healthcare Records Management V3.0, i.e., that all healthcare record entries are legible, clearly signed, have a printed name, job title and identification number.	legible, written in black ink, clearly signed and the authors name, job title and unique identification numer are documented		Midwifery
	4. The senior most accountable person in St. Luke's Hospital must ensure that all policies, procedures, protocols and guidelines around healthcare record management are reviewed and kept in date to ensure compliance with *Standards and Recommended Practices for Healthcare Records Management V3.0*	The Healthcare Records Committee of St. Lukes General Hospital Carlow/Kilkenny has commemnced a review of all Policies, Procedures And Guidelines pertaining to Healthcare Records with a view to producing a comprehensive policy on Healthcare Records Management built around the national standards.	30/06/18	Nadia Shivgulam A/Medical Records Officer
	5. The senior most accountable person in St. Luke's Hospital must ensure the delivery of healthcare record management training to all relevant staff to ensure compliance with *Standards and Recommended Practices for Healthcare Records Management V3.0*	All relevant staff in the maternirty Department in the Hospital are being requested to undertake online training in Healthcare Records Managememnt through HSElanD.ie.	30/06/18	Paula Power A/CMM 3
	6. The senior most accountable person in St. Luke's Hospital must ensure that there is a documented approach to recording training delivered on the maternity healthcare record management by relevant staff to include records of attendance to ensure compliance with *Standards and Recommended Practices for Healthcare Records Management V3.0*.	Details of training undertaken by staff in Healthcare Records Management will be recorded in the local training databases	30/06/18	Paula Power A/CMM 3
	7. The senior most accountable person in St. Luke's Hospital must ensure the development and delivery of a structured audit programme around maternity HCR management. The HCR management audit programme must include outcomes, recommendations and implementation of audit findings through quality improvement plans to ensure compliance with the Standards and Recommended Practices for Healthcare Records Management V3.0.	The Healthcare Records Committee in St. Lukes General Hospital Carlow/Kilkenny has included in its workplan for 2018 a structured audit programme to ensure compliance with the HSE Standards And Recommended Practices For Healthcare Records Management V3.0 As part of this programme unnannounced audits of Healthcare Records will be carried out by members of this committee.	30/06/18	Pat Shortall Deputy General Manager/Nais Shivgulam A/Medical Records Officer

Mayo University Hospital	1. The senior most accountable person in Mayo University Hospital must ensure that a receipted communication is issued to all relevant staff reinforcing the need to adhere to the *HSE Standards and Recommended Practices for Healthcare Records Management Version 3.0* in relation to the recording of retrospective entries and to ensure that all relevant staff are aware of what a retrospective entry is as per criteria 3.3.22 and 3.3.23.	Priority	End April 2018	Associate Clinical Director H Stokes / Director of Midwifery A McGrail
	2. The senior most accountable person in Mayo University Hospital must ensure that a receipted communication is issued to all relevant staff reinforcing the need to adhere to criteria 3.3.9 of the *HSE Standards and Recommended Practices for Healthcare Records Management Version 3.0*, that is all healthcare record entries are clearly signed, have a printed name, job title and identification number.	Priority	End April 2018	Associate Clinical Director H Stokes / Director of Midwifery A McGrail
	3. The senior most accountable person in Mayo University Hospital must ensure that a receipted communication is issued to all relevant staff reinforcing the need to adhere to criteria 3.3.7 and 3.3.8 of the *HSE Standards and Recommended Practices for Healthcare Records Management Version 3.0*, i.e., that the date of entry and time of entry is recorded correctly against all entries on a healthcare record.	Priority	End April 2018	Associate Clinical Director H Stokes / Director of Midwifery A McGrail
	4. The senior most accountable person in Mayo University Hospital must ensure the development and delivery of a structured training programme for all relevant staff, around maternity healthcare record management to ensure compliance with the *HSE Standards and Recommended Practices for Healthcare Records Management Version 3.0*.	Priority	End May 2018	Associate Clinical Director H Stokes / Director of Midwifery A McGrail / Nurse Practice Development Caroline Conway

	5. The senior most accountable person for Mayo University Hospital must ensure the development of a structured audit programme for all relevant staff around maternity healthcare record management. The HCR management audit programme must include outcomes, recommendations and implementation of audit findings through quality improvement plans to ensure compliance with the *Standards and Recommended Practices for Healthcare Records Management V3.0.*	Priority	End June 2018	Associate clinical director H Stokes / Director of Midwifery A McGrail Nurse practice Development Caroline Conway
	6. The senior most accountable person in Mayo University Hospital must ensure that policies, procedures, protocols and guidelines relevant to maternity healthcare record management are reviewed and kept up to date.	Priority	End 3rd Quater	Medical Records Committee Lucy Martindale
	7. The senior most accountable person in Mayo University Hospital must ensure the development of a documented approach to recording training undertaken on the maternity healthcare record by relevant staff to include records of attendance to ensure compliance with the *HSE Standards and Recommended Practices for Healthcare Records Management Version 3.0*.	Priority	End May 2018	Director Of Midwifery A McGrail
Aras Attracta, Swinford Co. Mayo	1. The senior most accountable person in Áras Attracta must ensure that all medical, nursing and other multi-disciplinary staff are aware that when an entry is being made on a healthcare record the time of entry is to be noted in 24 hour clock format as per criteria 3.3.8 of the *HSE Standards and Recommended Practices for Healthcare Records Management V3.0.*	Training requirement identified, working in collaboration with the CNME to provide a schedule for same. All Team Leaders notified of required of request for immediate implementation.	June 30th	DOS & PICs
	2. The senior most accountable person in Áras Attracta must ensure that a local policy, procedure, protocol or guideline	Update of local policies to include recording of alerts and allergies and the adaption of a red sticker alert for all	June 2018	Practice Development Co-

	relating to the recording of alerts and allergies is documented and circulated to all staff, and staff are aware of the requirements of the policy and how to meet them.	residents files-PCPs and medical files		Ordinator, & PICs
	3. The senior most accountable person in Áras Attracta must ensure that training be provided to staff, to ensure that all healthcare records entries are legible, clearly signed, have a printed name, job title and identification number as per criteria 3.3.9 of the *Standards and Recommended Practices for Healthcare Records Management V3.0.*	Training requirement identified, working in collaboration with the CNME to provide a schedule for same	30th June	DOS & PICs
	4. The senior most accountable person in Áras Attracta must ensure the PPPGs relating to HCR management are in line with the *Standards and Recommended Practices for Healthcare Records Management V3.0'.*	Policy circulated to PICS/Team Leaders for wider distribution to staff teams in each location. Local policy to be developed adapting the principles of the national document.	June 30th	Practice Development Co-Ordinator
	5. The senior most accountable person in Áras Attracta must ensure that HCR management training is delivered to all relevant staff to ensure compliance with the *Standards and Recommended Practices for Healthcare Records Management V3.0*'	Training requirement identified, working in collaboration with the CNME to provide a schedule for same	June 30th	Practice Development Co-Ordinator
	6. The senior most accountable person in Áras Attracta must ensure the development of a documented approach to recording training undertaken on the HCR management by relevant staff, to include records of attendance to ensure compliance with the *Standards and Recommended Practices for Healthcare Records Management V3.0'*.	System in place for recording training. Managed by Clerical Administration and Audited by PIC monthly	December 2018	PICs
	7. The senior most accountable person in Áras Attracta must ensure the development and delivery of a structured audit	Audit tool developed in conjunction with the Project Officer, in the CNME. New Personal Profiles being rolled out onsite to be complete in Sept 2018	December 2018	PICs

	programme around HCR management. The HCR management audit programme must include outcomes, recommendations and implementation of audit findings through quality improvement plans to ensure compliance with the *Standards and Recommended Practices for Healthcare Records Management V3.0.*			
Brothers of Charity Services Ireland, Belmont Park, Waterford	1. The senior most accountable person within Brothers of Charity Services Ireland, Belmont Park, must ensure that a receipted communication is issued to all relevant staff and to all others making entries on HCRs, reinforcing the need to adhere to criteria 3.3.1 of the *Standards and Recommended Practices for Healthcare Records (HCRs) Management V 3.0*, i.e *'The service user's name is on each side of the page where service user information is documented'* 2. The senior most accountable person within Brothers of Charity Services Ireland, Belmont Park, must ensure that: a. a local Policy, Procedure, Protocol or Guideline relating to the recording of alerts and allergies is documented and circulated to all staff, and, b. staff are trained to ensure they are aware of the requirements of the Policy, Procedure, Protocol or Guideline, and how to meet them. 3. The senior most accountable person within Brothers of Charity Services Ireland, Belmont Park, must ensure that a receipted communication is issued to all relevant staff and to all others making entries on HCRs, reinforcing the need to adhere to criteria 3.3.4 and 3.3.9 of the *Standards and Recommended Practices for Healthcare Records (HCRs)*	A communication to this effect will be issued to all staff A)This will be addressed in the review of the National Records Policy B) this will addressed through the structured training programme A communication to this effect will be issued to all staff	31st May 2018 30th September 2018 To commence September 2018 and ongoing 31st May 2018	Director of Services National Policy Review Group Records Officer Director of Services

	Management V 3.0, i.e., that all Healthcare Records entries are legible, are clearly signed, have a printed name, job title and identification number. The same communication can be used to remind staff that loose notes, that become part of the healthcare record, must meet the criterion 1.9.5 '*Healthcare records should not contain any loose documentation*'.			
	4. The senior most accountable person within Brothers of Charity Services Ireland, Belmont Park, must ensure that a receipted communication is issued to all relevant staff making clear that the only abbreviations that may be used are those on the *HSE Code of Practice for Healthcare Records Management Abbreviations* booklet (2010). If any other abbreviations are to be used, they must be written in full, followed by the abbreviation in brackets, and this procedure must be followed on every page where the abbreviation is used.	A communication to this effect will be issued to all staff	31st May 2018	Director of Services
	5. The senior most accountable manager in Brothers of Charity Services Ireland, Belmont Park must ensure the development and delivery of a structured training programme for all relevant staff, around healthcare record management to ensure compliance with the *Standards and Recommended Practices for Healthcare Records (HCRs) Management V 3.0*.	A structured training programme will be developed and delivered relevant staff .	30th September and ongoing	Records Officer in conjunction with TDEAQ Manager
	6. The senior most accountable person in Brothers of Charity Services Ireland, Belmont Park must ensure the development and delivery of a structured audit programme around HCR management. The HCR management audit programme must include outcomes, recommendations and implementation of audit findings	An HCR audit programme will be developed and implemented	30th September 2018 and ongoing	Records Officer

	through quality improvement plans to ensure compliance with the *Standards and Recommended Practices for Healthcare Records Management V3.0*			
	7. The senior most accountable manager in Brothers of Charity Services Ireland, Belmont Park must ensure that policies procedures, protocols and guidelines round healthcare record management are reviewed and kept up to date.	A review of the National Records Policy is underway	30th September 2018	National Policy Review Group
	8. The senior most accountable person in Brothers of Charity Services Ireland, Belmont Park must ensure that there is a documented approach to recording training to include records of attendance.	A documented approach to recording training and attendance thereat will be developed	30th June 2018	TDEAQ Manager
Ard Na Gaoithe, Cope Foundation, Co. Cork	1. The senior most accountable person in Ard Na Gaoithe must ensure that • a local Policy,Procedure,Protocol or Guideline relating to the recording of alerts and allergies is documented and circulated to all staff, and • staff are trained to ensure they are aware of the requirements of the PPPG and how to meet them.	The local Policy will be updated and circulated to all staff . All staff will be trained to ensure they are aware of the requirements of THE pppg and be compliant with same . All staff will be required that they receipt training on same .	31/08/2018	Liza Fitzgerald, ADON & Anna Broderick ,ADON.
	2. The senior most accountable person in Ard Na Gaoithe must ensure that a receipted communication is issued to all relevant staff reinforcing the need to adhere to criteria 3.3.7 and 3.3.8 of the *Standards and Recommended Practices for Healthcare Records Management V3.0.,* in relation to the recording of the date and the 24clock hour format.	Policy will be reviewed to include use of 24 hour clock .This policy will be rolled out to all staff and reciepted . All staff will be requested to reciept communication .	31/08/2018	Liza Fitzgerald, ADON & Anna Broderick, ADON.
	3. The senior most accountable person in Ard Na Gaoithe must ensure that a receipted communication is issued to	Senior most accountable person at Ard Na Gaoithe will ensure a reciepted communication is issued to all relevan	31/08/2018	Liza Fitzgerald, ADON & Anna

	all relevant staff and to all others making entries on HCRs, reinforcing the need to adhere to criterion 3.3.9 of the *Standards and Recommended Practices for Healthcare Records (HCRs) Management V 3.0*, i.e., that all Healthcare Records entries are legible, are clearly signed, have a printed name, job title and identification number.	staff .		Broderick, ADON.
	4. The senior most accountable person for Ard Na Gaoithe and within the Cope Foundation services regionally must ensure that the recommendations identified in the letter sent on the 02 February 2018 are implemented. These recommendations are as follows: • A review of all resident's charts in Ard Na Gaoithe is undertaken to ensure that residents allergies are correctly and consistently documented in the healthcare record. • A review of all residential or other settings within Cope foundation is undertaken to ensure that allergies are correctly and consistently documented in healthcare records. • Consideration be given to ceasing the practice of printing NKDA at the top of the medication sheet and hand write the advice in the space provided. The acronym NKDA is acceptable according to the national abbreviations booklet and may be hand written in the space provided.	Complete. Complete. A review of the practise of printing NKDA will be conducted and consideration given to the ceasing of practise of printing	30/5/2018	Liza Fitzgerald, ADON & Anna Broderick, ADON. Liza Fitzgerald, ADON & Anna Broderick, ADON.
	5. The senior most accountable person in Ard Na Gaoithe must ensure that all policies, procedures, protocols, and guidelines relating to healthcare records are in line with the *Standards and Recommended Practices for Healthcare Records Management V3.0.*	A review of Policy, procedures, protocols and guidelines will be carried out to ensure compliance with Standards and Recommended Practises for Healthcare Records Management V3.0	31/08/2018	Liza Fitzgerald, ADON & Anna Broderick, ADON.

	6. The senior most accountable person for Ard Na Gaoithe must ensure that healthcare record management training is delivered to all relevant staff to ensure compliance with the *Standards and Recommended Practices for Healthcare Records Management V3.0.*	Training will be delivered to all staff to ensure compliance	31/08/2018	Liza Fitzgerald, ADON & Anna Broderick, ADON.
	7. The senior most accountable person for Ard Na Gaoithe must ensure the development of a documented approach to recording healthcare record management training undertaken by relevant staff, to include records of attendance, in line with the *Standards and Recommended Practices for Healthcare Records Management V3.0*.	A Training package will be developed and delivered to staff, this will include records of attendance .	31/08/2018	Liza Fitzgerald, ADON & Anna Broderick, ADON. .
	8. The senior most accountable person for Ard Na Gaoithe must ensure the development of a structured audit programme around healthcare record management. The HCR management audit programme must include outcomes, recommendations and implementation of audit findings through quality improvement plans to ensure compliance with the *Standards and Recommended Practices for Healthcare Records Management V3.0.*	A structured audit programme will be developed around healthcare record management .	31/08/2018	Liza Fitzgerald, ADON & Anna Broderick, ADON.
Rosanna Gardens Sunbeam House Services (SHS), Ashford, Co Wicklow	1. The senior most accountable person in Sunbeam House Services (Rosanna Gardens) must ensure a receipted communication is issued to all relevant staff reinforcing the need to adhere to the national standard in relation to (i) the recording of the service user's name/ identification number on each side of each page in the healthcare record, and (ii) to ensure that all relevant staff record the time of entry against each healthcare entry in the HCR as per criteria 3.3.1 and 3.3.8 of the *Standards and Recommended Practices for Healthcare Records Management V3.0.*	**<u>Auditors' Response:</u>** The CEO of SHS (the Rosanna Gardens site) did not agree to implement the recommendations of the audit but instead challenged the validity of the audit within their service. It is the auditors' opinion that the report's recommendations must be implemented or that alternative controls are developed to address the identified risks		

	2. The senior most accountable person in Sunbeam House Services (Rosanna Gardens) must ensure that a receipted communication is issued to all relevant staff reinforcing the need to adhere to criteria 3.3.45 of the *Standards and Recommended Practices for Healthcare Records Management V3.0.,* i.e., that all Healthcare Records must adhere to the healthcare organisation's procedure regarding alerts and allergies. 3. The senior most accountable person in Sunbeam House Services (Rosanna Gardens) must ensure that training be provided to staff about legibility of healthcare records, to ensure that all healthcare records entries are legible, clearly signed, have a printed name, job title and identification number as per criteria 3.3.9 of the *Standards and Recommended Practices for Healthcare Records Management V3.0.* 4. The senior most accountable person within Sunbeam House Services (Rosanna Gardens) must ensure that controls are put in place to mitigate the risks identified by the auditors in relation to the recording and use of contemporaneous notes by care workers during appointments with medical/multi-disciplinary team members. 5. The senior most accountable person in Sunbeam House Services (Rosanna Gardens) must ensure that Policies, Procedures, Protocols and Guidelines relating to Healthcare Records are in line with the *Standards and Recommended Practices for Healthcare Records Management V3.0.*			

	6. The senior most accountable person in Sunbeam House Services (Rosanna Gardens) must ensure the delivery of Healthcare Record management training to all relevant staff in line with the *Standards and Recommended Practices for Healthcare Records Management V3.0.* 7. The senior most accountable person in Sunbeam House Services (Rosanna Gardens) must ensure the development of a documented approach to recording Healthcare Record management training undertaken by relevant staff to include records of attendance in line with the Standards and Recommended Practices for Healthcare Records Management V3.0. 8. The senior most accountable person in Sunbeam House Services (Rosanna Gardens) must ensure the development and delivery of a structured audit programme around HCR management. The HCR management audit programme must include outcomes, recommendations and implementation of audit findings through quality improvement plans to ensure compliance with the *Standards and Recommended Practices for Healthcare Records Management V3.0.*			