Internal Audit

Hospital Admissions

May 2014

Overall Opinion	Satisfactory

Contents

Executive Summary

Overall opinion	Satisfactory

Risks	**Control Opinion**
Patients do not attend or attend at wrong times or places	Satisfactory
Patients' assessments are not carried out at pre-admission or on admission	Satisfactory
Patients' records are not available when patients are admitted	Satisfactory

Overall opinion

In general, the framework for admitting patients to hospitals operates effectively.

Patients are sent appointment letters containing the necessary information, as well as admissions leaflets. NHS Lothian's Clinical Documentation Standards set out minimum information to be gathered when patients are admitted. However, specialties and wards have developed their own practices and forms, with the full range of information expected not always being recorded.

While patients' records are managed differently across departments and wards, procedures appear to be generally effective to meet requirements and preferences.

Notification of appointments

As well as appointment letters with details of where and when to attend, NHS Lothian's leaflet titled Going to Hospital - A Guide for Patients, Carers & Relatives is readily available on the internet and from Patient Information Centres at the main hospitals. Although no specific standards appear to have been set across NHS Lothian, letters and information reviewed during the audit appeared reasonable, including additional instructions for particular specialties. Nevertheless, the process for authorising changes to standard letters could be tightened to prevent wording being changed inappropriately (issue 2).

While Did Not Attend figures are produced for outpatient appointments, similar statistics are not generated for inpatients or daycases, as TrakCare is not used in the same way. Figures for inpatients or daycases who Did Not Attend are limited to information recorded on ORSOS which is used for scheduling operating theatres. While no major problems are reported with Did Not Attends, a better understanding of the reasons for cancellations could help promote efficiencies (issue 3).

During 2013, NHS Lothian received 8 complaints that were categorised as admissions, with the complaints relating mainly to delays in surgery after patients were admitted. One complaint was upheld and 3 complaints were partly upheld.

Patients' assessments

Clinical Documentation Standards set out minimum information to be gathered when patients are admitted or enter the service, eg personal details, medical histories and medication currently being taken. During the audit, visits to specialties and wards found that different practices and forms are used to collect patients' information, with admission forms not always capturing the full range of information expected (issue 1).

As part of drafting a patient-flow policy, a review titled Right Patient, Right Place, Right Time has already been launched which includes admission and pre-admission practices. The resulting policy is expected to be approved in September 2014.

Patients' records

Health Records provides files for outpatient clinics, with internal targets to monitor performance. For inpatients and daycases, Health Records provides records at the Royal Infirmary of Edinburgh and St John's Hospital, with specialty and ward staff pulling records at the Western General Hospital. As well as central records being held for each patient, some specialties keep their own additional files. While practices vary across sites, the Head of Health Records is confident that procedures are effective, with variations reflecting the requirements and preferences of specialties and departments.

The location of patients' records is meant to be tracked on TrakCare. Internal Audit has raised issues before about the location of records not always being recorded or known (eg the audit report on Patients' Records Management issued in January 2013). While not reported as a major concern, Health Records mentioned the issue again during the current audit.

Background, Objective & Scope

Background

Most patients are admitted to NHS Lothian's hospitals through University Hospitals Services.

During 2012/13, over 216,000 patients were admitted into acute specialties (excluding obstetrics), with around 3,300 patients admitted into non-acute specialties, eg mental health and long-term care. Within acute specialties, hospital admissions comprise inpatients (72%) and day-patients (28%), with the highest numbers of patients admitted to the Royal Infirmary of Edinburgh, Western General Hospital and St John's Hospital.

Patients are admitted following referrals from GPs or other clinicians, or directly as emergency admissions. Emergencies account for 36% of admissions into acute specialties.

Objective

The objective of the audit was to evaluate the adequacy and effectiveness of internal controls within the process for admitting patients to hospital.

The audit focused on specific risks.

- Patients do not attend or attend at wrong times or places.
- Patients' assessments are not carried out at pre-admission or on admission.
- Patients' records are not available when patients are admitted.

Scope

The scope of the audit included:

- patient notifications and pre-admission guidance;
- procedures for non-attendance;
- inpatients and daycases;
- record-keeping; and
- management information.

The scope excluded:

- medical decisions to admit patients;
- waiting times targets and scheduling;
- bed management;
- outpatients;
- overseas patients;
- procedures within Emergency Departments;
- patients' funds & valuables; and
- mental health – specific procedures apply within mental health hospitals.

Audit Issues & Recommendations

Issue 1 Significant	Different practices are being followed with information not always being recorded

NHS Lothian's Clinical Documentation Standards 2013 set out minimum information to be gathered when patients are admitted or enter the service. Examples of information to be gathered include patients' personal details (eg names, dates of birth, CHI numbers and ethnic groups), medical histories, current diagnosis, medication being taken, allergies and estimated dates of discharge. Also, tasks to be completed at admission include preparing medical and nursing forms, allocating beds, checking patients' identities and confirming any special requirements.

During the audit, visits to 15 specialties or wards found that locations use different documents to collect patients' information on admission. For example, areas may use the Unitary Patient Record, Integrated Care Pathway forms or input information directly into TrakCare. Even where areas use the Unitary Patient Record, the form has been adapted over the years. An electronic version of the Unitary Patient Record was introduced at the Royal Victoria Building when the facility opened 2 years ago. In September 2013, the electronic version was introduced to the Acute Receiving & Assessment Unit at the Western General Hospital, but the record has not yet been fully adopted within the unit.

Meanwhile, forms being used by specialties and wards do not capture all the information required by the Clinical Documentation Standards:

- 2 areas (13%) do not specifically record the reasons for patients being admitted;
- 2 areas (13%) do not record patients' medical histories relating to the reasons for admission;
- 5 areas (33%) do not record current diagnosis;
- one area (7%) does not record any medication being taken at the time of admission;
- one area (7%) does not record the name of the clinician responsible for patients' care;
- 5 areas (33%) do not record patients' religion or ethnic origins;
- 6 areas (40%) do not record estimated dates of discharge (although 4 areas were daycase units); and
- 7 areas (47%) do not record having discussed patients' funds and valuables.

During the audit, admission records for 46 patients were reviewed against the expectations set within individual specialties and wards. While all files recorded names, dates of birth, CHI or UHPI numbers and dates of admission, other information was not always completed on forms:

- 3 files (6%) did not record the reasons for patients being admitted;
- 7 files (15%) did not record patients' medical histories relating to the reasons for admission;
- 10 files (22%) did not record a current diagnosis;
- 9 files (20%) did not record any medications being taken;
- 10 files (22%) did not record the names of clinicians responsible for patients' care;
- 21 files (46%) did not record patients' religion or ethnic origins;
- 39 files (85%) did not record estimated dates of discharge; and
- 25 files (54%) did not record details of patients' known allergies.

For pre-admissions, the Clinical Procedure Manual (Adult) recommends that patients be seen one to 4 weeks before admission. In practice, specialties visited ranged from one week to 12 weeks for pre-admission checks. While direction is not known to be given anywhere else, Standard Operating Procedures for Waiting List Management advise that pre-operative assessments are valid for 3 months.

As part of a patient-flow policy, the Service Manager for Capacity & Site Management is leading a review titled Right Patient, Right Place, Right Time which includes admission and pre-admission practices. The resulting policy is expected to be approved in September 2014. Meanwhile, a Charge Nurse has recently started a review aimed at formalising pre-admission practices at the Royal Hospital for Sick Children.

Recommendation

Admission and pre-admission practices and documents should be reviewed across NHS Lothian. Where possible, practices and forms should be standardised to promote the collection of all information required on admission. Deviations from standards required by particular specialties should be formally evaluated and agreed, perhaps by the Clinical Documentation Group.

Management Response

This is a very useful report that directly links to our agenda for standardisation and cascade of good practice. We welcome this report and its recommendations.

Management Action

A formal improvement team will be established by September 2014. Chaired by the Associate Director of Person Centre Care & Quality, this group will build on this audit's findings and establish a timetable for standardisation.

Recommendations from this group will be reviewed at the Acute Hospitals sub-committee by March 2015, with implementation thereafter.

Responsibility:	Target date:
Jim Crombie Director of Scheduled Care & Melanie Johnson Director of Unscheduled Care	31 July 2015

Issue 2 Important	The text of admission letters could be changed inappropriately

Letters to patients advising about admissions and pre-admission checks are produced from TrakCare. The letter templates on TrakCare can be configured easily, with hundreds of variations evident across NHS Lothian. To change the content of letters, specialties send instructions to eHealth where changes are actioned.

During February 2014, eHealth received instructions to change 180 paragraphs within letters on TrakCare. While many of these changes only involved contact details (eg phone numbers), potentially services could alter terminology that is legally binding, eg Treatment Time Guarantee.

The Clinical Application & Integration Manager and Modernisation Manager have previously tried to set up a group to authorise changes to letters, but doing so has proved more difficult than expected.

Recommendation

The group previously proposed for overseeing standard letters and authorising changes should be reconsidered. While minor changes such as contact details should remain easy to instruct, changing standard paragraphs relating to aspects such as Treatment Time Guarantees should require formal approval.

Management Response

Work is already progressing in this area.

Management Action

A process to standardise letters from Trak has been established by the Director of Scheduled Care (April 2014). This local work will be linked to national process and will see recommendations for format and content being reviewed at the Access, Performance & Governance Committee in August 2014. Implementation will be in September 2014.

Responsibility: Jim Crombie Director of Scheduled Care	Target date: 30 September 2014

Issue 3 Important	The reasons for patients not attending inpatient or daycase appointments are not clearly recorded

While Did Not Attend figures are produced for outpatient appointments, similar statistics are not generated for inpatients or daycases. In particular, attendance rates for outpatient appointments are monitored through TrakCare, but TrakCare is not used in the same way for inpatients and daycases.

On ORSOS, the reasons for theatre slots being cancelled are split into 24 categories. During November 2013, 30% of cancellations (419 cases) were categorised as Cancelled by Patient - Unable to Attend, 10% (135 cases) categorised as Cancelled by Patient - Did Not Attend, and 7% (103 cases) categorised as Cancelled by Patient - Other. During the audit, Service Managers provided reasonable explanations about how cancellations are managed to minimise any loss of theatre capacity.

The Head of Performance Review and Associate Director for Strategic Planning have recently been tasked with reviewing how cancellation figures are gathered and monitored.

Recommendation

As already planned, the gathering and monitoring of cancellation figures should be reviewed, including how the underlying reasons for cancellations are recorded and used to promote efficiencies.

Management Response

This is a complex arena and one which will require significant review and perhaps capital investment.

Management Action

A review of functionality and system architecture will be established in June 2014. Led by the Associate Director of Information, this review will establish medium and long-term options to resolve. An interim report will be discussed at Access, Performance & Governance Committee in September 2014.

Responsibility: Jim Crombie Director of Scheduled Care	Target date: 30 September 2014

Definition of Ratings

Audit Opinions

- Fully satisfactory - the control framework is fully adequate and effective to manage the main risks within acceptable limits.
- Satisfactory - although improvement is possible, controls are adequate and effective to manage the main risks within acceptable limits.
- Requires improvement - significant issues exist with the adequacy or effectiveness of controls which could result in disruption, loss or reputational damage.
- Unsatisfactory - the control framework is generally inadequate or ineffective with issues that require immediate attention to prevent disruption, loss or reputational damage.

Issue Ratings

- Critical - the issue has a material effect upon the wider organisation.
- Significant - the issue is material for the subject under review.
- Important - the issue is relevant for the subject under review.

Audit Team

[redacted], Principal Auditor
[redacted], Chief Internal Auditor

Distribution List

Tim Davison, Chief Executive
Susan Goldsmith, Director of Finance
David Farquharson, Medical Director
Melanie Johnson, Director of Unscheduled Care
Jim Crombie, Director of Scheduled Care
Alex McMahon, Director of Strategic Planning, Performance Reporting & Information
Alan Boyter, Director of Human Resources & Organisational Development
Alex Joyce, Employee Director
Sarah Ballard-Smith, Nurse Director
Martin Egan, Director of eHealth
Stuart Wilson, Director of Communications & Public Affairs
[redacted], Head of Health Records
Audit Scotland, External Audit

This report has been prepared solely for internal use as part of NHS Lothian's internal audit service. No part of this report should be made available, quoted or copied to any external party without Internal Audit's prior consent.