Audit of record keeping of Intake & Output charts

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146 intake and output charts were audited, by random selection on the wards at different times of day, 10 charts from each ward as appropriate. 3 wards had no patients on intake & output charts.

Is the patient's name on the chart?

All wards scored 100%, except ward 7 (70%)

Is the ward on the chart?

Ward appeared on 64%
4 wards scoring 100% = 1, 22, 10 & 41

Is the date on the chart?

Date appeared on 90%
11 wards scoring 100% = 1, 2, 20, 21, 22, Spruce, NNICU, 5, 8, 10 & 42

Is the hospital number on chart?

Number appeared on 69%
7 wards scoring 100% = 1, 2, 20, 21, 22, NNICU & 5

Is the patient on I.V fluids?

53/146 (36%) on I.V fluids

Are they prescribed?

39/53 (74%) prescribed
4 wards scored 100% = 20, 5, 8 & 41

Is the prescription legible?

38/53 (72%) legible
3 wards scored 100% = 5, 8 & 41

Is the prescription signed?

37/53 (70%) signed?
4 wards scored 100% = 21, 5, 8 & 41

Were they commenced as prescription?

12/53 (23%) commenced as prescription
No wards scored 100%

Is the patient on restricted fluids?

6/146 (4%) on restricted fluids

Is the patient aware of this?

3 patients not applicable (Asleep/unable to answer)
3/3 (100%) aware of this

Received greater than restriction	75%
Received less than restriction	25%
No one received the prescribed fluids	

Is the intake recorded regularly?

14 patients fasting
Total patients = 132
Intake recorded = 119/132 (90%) but no wards had entries after 8pm
Not recorded = 13/132 (10%)

Urinary output entered by

Recorded "mls"	: 62/146	(42%)
Recorded "Description"	: 46/146	(31%)
Recorded "++++"	: 9/146	(6%)
No Detail	: 29/146	(20%)

Had the patient diarrhoea?

7 patients (5%)

If yes, how was it described?

4/7 "Description" (57%)
3/7 "++++" (43%)

Was the patient vomiting?

6 patients (4%)

If yes, how was it described?

1/6 "mls" (16%)
5/6 "Description" (83%)

Was the chart totalled at the end of the day?
Yes 73%
No 27%
6 wards scored 100% = 1,2,CCU, 22,9 & 41

If yes, was it accurate?
Yes 85%
No 15%
9 wards scored 100% = 1,3,20,NNICU, CHW, 8,9,41 & 42

Comments on each ward by directorate

Medical Directorate

Ward 1

Two patients - IV fluids were prescribed but no times indicated

No oral fluids entered after 5pm

CCU

One patient was admitted today therefore no previous chart.

One patient had IV fluids with no start time indicated, (prescription over 90 mins.)

Ward 2

IV fluids not running as prescribed

Previous day Fluid charts are filed in notes each day, but very difficult to find even though they were filed that morning.

Ward 3

One patient had no entries on fluid chart, audit took place at 15:45hrs

Ward 20

One patient – IV fluids prescription had very unclear instructions and illegible

One patient – "PU+++"

One patient – recording output only

Two patients had no entries on fluid chart, audit took place at 11:35hrs

Ward 21

Intake was totalled but not output

Ward 22

No comments

Anderson House

There were no patients on intake and output charts at time of audit

Ward 5 Waterside

There were no patients on intake and output charts at time of audit

Spruce House

All patients were on PEG feeding

Women and Children's Directorate

Ward 4

No patients had an intake and output chart at the time of audit

NNICU

1 baby had IV fluids discontinued at 10am and no fluids were prescribed for that day

Ward 5

Only 1 patient had an intake and output chart the previous day, as most patients were post-op.

Ward 15

Only 1 patient had an intake and output chart at time of audit, post C/S

CHW

Children's ward has a different intake and output chart that the other wards, which they are reviewing at present

2 patients had record of orals only

Surgical Directorate

Ward 7

1 patient had no details on the intake and output chart, was receiving IV fluids. One entry was on the cannula chart at 9am that morning, audit took place at 11:45hrs.

Ward 8

1 patient was allocated an intake and output chart on admission the previous day but no entries were made on it.

Oral fluids were not documented after 5pm.

Ward 9

1 patient was prescribed 100mls of IV fluids, only had 60mls and no comment noted as to reason why.

Ward 10

Patients on this ward had current day charts e.g. post op

1 patient had a previous day's chart but was transferred from another ward.

Ward 41

2 patients had only output recorded and this was noted on the chart.

Ward 42

1 patient had no entries on intake and output chart for that day, audit took place at 16:15hrs.

2 patients were post op and therefore had no previous day chart.