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The Clinical Documentation Quality Improvement Project: The Way Forward for Quality of Care Delivered to the Patients

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Key words: *Patient, documentation, standards, quality*

1. Introduction

Clinical documentation is an integral part of healthcare profession job. The good and accurate records keeping are essential for patients care and for effective communication within multidisciplinary team. The quality improvement project conducted inPediatric Department of CHUB, Rwanda**.**

2. Objectives

To evaluate the documentation is conducted as by policiesto identify the gaps against standards and closing them.
To demonstrate improvements in the quality of documentation

3. Methods

Retrospective analysis of files of consulted patients.
The sample size the sample is made on monthly basis, randomly 10 files every month from January 2015-September 2016.
Data sources: patients files which have been chosen in these months
Data collection and analysis: The questionnaire was used to collect data and analyzed using Microsoft Excel.

4. Results

31% of the audited files did not have complete patients details; 23% overalldocumentation in the files audited was insufficient to give a clear picture of the patients care; 66 % of files were compliant with information for patient with the gap of 24%; 90% of the files showed compliance with discharge transfer of patients with the gap of 10% .Generally this is explained by the lack of knowledge and familiarity on existing standards, lack of orientation for new residents, workloads, language barriers ,inadequacy of patients file, attitudes and lack of feedback, lack of familiarity on existing standards.

5. Conclusion

Regular refreshment on policies and procedures, orientation to the residents and staffs, appropriate patient 'files, respect of patient's rights, training on palliative care, changing attitudes, improving knowledge and communication skills, reacting to guideline deviations, feedback to the healthcare providers will improve quality of clinical documentation.

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