



Data Quality Newsletter (May 2011) Edition 3

Royal College of Paediatrics and Child Health

in partnership with the National Reyes Syndrome Foundation, UK

WELCOME to the third edition of the DeCon Data Quality Newsletter. This edition covers:

1. Methods for case identification
2. Methods for audit promotion
3. Positive evidence for selected audit standards: Features of the Clinical History & Observations

Thank you to the following hospitals for sharing information on their approach to data collection and audit promotion with us: Alder Hey Children's Hospital, New Cross Hospital, Royal Devon & Exeter Hospital, Royal Surrey County Hospital, Southampton General Hospital, Sunderland Royal Hospital, Tameside General Hospital and University Hospital of North Durham

1. Methods for case identification

Struggling to identify cases? Why not try some of the methods used by the other trusts in the audit.

If you require any audit logbooks or A3 laminated posters, please contact carla.long@rcpch.ac.uk



2. Methods for audit promotion



3. Positive evidence for selected audit standards

Clinical Audit Question	Positive Evidence
<p>8. At presentation to hospital, was the presence or absence of the recommended features of the clinical history documented in the clinical record?</p> <ol style="list-style-type: none"> vomiting before or at presentation headache before or at presentation fever before or at presentation, convulsions before or at presentation alternating periods of consciousness trauma ingestion of medications or recreational drugs presence of any medications in the child's home any previous infant deaths in the family length of symptoms 	<ul style="list-style-type: none"> Documentation in the clinical record (electronic or written) that these features were elicited at presentation to hospital. <ul style="list-style-type: none"> ◇ Documentation of a temperature in the clinical notes is not considered as positive evidence for c. ◇ Documentation of a family tree may be considered as positive evidence for i. <p>The purpose of this question is not to determine whether a clinical feature was present or absent at the time of presentation. But rather it is to determine whether the doctor undertaking the clinical history at the time of presentation elicited the recommended features of the clinical history as appropriate to the child's condition and recorded this information in the clinical record irrespective of whether the feature was present or absent.</p>
<p>9. Were the following observations documented in the patient's clinical record at presentation to hospital?</p> <ol style="list-style-type: none"> heart rate respiratory rate oxygen saturation blood pressure temperature 	<ul style="list-style-type: none"> Documentation in the clinical record (electronic or written) that these observations were performed at presentation to hospital. <ul style="list-style-type: none"> ◇ Documentation of these observations in clinical notes, observation charts, resuscitation sheets and electronic formats such as spread sheets are considered as positive evidence. ◇ Documentation of observations by ambulance staff prior to the child's presentation to hospital is not to be taken as positive evidence.