

Audit of Head and Neck Cancer Records at a State Run Tertiary Care Referral Centre in India

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1. Abstract

A comprehensive documentation of medical records helps in reducing diagnostic and treatment errors, and aids in improving quality of care to patients with head and neck cancer. A retrospective study was conducted on 25 Head and Neck Oncology case sheets using the standards adopted by the British Association of Head and Neck Oncosurgeons (BAHNO). A total of 10 questions were used to assess the completeness of the case sheets and the results were analyzed. A total average score of 81.6% was achieved and we have a target of more than 90% to be achieved in the near future. Engaging more fellows and supervision of cancer records by conducting frequent audits would help in achieving our projected target.

1.1. Background: Due to the increase in number of patients receiving treatment in State Run Hospitals in developing countries like India, many a times it is difficult to maintain accurate records of data. Through digitalization, a lot of such problems have been overcome but the level is not upto the mark it that of developed countries. Head and neck cancer is an area where morbidity both before and after the surgery makes the patient a regular visitor to the Out Patient Department. Since the residents and fellows work in the Department for a limited period of time ranging from 1-3 years, long term follow up of cancer patients needs accurate archiving of data. A complete, and adequate documentation of medical records helps in reducing diagnostic and treatment errors, and

improves the prognosis of the cancer patient [1].

1.2. Aims and Objectives: The aim of the Audit is to improve quality of care to those patients with head and neck cancer by raising standards of care to match those of the best performing teams.

The Audit focuses on evidence of delivery of appropriate primary treatment, including adjuvant therapy, in the management of head and neck cancer by a multi-professional team, ensuring that patients are diagnosed and treated without unnecessary delays.

1.3. Methodology

1.3.1. Study period: 1 March 2020 to 28 February 2021

This retrospective study was conducted to assess the policies and procedures in relation to medical documentation using guidelines from British Association of Head and Neck Oncosurgeons (BAHNO) [1]. A total of 25 discharged inpatient records were analyzed to understand the quality of documentation in practice.

A total of 10 Audit questions were framed based on recent oncology guidelines and respective attributes with options of 'Yes', 'No', were evaluated for their completeness and accuracy. The entries in the medical records were assessed based on the laid down standards in the checklist. The respective items were observed and findings were noted down.

1.3.2. Inclusion Criteria:

25 case records of head and neck cancer patients picked randomly

during 1 March 2020 to 28 February 2021

1.4 Results: Using the questions mentioned in the Annexure, the Audit was conducted on 25 Head and Neck Cancer Records and the results were tabulated as shown in the Table.

2. Discussion

2.1. Multi-Disciplinary Tumor Board (MDT) Assessment

The multidisciplinary tumor board (MDT) is an important part of head and neck cancer evaluation and management. The benefits of MDT are multifactorial, improving multiple elements of cancer care, including staging, treatment planning, treatment coordination, and ancillary service. The available clinical and pathological data is presented and discussed in MDT, for making diagnosis, staging and better management of patient [2].

In our audit we found that 22cases out of 25 were discussed in MDT. The data collected for the head and neck cancer audit does not indicate the understanding of what constitutes MDT. Overall more than 90% of patients were confirmed as having been discussed at an MDT meeting. The National Head and Neck Cancer Audit done in 2014 has documented that 90% of their cases are audited regularly [1]. Our figures are at par with them.

2.2. Interval from First OPD Visit to Diagnosis and from Diagnosis to First Definitive Treatment

Delay between the initial symptoms, diagnosis, and the definitive treatment of head and neck cancers is associated with tumor progression and upstaging. These delays may lead to poor outcomes and may mandate more aggressive treatments with unnecessary

morbidity and even mortality. In our audit we found that 16 cases out of 25 were diagnosed within 2 weeks from initial OPD visit, and 11 cases are operated within 2 weeks of diagnosis. Study done by Pelaz A et al has shown that most of the cases are diagnosed within 30 days of presentation and are treated within 30 days of diagnosis [3]. We have managed to achieve in 64% of the patients the diagnosis within 2 weeks and treatment within 2 weeks in 44% cases. The reasons could be due to lack of access to transportation facilities and hence a delay in access to healthcare due to the lockdown announced during the Covid pandemic. Also, the hospitals prioritized treatment of Covid cases during the pandemic and hence cancer patients had to wait for a relatively longer period of time to get treatment.

2.3. Clinical Staging Information

Staging of tumors is a critical part of the treatment pathway as well as being a key determinant of outcome [4]. All MDTs should be strongly encouraged to complete and validate staging information and validate outcome. Overall, of those patients with a recorded careplan, 75% had recorded staging information. Whilst this figure is encouraging, we need to work towards a higher figure for future audits.

2.4. Diagrammatic Representation for Tumor Location

It is easy to represent a lesion through pictures and they can be easily understandable to everyone. In our audit we found that 20/25 of the case records were recorded with pictures. The use of diagrams or tumour maps allows standardization of the records of patients with head and neck cancer [5].

Table

S.NO	AUDIT QUESTIONS	RESULTS
1	Multidisciplinary Tumor Board Assessment	22/25
2	Clinical staging information	22/25
3	Cases Diagnosed within 2 weeks	16/25
4	Cases Received Primary Treatment within 2 weeks	11/25
5	Diagrammatic representation for tumor location in case sheets	22/25
6	Marking of Resected Specimen through Pictures in Operative notes	20/25
7	Marking of Resected Specimen through Pictures in Discharge Summary	20/25
8	Post-operative Pathological Staging	21/25
9	The performance status	25/25
10	Use of Hospital Medical Information System	25/25

2.5. Marking of Resected Specimen Through Pictures in Operative Notes and Discharge Summary

Head and neck Cancer requires long term follow up (5 to 10 years). Hence, it will be easy to understand the procedure through one diagram showing excised specimen in long term follow up.

In our audit we found that 20/25 of the operative notes or discharge reports were recorded with picture

2.6. Postoperative Pathological Staging

In oral cancer the prognostic significance of clinical staging (cTNM) is regarded inferior to histopathologic staging (pTNM) after surgery. Also, pathological staging is necessary to plan adju-

vant therapy. So, it is mandatory to mention pathological staging in all postoperative cancer record [6].

In our audit we found that 21/25 of the cancer records have mentioned pathological staging.

2.7. Performance Status of Patients

The performance status of the patient (Karnofsky score/ECOG Scale) is a simple and rapid method to assess patients' performance. The score has proven useful not only for following the course of the illness, but also for obtaining prognostic information [7].

In our audit we found that 25/25 of the case sheets have mentioned regarding performance status of the patient.

2.8. Use of Hospital Record Systems

Hospital Medical Information System (HMIS) is a organized way of digitally saving vital patient information for further use during follow ups and referrals. In our study, all the case records 25/25 were entered in the HMIS as a part of routine protocol. Use of Hospital Record Systems helps to archive all patient related data conveniently and digitally. This also helps to code the information and present large volume of data to the funding agencies and government to provide financial support to the institute [8].

3. Conclusion

This audit is a simple attempt to emphasize on the completeness of case sheet writing with respect to patients with head and cancer as the records will be referred time and again during routine follow up of the patients for years.

Completeness of the records helps the treating doctors to get an idea about what was done for the patient even if the residents have finished their tenure of training in the Institute. Use of diagrams to represent data will aid in understanding of a significant amount of information without the use of textual matter. This avoids mis-interpretation of data due to errors in clerking by the residents.

This also helps setting up standards in referring patients for other treatment modalities like chemotherapy and radiotherapy as the oncologists can get ideas about staging, diagnosis etc. Also communication between different cancer centers gets standardized by using this checklist so that there is completeness of information conveyed.

4. Future Recommendations

In future we recommend that patients should be diagnosed and treated as early as possible not breaching the 4 weeks time period from the first OPD visit for better management and prognosis of the cancer patient thus avoiding delay and upstaging of the disease. The present study shows a completeness of 81.6% on an average for each of the questions assessed independently. After sensitizing our residents about the importance of documenting these data accurately, we hope to achieve a result of more than 90% and set a standard in documentation of head and neck cancer case records. Engaging more fellows and supervision of cancer records by conducting frequent audits would help in achieving our target in the next 2 months.

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