FACTSHEET

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The Importance of Good Medical Records

Good medical records, whether recorded on paper or in electronic format, are essential for the care of patients in general practice.

Medical records are intended to support patient care and should authentically represent every consultation (including by telephone or video). Memory is unreliable regardless how well you know your patients and records provide a factual reminder of a course of events, steps taken, outcomes and further action required.

Records should ensure continuity of patient care and be comprehensive enough that another doctor can carry on the care and treatment of a patient where you left off when required.

Your patient records will be very important in the future if there is a complaint or claim made against you (which may often occur months or years after a consultation). Inadequate medical records may compromise your ability to defend your practice and decisions about patient care in a legal or professional context.

Professional responsibilities for doctors are clearly defined in the Medical Council's *Guide to Professional Conduct and Ethics,* (available on the Medical Council website) states in section 33.2, Medical Records:

You must keep accurate and up-to-date patient records either on paper or in electronic form. Records must be legible and clear and include the author, date and, where appropriate, the time of the entry, using the 24-hour clock.

Notes should be made following all patient contacts, i.e., consultations, both face-to-face and virtual, home visits, or telephone advice. In providing patient care you must keep clear, accurate, legible and contemporaneous patient records which report relevant examinations and clinical findings, the decisions made, any drugs or other treatments prescribed, the information given to patients including safety netting and follow up advice.

Challenges may arise when trying to balance how much detail to write in the notes versus the time available to do so. It is important to bear in mind that there may be occasions when it is prudent to write more in particular in high risk complex situations.

What's included in a medical record?

Medical records include not just the clinical entries from a consultation, but all results and medical information relating to the patient, such as emails, consent forms, text messages, verbal correspondence between health professionals, laboratory results, x-ray films, photographs, video/ audio recordings, and any printouts from monitoring equipment.

Electronic Records

Whilst entering the notes of a consultation on a computer, it is important to ensure they are easily understood. Avoid using text speak or shorthand in order to save time as you may understand what you mean but others who need to access the records may not. If you use note templates to record a consultation, they should be amended and personalised to reflect the details and findings of the specific consultation.

Structure of medical record

Consider using a constructive method to recording consultations in the record, for example the problem-oriented approach *S.O.A.P (originated by Weed L.L·1968)* i.e.*:*

- **S**ubjective - what the patient tells you i.e. the history
- **O**bjective - what you find on examination and test results
- **A**ssessment - includes problem title and differential diagnosis
- **P**lan - includes management options

In addition to the above, record:

- **I**nformation given to the patient
- **S**afety netting and follow up**.**

Tips for good record keeping

1. Making entries into the record

Entries should be made in the medical record following all consultations and whenever any action is carried out on behalf of the patient, i.e.

- In the consultation room at the surgery
- Remote consultations, telephone or video conferencing
- Home visits
- Text and e-mail
- Discussion with another health professional regarding the care of the patient.
- Administrative tasks - e.g, an administrator telephoning a patient with a request to make an appointment to see the clinician etc. It is also important to record a failed attempt to contact the patient.

All consultations should be recorded by type, i.e., in surgery, home visit, video consultation, telephone consultation etc.

2. Entered for the correct patient

Double-check that you are entering notes into the correct patient record, especially when you have patients with similar names and surnames, e.g, two patients in the one family with the same name and address.

3. Record all notes clearly

Take extra time and care to write or type notes in a way that they are clear to other people who need to read them.

4. Dated, timed and signed (attributable)

Dated, timed and signed handwritten notes are essential not only for continuity of patient care but if a complaint or claim should arise these details will clarify the sequence of events during your treatment of the patient. With electronic records, the date and time should be recorded automatically.

For electronic records, all staff should have a unique login and password that is not shared with others. Locum doctors should have their own personal named log in, not a generic locum ID e.g.“Dr Locum 1”.

5. Abbreviations and shorthand

Use abbreviations sparingly and as standardised within your practice. Avoid abbreviations that are ambiguous, for example, PID can mean - *prolapsed intervertebral disc* or *pelvic inflammatory disease*. Shorthand symbols grading clinical findings should also be standardised. As mentioned above, avoid text speak.

6. Record all positives and pertinent negatives

During a consultation, it is important to record positive findings and in addition pertinent negative findings, as this may demonstrate that a differential diagnosis had been considered.

7. Altering records

Clinical notes should be contemporaneous, made at the time of consultation with the patient or as soon as possible afterward. If it turns out that the notes are factually incorrect, for example, an entry has been made in the wrong patient record, then the amendment must be clear.

If it is necessary to alter any paper records, deletions should be done by scoring through with a single line only so that the original text is still visible. The deletion should be signed and dated, with the name printed and an entry should be made recording the reason for the deletion. Correction fluid or markers should not be used. The corrected entry should be written alongside with the date, time and your signature.

From electronic records, the entry may be deleted, and an additional entry made, to make it clear what has been deleted, by whom, on what date and why. Computer records have an 'audit trail' that will allow any alteration to the notes be recorded in real time.

Any changes to documentation should be overt and be free from the suggestion that the changes were meant to mislead.

Tampering with medical records has in the past led to investigation by the Medical Council and the courts.

Patients have the right under GDPR to apply to have their personal data erased or rectified. Clinical records are intended to be a contemporaneous record of a consultation and it may not be appropriate to rectify or erase records. It may be possible to deal with a request for rectification by creating a new, separate entry which notes the details of the patient's request and records the doctor's decision and reasoning.

Medisec strongly advises any member receiving such a request to contact us for specific advice.

8. Avoid unnecessary comments

Offensive personal or humorous comments are unprofessional, often misunderstood and could portray a poor impression of you or your practice. Patients have a right to access to their records. A flippant remark in the notes is difficult to explain in a court of law or in front of a Medical Council Fitness to Practise committee.

Ideally, do not document personal feelings about a patient. If you feel that a remark made by a patient is applicable then document it using quotation marks. E.g., X says they are "very angry about a lack of care."

9. Allergies

To ensure the safe prescribing of medications, it is best practice to record drug allergies onto the computer via the medication screen. It should be added to the prescribing part of the computer system in such a way that it will alert any clinician to that allergy if they try to prescribe the medication to which the patient has an allergy.

10. Check all letters and reports

Letters dictated and then typed up later by administrative staff should be checked, corrected if necessary and signed by the doctor who dictated it. Errors often arise due to problems with the quality of the recording or simple misunderstanding of medical terminology. Follow-up, evaluate and initial every report or letter before it is filed in the patient's records. Most test results are now electronically transmitted so ensure that any abnormal findings are recorded in the clinical records, as well as any appropriate actions required or taken.

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Managing unresolved clinical issues

Doctors should have a facility to highlight any unresolved issues on a patient's record so that these would be evident at a glance before patient attends for consultation. If a doctor uses computerised records, this entry should be highlighted. If a doctor operates a manual written system, a "highlight sheet" should be permanently attached at the front of the patient's file.

If an issue is highlighted, the doctors should review this with the patient in addition to dealing with the presenting complaint.

Please also refer to Medisec's factsheets, available on our website:

- Storage and retention of medical records
- Patient requests for medical records
- FAQs regarding access and retention of records
- Third party requests for records
- GDPR – Data Subject Access Requests
- Garda requests for records.

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