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 each and 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 will often be made 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., face to face consultations, home visits, telephone advice or video calls. 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.

Electronic Records

Whilst entering the notes of a consultation on a computer, it is important to ensure they are legible and 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.

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.* 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, add: information given to the patient, safety netting and follow up.

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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
- home visits
- telephone
- text and e-mail
- administrative tasks
- discussion with another health professional regarding the care of the patient.

2. Write all records legibly

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

3. Dated, timed and signed

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.

4. Abbreviations and shorthand

Use abbreviations sparingly and as standardised within your practice. Avoid abbreviations which 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.

5. 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. Errors should be bracketed and scored through with a single line only so that the original text is still visible. Do not use tippex or markers if records are handwritten . The corrected entry should be written alongside with the date, time and your signature. Never attempt to insert new notes. Computer records have an 'audit trail' that will allow any alteration to the notes be recorded in real time. Tampering with medical records has in the past led to investigation by the Medical Council and the courts.

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

6. 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 and 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.

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7. Allergies

To ensure the safe prescribing of medications, it is best practice to record drug allergies onto the computer via the medication screen. It must 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.

8. 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.

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:

- Retention and storage of medical records
- Patient access request to medical records
- FAQs regarding access and retention of records

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