Improved record keeping in general practice

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SUMMARY. This paper describes a system of record keeping emphasising:

(1) The collection of basic data on each patient recorded on a summary card,
(2) The recording of chronic or continuing illnesses on the summary card,
(3) The typing of medical records, at least the typing of referral letters with the retention of a copy in the record folder,
(4) The use of a problem orientated record and a problem sheet either separately or as part of the summary card,
(5) The use of a drug card,
(6) The use of other specialised cards for special interests or clinics i.e. paediatric and geriatric cards.

Introduction

The importance of good medical records and record keeping in general practice is widely acknowledged.[1] The increased mobility of patients, the growth of group practices, health centres, and night and weekend rotas make it more important than ever to have a clear, precise, and complete record.

It is widely accepted that the standard of general-practitioner records and record keeping in the past was abysmally poor. Collings (1950) who made an extensive review of general practice reported that he never saw anything approaching good records and most of them were poor in the extreme.[2] Kuenssberg (1968) reported on a survey of 2,000 records received from NHS doctors of which 43 per cent had either a blank continuation card or none at all.[3] Cormack (1970) compared the data from a questionnaire of 187 patients with their clinical records and concluded that difficulties and deficiencies in the field of recording in general practice are becoming increasingly apparent.[1]

More recently Dawes (1972), examined 1,628 medical records from eight practices and found that less than half of the episodes had any symptoms recorded and only one third had a physical sign recorded.[4] He also found that the therapeutic agent was the most frequently recorded item occurring in 70 per cent of episodes, but the amount prescribed was recorded in only one quarter of the episodes and the dosages in less than one fifth. He concluded " it appears that there are wide variations in the records kept by general practitioners and that severe deficiencies exist in the information about patients, their diseases, and their treatments contained in general-practice records."

Family and social history are a part of the general practitioner's records which have been particularly neglected.[1,6] On the other hand it must be admitted that the problem of recording family histories in each patient's record in general practice is a tremendous undertaking, the value of which has never been proven. Various methods of constructing family morbidity indices or family record cards have been described in the past.[6-9]

The present record envelope introduced in 1911 undoubtedly made good record keeping difficult. The advent of the A4 folder for general use in the future affords family doctors a unique opportunity to improve their record keeping—an opportunity which must not be lost. Much that has been written to date on improved record keeping has been by enthusiasts in this field and widespread use of their excellent suggestions appears doubtful. This paper purports to outline present and possible future developments in medical records and to suggest methods of improved record keeping for general use by the average busy general practitioner.

The A4 folder

The Department of Health has recently agreed to the introduction of an A4 folder for general practice.[10] This folder is likely to come into general use soon in some areas. It is apparently based on the Wantage folder which was described in detail by Loudon in 1971 and has been in

use in 46 practices in the Oxford region since 1970.[11] The folder, similar to a hospital folder, is 31 × 24 cm. (12½ × 9½ inches), double spined with a pocket at the front to hold the present National Health Service medical record envelope EC5 and 6 and the continuation cards EC7 and 8.

The folder contains various sheets of notes for use by the practice team. These folders, which are best filed laterally on open shelves will occupy twice to three times the space required for the present record envelopes. The use of A4 folders for individual patients would probably make family folders so cumbersome as to be impractical for general use, a feature that will be regretted by most doctors who have used family folders.

Folders of size similar to A4 have been used for this past three years for all the 19,000 patients at the Armagh Health Centre. There is no doubt of their value, for apart from the additional space for note taking, letters can be filed flat and are more accessible.

An improved folder with additional space for note taking does not necessarily ensure a higher standard of recording. In the view of the working party on medical records of the Northern Ireland Faculty of the Royal College of General Practitioners the use of structured record cards as outlined in this paper should improve record keeping.

No. _____

ROYAL COLLEGE OF GENERAL PRACTITIONERS

SUMMARY CARD

N. IRELAND FACULTY

SURNAME	*NHS no.*	
CHRISTIAN NAMES	*Date of birth*	
ADDRESS 1.	*Civil status*	
2.	*Change of status with date*	
3.		
OCCUPATION (If housewife—Husband's occupation) (If child —Father's occupation)	*Social class*	*Tel. no.*
1.	.....	
2.	.....	*Blood group*
3.	.....	

OTHER SOCIAL DATA (HOUSING, HABITS, ETC.)

Date	*Ref. no.*	*Major problems, illnesses and operations*	*Family history*
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	*Drug reactions and allergies*
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Figure 1
Summary card.

The summary card

This has been designed as a record of basic data about patients. Other important data which might have been included are the distance from home to surgery, the doctor with whom registered, date of registration, and the doctor usually seen. This data is important clinically, but is also useful for the selection of patients for screening procedures, for research and as a patient profile for future computerisation and record linkage. These data have been poorly recorded in the past partly because of the present medical record card.

Secondly it can be used for recording major illnesses and operations. This should prove more acceptable to most general practitioners than total morbidity recording. This could be used in association with the " boxing in " of diagnoses in the clinical record as suggested by Hodgkin.[1,2] The value of such a record in the completion of, for example, a life insurance report is obvious.

Thirdly, this card can be used as a limited form of problem-orientated record by the inclusion of major problems with the major illnesses and the enumeration of each of these. It is doubtful whether the complete problem-orientated record as envisaged by Weed is necessary for the straighforward consultation in general practice; on the other hand, the theme is appealing and if used must improve the standard and clarity of the written record.[13,14] Enthusiasts would probably want to use more detailed and separate summary and problem cards.

The use of a questionnaire to update and collect additional information on basic data, chronic and continuing illnesses, family and social history has been suggested.[1,14] Cormack (1970) issued patients with a questionnaire, explanatory letter and stamped addressed envelope with a brief verbal explanation of the purpose of the questionnaire at the end of a surgery attendance.[1] He found it a useful method of obtaining much information especially about family history which was previously unrecorded. A modification that could be employed before or with the introduction of the new record system would be for the receptionist to issue each patient with a questionnaire to be completed in the waiting room while they await their appointment.

Drug card

The use of a drug record was recently suggested by Tait and Stevens in this *Journal*.[15] The purpose of this card is to afford an accurate updated record of the drug treatment that a patient is receiving with the drug sensitivities or prescribing problems the patient may have. This card would appear to be an excellent idea particularly in view of Dawes' findings. The suggested card is shown (figure 2). It is essential for adequate control of drug therapy that each repeat prescription should be recorded by the doctor or receptionist. The reverse side of the drug card could be used. The name of the drug or its number on the drug card is simply recorded with the date of each repeat prescription underneath.

Obstetric card and obstetric co-operation card

A suggested design for an obstetric record card for use with the new A4 folder is shown in figures 3 and 4. An obstetric co-operation card, to be carried by the patient, as shown in figure 4 and can be a scaled down version of the obstetric record card and is more compact than a carbon copy of the larger obstetric card, which is the other alternative. It is suggested that with the co-operation of the local consultant and general-practitioner units the back of this card would be used for the hospital discharge summary thus reducing the amount of correspondence. This card would then serve the general practitioner as a complete record for payment purposes and as a reference for future pregnancies.

Paediatric card and paediatric reference card

There are some details of birth and of the newborn child which require to be recorded in an easily accessible part of the general practitioner's record. There are other procedures such as immunisations which are carried out in childhood which also require to be recorded. These facts can be recorded on the summary card, but as most of these facts are only of importance in the childhood period they are best recorded in structured form on a special paediatric card (figure 5). This card is designed to be completed in the most part by an attached health visitor and is partly a summary of her child health record. It has the additional advantage that it can

DRUG RECORD

SURNAME	FORENAME

PRESCRIBING PROBLEMS

Drug	*Contra-indications*

PRESCRIPTION RECORD

Date started	*Drug ref. no.*	*Drug*	*Strength*	*Instructions*	*Quantity*	*Date stopped*

Figure 2
Drug record.

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N. IRELAND FACULTY

OBSTETRIC CARD

NAME ..... DATE OF BIRTH ..... AGE .....

ADDRESS ..... N.H.S. NUMBER ..... DOCTOR .....

.....

.....

TELEPHONE NUMBER .....

BOOKED FOR .....

Previous pregnancies:

Previous illnesses or operations	*Family history*	
	Twins *Diabetes* *T.B.* *Hypert.* *Other*	

	Date of birth	*Health in pregnancy*	*Maturity*	*Delivery*	*Complications of labour and puerperium*	*Baby*		
						Sex	*Weight*	*AW/SB*
1								
2								
3								
4								
5								
6								
7								
8								

L.M.P. [ ] E.D.C. [ ] BLOOD GROUP [ ]

DATE OF QUICKENING ..... LAB. REF. NO. .....

HEIGHT ..... VVs ..... W.R. .....

Date	*Wt.*	*B.P.*	*Urine*		*Oed.*	*Wks.*	*Fundus*	*P.P.*	*FH*	*Observations*	*HB*	*Anti-bodies*	*See*
			A	*S*									

Figure 3
Obstetric record.

LABOUR RECORD

DATE OF BIRTH ..... PLACE .....

ANTENATAL TRANSFER FROM: DATE .....

DURATION FIRST STAGE .....

SECOND STAGE .....

THIRD STAGE .....

TOTAL _____

TYPE OF DELIVERY .....

.....

COMPLICATIONS .....

.....

BABY SEX ..... CONDITION .....

WT. ..... FEEDING .....

POST-NATAL TRANSFER FROM DATE

PUERPERIUM .....

.....

DATE OF DISCHARGE ..... Hb. .....

POST NATAL VISITS					

POST-NATAL EXAMINATION DATE .....

BREASTS .....

ABDOMEN .....

PERINEUM .....

CERVIX .....

UTERUS .....

SMEAR .....

FAMILY PLANNING ADVICE .....

CONCLUSION *re* FUTURE CONFINEMENTS .....

.....

Signature .....

Code..... *Date*.....

Figure 4
Obstetric record (continued.)

be used as a clinical record by the increasing number of doctors who are conducting well-baby clinics either in their own practices or in health authority clinics—a trend which should be encouraged by an efficient record system.

The paediatric reference card has printed on one side of it a Tanner growth chart and on the other side a space for serial skull measurements with associated normal values with a list of antenatal, natal and postnatal factors, which render a new born child at risk. It is thus a reference card which will only be required in the occasional case, but should be available in a complete general-practitioner record system.

ROYAL COLLEGE OF GENERAL PRACTITIONERS

CHILD HEALTH RECORD

N. IRELAND FACULTY

SURNAME	DATE OF BIRTH
OTHER NAME	BIRTH WEIGHT
ADDRESS 1.	MATURITY WEEKS
2.	
3.	PLACE OF BIRTH
FAMILY DOCTOR HEALTH VISITOR	AT RISK REASON:—
CONGENITAL ABNORMALITY	PHENYLKETONURIA TEST DATE

IMMUNISATIONS				INFECTIOUS DISEASES	
TRIPLE 1	.....	POLIO 1	.....	MEASLES	.....
TRIPLE 2	.....	POLIO 2	.....	MUMPS	.....
TRIPLE 3	.....	POLIO 3	.....	WHOOPING COUGH	.....
TRIPLE 4	.....	MEASLES	.....	CHICKENPOX	.....
TETANUS BOOSTER	.....	RUBELLA	.....	RUBELLA	.....
,, ,,	.....	SMALLPOX	.....		
,, ,,	.....	B.C.G.	.....		

MEDICAL EXAMINATIONS

SIX WEEKS	PHYSICAL
SIX MONTHS	PHYSICAL ..... DEVELOPMENTAL ..... HEARING
ONE YEAR	PHYSICAL ..... DEVELOPMENTAL ..... HEARING
EIGHTEEN MONTHS	PHYSICAL ..... DEVELOPMENTAL
TWO YEARS	PHYSICAL ..... DEVELOPMENTAL ..... VISION

Figure 5
Child health record.

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HEALTH VISITOR'S
GERIATRIC SCREENING CARD

SURNAME		DATE	No.
CHRISTIAN NAME		FAMILY DOCTOR	
ADDRESS		HEALTH VISITOR	
	.....	DATE OF BIRTH	

Please tick appropriate column (see attached explanatory notes):

A — GOOD
B — REASONABLE
C — UNSATISFACTORY

X — IF RECEIVING
Y — IF RECOMMENDED
Z — IF ARRANGED

	A	*B*	*C*			*X*	*Y*	*Z*
HOME i.e. (a) with family (b) with husband/wife (c) alone				1	Old people's club			
				2	Day centre			
				3	Handicraft class			
SOCIAL CONTACT				4	Library			
				5	Holidays			
				6	Voluntary group to visit			
MOBILITY				7	Walking aids			
				8	Hearing aids			
ABILITY TO COPE WITH HOUSE				9	Home help			
				10	Laundry			
HOUSING				11	Residential accommodation			
				12	Housing executive			
INCOME				13	Supplementary benefit			
DIET				14	Meals on wheels			
				15	Lunch club			
OTHER:—				16	Other:—			
				17				
				18				

Figure 6
Geriatric record.

Figure 6
Geriatric record (continued.)

	Result	*Tick if abnormal*		*Referral*	*X*	*Y*	*Z*
Vision			19	Optician			
Hearing			20	Audiology clinic			
Teeth			21	Dentist			
Feet			22	Chiropodist			
Weight			23	District nurse			
Blood pressure			24	Family doctor			
Urine			Notes:				
Blood count							
E.S.R.							
Urea							
Sugar							
Cholesterol							
Other:—							

FOLLOW-UP VISITS. Please enter the appropriate number in box provided (see explanatory notes).

Date	*Service received as a result of previous visit*					*Appointment or service still awaited*					*Follow-up in*

Geriatric card

There is also an increasing number of general practitioners interested in geriatric screening both socially and medically. The trend appears to be that this should be performed initially by the attached health visitor.[16-18] This may be best recorded on a separate geriatric screening card (figure 6). In a recent review of geriatric care in general practice Elliott and Stevenson stated " It is also of paramount importance in the organisation of comprehensive care for the elderly that a special record card be devised." This is essential if omissions in recording are to be avoided and will also enhance the element of continuity, especially when members of several disciplines are involved in total care. Furthermore, it should act as a check to ensure that appropriate action has been taken when required.[19] As experience in this field is limited and as individual interests must be catered for only guide lines can be given. The geriatric card as shown (figure 6) is one particular form which should provide a useful basis for those interested and could encourage further developments in this field.

Typing medical records

As stated, a clear record is now more essential than ever with the increase in group practices and the wider access to an individual's record. A typed record improves the clarity of a clinical record and is quite feasible. A small Phillips or Grundig tape recorder can be used to dictate a clinical summary on the departure of each patient and after home visits. It is said by those with experience, to be considerably less time-consuming than the written record. The amount of extra secretarial help required solely for this purpose varies with extent of the clinical notes dictated. On an average it is estimated that one experienced full-time medical audiotypist is required for every 4–5,000 patients.[20,21] The dictation and typing of the medical record appears to be the most practical and economical way of feeding clinical data to a computer as at Livingstone New Town, near Edinburgh and for this reason is of particular importance for the future.

The dictation of hospital referral letters with the retention of a copy in the record folder, as already used by many doctors, is a step in the right direction and surely within the scope of every general practitioner with a receptionist who can type.

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REFERENCES

1. Cormack, J. J. C. (1970). *Journal of the Royal College of General Practitioners*, **20**, 333–353.
2. Collings, J. S. (1950). *Lancet*, **1**, 555–585.
3. Kuenssberg, E. V. (1968). *British Medical Journal*, **2**, 420–423.
4. Dawes, K. S. (1972). *British Medical Journal*, **3**, 219–223.
5. Walford, P. A. (1955). *College of General Practitioners Research Newsletter*, N.S. 2, 53–57.
6. Kuenssberg, E. V. (1964). *Journal of College of General Practitioners*, **7**, 410–422.
7. Watson, G. I. (1967). *Journal of the Yorkshire Faculty of the Royal College of General Practitioners*, Jan., 8–37.
8. Williams, D. L. (1967). *Journal of the Royal College of General Practitioners*, **14**, 249–261.
9. Jameson, M. J. (1968). *Journal of the Royal College of General Practitioners*, **16**, 135–143.
10. Department of Health and Social Security. Circular to Executive Councils 20.333.
11. Hawkey, J. K., Loudon, I. S. L., Greenhalgh, G. P. & Bungay, G. T. (1971). *British Medical Journal*, **4**, 667–670.
12. Hodgkin, K. (1963). *Towards earlier diagnosis*. Edinburgh and London: E. & S. Livingstone.
13. Weed, L. L. (1968). *New England Journal of Medicine*, **278**, 593–600.
14. Weed, L. L. (1969). *Medical Records, Medical Education and Patient Care.*: Press of Case Western Reserve University, Cleveland, Ohio.
15. Tait, I. & Stevens, J. (1973). *Journal of the Royal College of General Practitioners*, **23**, 311–315.
16. Williamson, J. (1967). *Gerontologica Clinica*, **9**, 236–244.
17. Lowther, C. P., MacLeod, R. D. M. & Williamson, J. (1970). *British Medical Journal*, **3**, 275–277.
18. Hodes, C. (1971). *Journal of the Royal College of General Practitioners*, **21**, 469–472.
19. Elliott, A. E. & Stevenson, J. S. K. (1973). *Journal of the Royal College of General Practitioners*, **23**, 615–625.
20. Irvine, D. H. (1973). Personal Communication.
21. Lefever, J. R. (1973). Personal Communication.