Guidelines for medical records in general practitioner hospitals

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Introduction

IN June 1981 the Association of General Practitioner Hospitals adopted a set of guidelines on medical records. I drafted the guidelines on behalf of the Association, basing them on the findings of two surveys I carried out in 25 general practitioner hospitals in the South Western Region, and on the experience of the Canadian Council on Hospital Accreditation. The guidelines are presented here for local consideration.

Purpose of the record

Every person attending the hospital, whether as an inpatient, outpatient or casualty, should have an individual and adequate clinical record. The purposes of this record are:

1. As a basis for planning and for continuity of care.
2. For communication among doctors and other professional staff contributing to the patient's care.
3. As documentary evidence of the course and management of each hospital stay.
4. As a basis of evaluation of clinical care.
5. As data for research and education.
6. To assist in legal interests of patient, hospital, doctors and professional staff.

Content

General

Identification: patient's name (on every page), hospital number, date of birth, address, next of kin and name of doctor.

Admitting diagnosis: may be provisional.

History: chief complaint, relevant direct questions, and past social and family history.

Physical examination: if complete history and examination were done soon before admission or transfer, a copy should be included in the hospital record.

Consent form: specific, informed consent should be signed by the patient or appropriate relative for any procedure involving a general anaesthetic or when there is risk of significant pain or injury.

Diagnostic and therapeutic orders: verbal orders should be avoided or used in accordance with hospital policy, and should subsequently be countersigned by the responsible doctor.

Observations: progress notes (by medical and other professional staff) and consultation reports should be written as events occur. They should provide a relevant chronological account of the patient's course and justify clinical decisions.

Reports of actions and findings: all diagnostic and therapeutic procedures and their results should be recorded.

Operative reports: should be written by the surgeon immediately after surgery and include pre-operative diagnosis, a description of findings, technique used, tissue removed or altered and post-operative diagnosis.

Anaesthetic records: should state medications given, including intravenous fluids, anaesthetic agents used and the patient's condition before, during and after anaesthesia.

Conclusions: prior to discharge, the admitting (provisional) diagnosis and all relevant final diagnoses should be recorded by the doctor, using standard nomenclature. An easily identifiable discharge summary should include continuing medications and arrangements for follow-up.

Continuity: many patients in general practitioner hospitals are admitted more than once. In these cases it is not necessary to record full basic data at each admission; there should be a means of maintaining simple continuity of a record to provide a chronological account of events over months or years which may embrace multiple admissions and discharges.

Casualty

Identification

Arrival time and method of arrival

History: including care given prior to arrival at hospital.

Examination: clinical, laboratory and radiological; continuing assessments by doctor and nurses.

Diagnosis and treatment

Final disposition: condition on discharge/admission/transfer; instructions for follow-up.

In addition to individual casualty records, there should be a casualty register containing at least: name, date and time of arrival, address and date of birth, by whom seen and disposal.

It is desirable that the casualty record is incorporated with any existing inpatient record and that a copy is provided to the patient's doctor.

Characteristics of acceptable records

A patient's record should be confidential, accurate, complete and readily available.

Security

It is the responsibility of the hospital to safeguard the information in the record against loss, damage or use by unauthorized persons. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive it. Records should not be removed from the hospital's jurisdiction and safekeeping.

Completion

The medical staff committee should define individual and corporate responsibility for medical records. Guidelines may be adopted such as:

1. That initial history and examination should be recorded within 24 hours of admission.

2. That, except in emergency, they should be recorded prior to any surgical procedure.

3. That operative and procedural reports should be recorded as soon as possible after completion.

4. That all medical records should be complete and ready for filing within 14 days after discharge.

Clarity

All entries should be signed, be legible and should avoid confusing abbreviations.

Retention

Medical records should be kept for at least eight years (DHSS Circular HC(80)7), and preferably microfilmed before disposal.

Retrieval

Each hospital should have a workable system for identifying and filing records such that they can be retrieved whenever a patient receives subsequent care (including at night).

A system should also be maintained for indexing statistical and clinical information, such as operations and diagnostic groups, to enable medical staff to review and evaluate medical care.

Review

It should be a recognized responsibility of the medical staff to review regularly the quality of medical records within the hospital, in conjunction with others (such as nursing staff) who contribute substantially to the records.

Organization, staffing and facilities

There should be staff, responsible to a trained records officer, to develop, analyse and maintain medical records. If a trained records officer is not based locally, the hospital should arrange for regular consultation and visits from a qualified person.

Records personnel should attend a hospital induction course, and receive on-the-job training and continuing in-service education.

The records department should have sufficient conveniently located space and should be adequately equipped so that clinical records are well filed and easily retrieved.

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Words our patients use

'Bachle'—untidy, wretched person (Glasgow).
"Shilpit wee creature"—undernourished, unprivileged small person (Glasgow).
'Bonny'—fat (South Yorkshire).
"He's a big girl's blouse"—he is effeminate (South Yorkshire).
'Puddings'—bowels; for instance "me puddings gave a sideways jerk"—a hernia has appeared (North-east England).
'Moderate'—not very well (North-east England).
'Dead-felled'—very ill, moribund or nearly so (North-east England). (It has been said that Sir James Spence, in recalling the history in a clinical lecture, would say "Mother, was your child dead-felled?")