Format and content of medical record summaries in 27 training practices

PAUL PRESLEY, BSc, MRCGP
General Practitioner, Gloucester and Course Organizer, Gloucestershire Vocational Training Scheme

SUMMARY. Twenty seven established trainers enrolled on an advanced course for trainers were sent a set of medical records with the instruction to summarize them as they would any set of records going into their practice. The main finding of the study was the great variability of the summaries produced, often owing to the failure to include important information from the continuation cards. The need for nationally recognized standards in summary making is discussed.

Introduction

THE Joint Committee on Postgraduate Training for General Practice (JCPTGP) provides broad guidelines to the regional authorities on the criteria for approval and re-approval of trainers for vocational training under the auspices of the 1981 Vocational Training Act. The regional general practice educational committees then interpret the JCPTGP guidelines and set out the criteria for each region. The criterion which requires patients' notes to be summarized in training practices is mandatory, not advisory. The South West Regional General Practice Education Committee has suggested that training practices should have summarized their records at the rate of one-third by January 1988, two-thirds by January 1989 and completion by January 1990.

The aim of the study was to assess the format, quantity and quality of information which trainers in the South West Region were summarizing from their records.

Method

In February and March 1987, 27 established trainers from the South West Region who were about to attend an established trainers' course, were sent a copy of a set of patient's records. An actual record was used with an altered name and National Health Service number, but certain fictitious incidents were added to the continuation cards. The patient's consent was obtained to use the records in this way. The continuation cards, hospital records and reports were coded so they could be identified at a later date. The records were sent to the regional adviser's office to be distributed to the trainers attending the course. The identities of the trainers were unknown to the author at the time of distribution and analysis.

Instructions were given to treat them in exactly the same way as any other set of records going into the practice, for example to place them in the midst of a pile of routine records, and to prepare a summary card. Papers which were discarded from the notes were to be returned with the records for analysis.

The format of the summaries, including which papers were discarded, was recorded. The content of the summaries was analysed with reference to guidelines from the South West Regional General Practice Educational Committee distributed to trainers throughout the region in April 1987.

© *Journal of the Royal College of General Practitioners,* 1988, **38,** 26-27.

After the data had been analysed, a workshop was held for the trainers at which they discussed the compiling of record summaries, including how the summarizing was organized in their practice.

Results

All 27 sets of notes were returned; four were found to be in A4 format and three of these were tidier and easier to use than traditional FP5/6 wallets. The hospital number of the patient was found on four sets of notes. Many sets had been tagged with a variety of stickers, the meaning of which was not clear, and some sets had additional comments, for example *A/S which presumably meant an age–sex card had been produced. Other codes referred to personal diagnostic indexes and computer abbreviations and were likewise not familiar to the author.

Format of summaries

Some summary cards were typed and lengthy, while some were short 'one-liners'. One doctor had produced a large four-page computer print-out which was not considered a summary, as it was too lengthy; this was excluded from further analyses of summaries.

There was some consensus regarding the colour of the summary cards in that 19 doctors chose a pink card. Three doctors, however, chose blue, one white, one green, one yellow and one used the back of the immunization card.

The years from which the summaries started varied greatly between the doctors: two summaries started from 1964, four from 1966, nine from 1967, one from 1968, three from 1973, two from 1974 and five from 1979.

Handling of records

None of the doctors had discarded any of the six continuation cards. The number of doctors discarding the investigation sheets A–F (some of which were repeats) and the sheets G–N which were letters from the hospital and other sources are shown on Table 1. Eleven doctors had discarded one or more of the investigation sheets and most had not recorded all the information on the summary card. The majority of doctors had discarded the letters related to a grazed elbow incident when the patient was seen in casualty in 1971, and a letter which was an acknowledgement of receipt of a previous correspondence. In most cases the contents of these three letters were not recorded on the summary card. Nine doctors had discarded one or more of the other five letters. In addition, a sheet summarizing investigations was found in four sets of notes.

No information was discarded from two sets of notes. One doctor had discarded all the documents A–N from the records to be stored in his general practice basement, in line with Medical Defence Union advice he had received.

Tagging of the continuation cards was done in a variety of ways. Two of the trainers left the current continuation card untagged from the main bulk of continuation cards and the remaining 25 had continuation cards fastened together. The majority placed the most recent continuation card at the front (some doctors provided a new blank continuation card). Seven doctors chose to tag the hospital notes and investigation reports

Table 1. Information discarded by the doctors.

Sheet	Number of doctors discarding
Investigations	
A Second biopsy sebaceous cyst; normal	2
B Chest X-ray; normal	0
C Sputum TB test; negative	2
D Sputum TB test; negative	6
E Sputum TB test; negative	5
F Chest X-ray; opacity in right upper lobe	1
Letters	
G Note X-ray suggests TB investigations	4
H Consultant's 2nd opinion; duodenitis post-endoscopy	4
I Consultant's 3rd opinion; duodenitis post-treatment	0
J Initial consultant opinion; duodenal disease	1
K Skin laceration A and E department	16
L Grazed elbow A and E department	13
M Acknowledgement of report received (school MO)	17
N ENT opinion (childhood); no significant diagnosis	8

admixed in chronological order and the rest tagged the reports and hospital letters in separate piles. One doctor had not tagged the hospital notes and investigations at all.

Content of information summarized

The content analysis of the summaries, based on the eight categories in the guidelines to trainers, is shown on Table 2. The only categories for which all doctors (except the one who did not compile a summary) recorded information were 'threats to life' and 'major chronic disease' — in both cases recording the patient's history of upper gastrointestinal disease. Two-thirds of the doctors recorded that the patient smoked but only half recorded other lifestyle factors and few summarized preventive care factors, risk factors or the patient's drug allergy.

This patient had had upper lobe pneumonia and was investigated for tuberculosis, the tests being found negative. In many cases this information had been misread and reported in the summary as 'TB', 'AFB negative' or 'suspected TB'. Likewise duodenitis proven endoscopically was variously reported as 'duodenal ulcer', 'high basal acids', 'operation' or 'diverticulitis' (this last owing to bad handwriting on the continuation card).

Table 2. Content analysis of the summaries.

Categories in trainers' guidelines	Items in index set of records	Number of doctors recording[a]
Threats to life of patient	Upper GI disease	26
Aiding colleagues on referral	Pneumonia	22
Major chronic disease	Upper GI disease	26
Lifestyle	Smoking	18
	Alcohol	13
	Divorce	14
Preventive care	Tetanus status	7
	Blood pressure record	10
Clinical pattern of disease	Not applicable	—
Risk factors	Father's myocardial infarct	12
	Family history of glaucoma	8
Drugs	Flucloxacillin allergy	5

GI = gastrointestinal tract. [a] One doctor did not produce a summary.

Compiling record summaries

Four of the trainers compiled all the summaries themselves. The other 23 were divided between using a state registered nurse or a records clerk who was trained by the doctor to follow a proforma. Quality control was ensured by the doctor checking a random sample of one in 10 records to ensure that the summary had been correctly compiled. All records clerks were reminded of the importance of confidentiality.

Discussion

The 100% return of the index notes showed that trainers were willing to participate in discussion about record summaries. The main impressions from the exercise were the great variability of information recorded in the summary and the poor quality of a large number of summaries owing to information on the general practitioners' continuation cards not being recorded. Some summaries were clearer to read than others, partly because of good handwriting or typing but also because they were neatly laid out, and some appeared good but were in fact very incomplete. In other cases most of the salient points had been extracted from the records but this information had been redistributed in a variety of locations, for example, on the summary card, on the wallet, on an investigations card or a preventive medicine card, or on the back of the immunization card.

Most general practitioners employed ancillary staff to produce medical records summaries with the staff following written instructions and the doctor making spot checks of records. The consensus of opinion among the 27 established trainers was that the financial aspects of producing medical records summaries should not be overlooked, as this sum was considerable and was not fully reimbursed by family practitioner committees. There seems to be little or no advantage, in terms of quality or finance, in employing a qualified nurse as an alternative to a records clerk.

During analyses of the notes, it often took more than five minutes to sort out the patient's history and this would also apply to trainees seeing notes for the first time or a team looking at records on a training approval inspection. This raises questions about the function of summaries we make for trainees and how the quality of the summary can be determined at practice inspections.

It is unfortunate that the JCPTGP produced a requirement for summary cards in training practices without qualifying a method of assessing the quality of those summaries, as many practices have now summarized their records. This study highlights the need for clearer guidelines when future criteria for trainers are being considered. It would be timely to suggest that quality criteria should be applied to those records which are summarized from now on, and from the author's limited experiences with this study it seems it would take relatively little time to upgrade many sets of notes, particularly with preventive medicine information, to produce reasonable summaries.

References

1. Presley AP, Till AM. How one practice radically revised its notes system. *Modern Medicine* 1983; 60-61.
2. Joint Committee on Postgraduate Training for General Practice. *Recommendations to region for the establishment of criteria for the approval and re-approval of trainers in general practice.* London: JCPTGP, 1985.

Acknowledgements

Thanks to Dr Roddy Hughes for reading the first draft of the paper and helping with allocation of the records via the Postgraduate Department of General Practice at Bristol University.

Address for correspondence

Dr A.P. Presley, Glevum Way Surgery, Abbeydale, Gloucester GL4 9BL.