Royal College of Physicians | Health Informatics Unit

Information on the quality of medical note keeping to support appraisal and revalidation

A report for the Academy of Medical Royal Colleges: April 2011

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ACADEMY OF MEDICAL ROYAL COLLEGES

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Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE

www.rcplondon.ac.uk

Registered Charity No 210508

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1 Executive summary

1.1 Background

Good quality medical record keeping is fundamental to efficient and high-quality patient care.

During 2009, the NHS spent £798 million on settling complaints and litigation cases. Such cases are often settled out of court because they cannot be defended, owing to substandard medical notes.

In April 2008, the Royal College of Physicians (RCP) developed evidence-based standards for medical records, and for the structure and content of admission, handover and discharge documents – in order to form the basis for national standardisation of patient records.[1]

1.2 Aims and objectives

The aim: to determine the extent to which evidence on generic matters relating to medical record-keeping can be used in support of appraisal and revalidation, and how that evidence may be used.

The objectives:

1. to identify what doctors view as their responsibilities regarding good clinical practice in relation to medical notes
2. to determine doctors' views on the use of medical notes information at appraisal
3. to produce guidance for the use of information on the quality of medical record-keeping at appraisal and revalidation.

The guidance produced does not address specialty-specific matters which are covered by the relevant professional organisations.[2] Examples of specialty-specific standards include *Good psychiatric practice* (Royal College of Psychiatrists),[3] *Good surgical practice* (Royal College of Surgeons of England),[4] and *Good practice: a guide for departments of anaesthesia, critical care and pain management* (Royal College of Anaesthetists).[5]

1.3 Method

Links were established between the Royal College of Physicians' Health Informatics Unit (HIU) and the revalidation clinical leads and project managers of all the medical royal colleges and specialist societies. These links facilitated a series of consultations to inform the guidance, including: email consultations throughout the process; the running of representative workshops; the convening of a steering group meeting; and consultation via an online questionnaire.

The final guidance has been approved by 42 of the 44 royal colleges and specialist societies that confirmed interest in this project (see Appendices 1 and 2), and has been submitted to the Academy of Medical Royal Colleges.[2]

1.4 Results

Five lay people and 610 hospital consultants responded to the web-hosted consultation questionnaire. The consultants came from 17 specialist backgrounds with a variety of working patterns (eg those who: work with clinical teams; see inpatients and outpatients; see only outpatients; primarily advise or provide reports on patients who are not under their own care, etc).

The ways in which information on medical note keeping is used in appraisal will vary according to consultants' differing working patterns. Also, the way that junior doctors work within and across consultants and clinical teams is changing. There are particular difficulties with locums and where juniors work for short periods within clinical teams on a shift basis. In these situations, there may be little contact between the responsible consultant and the junior doctor.

Analysis of the quantitative and qualitative data resulting from the consultation questionnaire showed majority agreement with the following views:

Responsibilities regarding good clinical practice in relation to medical notes

- What individuals write in clinical notes is their own explicit responsibility.
- Medical notes are an important component of clinical care and consultants have a responsibility to ensure that what they write in the medical notes is clear, accurate and legible.
- Consultants have a responsibility for the entries made by their clinical team (eg junior medical staff) under their supervision in notes of both (1) the patients under their care and (2) the patients under the care of another consultant. There may be external constraints on the extent to which consultants are able to meet this responsibility (eg locums and some forms of shift working).
- What other clinicians write in the notes of a patient under a consultant's care is not part of the consultant's responsibility, as those clinicians all have a responsibility to ensure that what they write is clear, accurate and legible.
- Other individuals should be informed if their note entries are illegible, irrespective of the extent to which consultants feel that what is written is part of their responsibilities.

Views on the use of medical notes information at appraisal

- Information on the quality of medical note-keeping can be used as supporting information at appraisal.
- Information from a medical notes audit should be included only as one option amongst many at appraisal.
- Information from audits can be included: with audits conducted by consultants themselves; by members of their clinical team (including junior medical staff); or by trust clinical audit staff who are deemed acceptable.
- Information from an audit of medical note keeping could be included in appraisal at least once every five years.

- The quality of record medical note keeping is an appropriate item for 360° feedback (multisource feedback (MSF)), though this would be unlikely to be information from an audit.

1.5 Discussion

Despite the fact that clinical teams (including junior medical staff) and patterns of working are changing, and lines of responsibility are far less clear than they once were, consultants are clear about the importance of medical notes and their own responsibility for what they write. There is an unambiguous message that responsibility for what others write is not theirs, but the great majority would do something if the entries of others were found wanting.

In addition, the majority view (54% for, versus 14% against) is that information from medical notes could be brought as part of the supporting evidence at appraisal, and that information from notes audits is acceptable evidence.

Notes audits can be conducted using the Royal College of Physicians' *Generic medical record standards audit tool* (http://www.rcplondon.ac.uk/resources/clinical-resources/standards-medical-record-keeping/audit-tool-generic-standards/).

2 Background

Medical records are a fundamentally important component of medical care, and are frequently reported to be substandard. Poor quality records contribute to inefficient and delayed care, increased risk to patients, and clinical incidents. Inadequate medical record keeping is a recurrent component of fitness to practise cases heard by the General Medical Council (GMC). During 2009, the NHS spent £798 million on settling complaints and litigation. Litigation cases are frequently settled out of court as they cannot be defended as a result of inadequate medical notes.

The GMC's *Good medical practice appraisal framework* states that the doctor should adequately assess a patient's condition, and investigate and treat accordingly (attribute 2) and that doctors should ensure that all documentation (including medical records) formally recording work is clear, accurate and legible (attribute 3).[6] Attribute 8 requires consultants to provide effective leadership, including supervision of a clinical team (including eg junior medical staff), teaching and training, appraising and assessing, and ensuring that staff perform to acceptable standards of practice. These are high-level statements, and in practice are interpreted in relation to best professional practice in those areas. In relation to medical notes, for example, it would be in relation to the Academy of Medical Royal College's record-keeping standards. Assessing a patient's condition thus implies taking a good history that includes a patient's concerns, expectations and wishes; and in relation to teaching, appraising and assessing junior staff on their note keeping.

Medical records have been identified by the majority of medical royal colleges as a source of information that can be used by clinicians in support of appraisal and revalidation. The focus of attention has been on the content of the medical notes that could be used to demonstrate quality of care and compliance with specialty-specific standards. There has not been attention to the quality of medical record keeping in general.

In April 2008, the Academy of Medical Royal Colleges approved consensus- and evidence-based standards for medical records and for the structure and content of admission, handover and discharge documents. These standards were developed in a project led by the Royal College of Physicians and funded by Connecting for Health (April 2008), and provide a basis for national standardisation of patient records from a clinical perspective.[1]

The combination of the establishment of national standards for inpatient records and the introduction of revalidation provides an opportunity for the medical profession to make a significant impact in an area that is highly relevant to good medical practice, but has so far been regarded as difficult to resolve.

The aim of this project is to determine the extent to which evidence on generic matters relating to medical record keeping can be used in support of appraisal and revalidation, and how that evidence may be used. It does not address specialty-specific matters in relation to notes. These are covered by the relevant specialty professional organisation, for example the Royal College of Psychiatrists' standards for *Good psychiatric practice,*[3] the Royal College of Surgeons of England's standards for what constitutes an adequate record of operative performance in *Good surgical practice*,[4] and the Royal College of Anaesthetists' best practice requirements for anaesthetic records.[5]

3 Objectives

The objectives of the project were to:

1 Identify what doctors view as their responsibilities regarding good clinical practice in relation to medical record keeping, ie to determine the boundaries of their responsibility for what is in the medical notes. Only once those boundaries are clear will it be possible to state what could reasonably be considered a measure of performance, relevant for revalidation.

2 Determine doctors' views on the use of medical notes information at appraisal.

3 Produce guidance for the use of information on the quality of medical record keeping at appraisal and revalidation.

4 Method

The steps adopted for delivery of this project are summarised below.

1 Links were established with revalidation clinical leads and project managers using information provided by the Academy of Medical Royal Colleges. The Royal College of General Practitioners was not included in this project, as the current record keeping standards apply to hospital records.

2 A steering committee was established.

3 Initial views of revalidation leads and managers were gathered by email consultation.

4 Two representative workshops were run. The workshops reviewed the responses to the email questions, explored the principles to underpin guidance for use of evidence from medical notes, and recommended how best to conduct an email questionnaire (or alternative) consultation to gain wider professional consensus.

5 The first steering group meeting was held. Meeting attendees agreed that an email with a web link to the consultation questionnaire would be sent to the revalidation leads identified by the Academy, who would distribute the email to consultants in the specialties they represented. It was agreed that subsequent meetings would take the form of email consultations.

6 A consultation questionnaire was drafted to gather views on the topics identified in the workshops, and it was emailed to workshop and steering committee members. An interim report, summarising feedback from the draft questionnaire and discussions at the workshops and steering committee, was distributed to all nominated revalidation leads and attendees of the workshops and steering group meeting.

7 An online questionnaire was produced and revised, which included the opportunity to comment on each question. A link was sent to the steering group, prior to emailing to all the revalidation leads for wider distribution to their specialty colleagues. Emails with links to the online questionnaire were also sent to members of the Health Informatics Unit register, and to patient and carer representatives of the RCP Patient Involvement Unit.

8 The guidance was drafted. The questionnaire results were analysed using SPSS (statistical analysis software) and NVivo (qualitative analysis software), and a draft project report and guidance were produced.

9 The draft report and guidance were emailed to revalidation leads of the royal colleges and specialist societies for review (Appendix 1).

10 The draft report and guidance were amended based on feedback.

11 The final report and guidance[2] were sent to the presidents and chairs of the royal colleges and specialist societies for signing off (Appendix 2).

12 There are groups of doctors whose practice is such that generally work outside hospital practice – 'Orphan Groups'. Orphan groups were reviewed and the consensus decision was that they do not have special requirements in relation record keeping that are

separate from the wider issues of revalidation for which they require particular attention.

5 Results

The Academy of Medical Royal Colleges provided a list of 20 contacts in the other medical royal colleges. The contacts provided the details of 107 individuals, representing 51 royal colleges and specialist societies (Appendix 1). Seven of these professional organisations either did not respond (four organisations) or reported that the project was not relevant to their specialist area (three organisations).

Twenty-six organisations provided comments to the initial email questionnaire (Appendix 3). Key points arising from these comments were incorporated into the discussion at the workshops and steering group. Eighteen people from 15 professional organisations attended one or other of the workshops, with 14 people taking part in the steering group meeting. Twelve people provided comments on the interim draft questionnaire, and a further five provided feedback on the online questionnaire pilot.

The email with the link to the final questionnaire (Box 1) was sent to 105 revalidation leads and clinicians for wider distribution to their specialty colleagues, to 114 members of the HIU register, and to the RCP Patient Involvement Unit, who distributed it to their members (Appendix 4).

Box 1 Questions in the final consultation questionnaire

1. What is your main specialty?

2. Do you agree that medical notes are an important component of good quality medical care?*

3. Different specialties work in different ways, the concept of a clinical team is changing, and the way doctors' work is changing with the increasing introduction of shift working. Please choose the option(s) that are applicable to you:
- I have inpatients under my care as the responsible consultant
- I work with a clinical team of junior doctors
- I have inpatients who are under the care of a team (they are not just my patients)
- I see inpatients who are not under my direct care
- I see only outpatients (with few exceptions)

4. Medical notes folders are often disorganised, the larger they are, the more disorganised they can become. Do you as a doctor have some responsibility for doing something about it?
- No, it is the responsibility of trust Management
- Yes, as a doctor, I should inform trust Management
- There is no point in doing anything, they never get better

5. Do you agree that you have a responsibility to ensure that what you write in the medical notes is clear, accurate and legible?*

6. Do you agree that you have a responsibility for the clarity, accuracy and legibility of notes written about patients under your care by YOUR TEAM? *

7. Do you agree that you have a responsibility for the clarity, accuracy and legibility of notes written by YOUR TEAM ABOUT PATIENTS UNDER THE CARE OF ANOTHER CONSULTANT?*

8. Do you agree that you have a responsibility for the clarity, accuracy and legibility of what OTHER CLINICIANS write in the notes of YOUR PATIENTS?*

continued

Box 1 Questions in the final consultation questionnaire *continued*

9. If what is written in the medical notes of a patient under your care by a doctor who is NOT a member of your clinical team is not accurate, clear and legible, what would you do?

- Let them know
- Let their manager know
- Let trust management know
- Do nothing because it is not your responsibility

10. If what is written in the medical notes of a patient under your care by a person from a different clinical discipline (eg physio, nurse, OT) is not accurate, clear and legible, what would you do? (you may choose more than one response)

- Let them know
- Let their manager know
- Let trust management know
- Do nothing because it is not your responsibility

11. Do you agree you should be able to use supporting information from medical notes in appraisal?*

12. Do you agree you should be able to use information from audits of medical notes of patients who have been under your care as supporting information in appraisal for revalidation?

- Audits you have conducted yourself
- Audits conducted by members of your clinical team
- Audits conducted by the trust clinical audit department
- Information from audits should not be used as supporting information
- Not Applicable

13. How should information from audit of medical notes of patients whom you have treated or cared for be used as supporting information at appraisal?

- At least one medical notes audit (undertaken by anyone) in a five-year cycle
- Information from medical notes audits (undertaken by anyone) should be only one of several options
- Information from medical notes audits should only be required if it has been suggested there is a problem with medical notes of my patients
- Information from medical notes audits should not be used in appraisal

14. What other options for using information from medical notes would be relevant as supporting information for appraisal?

- A selection of notes of your patients chosen at random (by someone else) could be brought as supporting evidence to an appraisal
- A selection of your medical note entries (selected by someone else) could be brought as supporting evidence to an appraisal
- Quality of record keeping should be a specific question in 360 degree feedback
- Information about record keeping is not relevant at appraisal

* Responses were recorded on a 5-point scale ranging from Strongly Agree to Strongly Disagree

5.1 Questionnaire findings

A total of 610 hospital consultants (44 from the HIU register) and five lay people responded to the questionnaire. There were 1,496 written comments. Some specialties had a significantly greater number of respondents than others, with many from anaesthetics (144 – 24%), palliative care (110 – 18%) and emergency medicine (73 – 12%) (Table 1). We looked for but did not find any significant difference between these specialties' responses and those of other specialties. We therefore report the findings for the whole population.

Table 1 Clinical specialty of respondents

Main specialty	Number	%
non-specified clinician	11	1.8
allergy	11	1.8
anaesthetics	144	23.6
ear, nose and throat	35	5.7
emergency medicine	73	12.0
geriatric medicine	32	5.2
intensive care medicine	11	1.8
medical specialties	37	6.1
obstetrics & gynaecology	3	0.5
primarily outpatient medicine	53	8.7
paediatrics	6	1.0
palliative care medicine	110	18.0
pathology services	9	1.5
psychiatry	4	0.7
rehabilitation medicine	1	0.2
surgery – paediatric	36	5.9
surgical specialties	3	0.5
trauma & orthopaedics	31	5.1
Total	**610**	**100**

A variety of patterns of working were represented, ranging from those who have patients under their direct care as the responsible consultant (297 – 49%), those who see only inpatients under the care of other consultants (81 – 13%), and those who see only outpatients (107 – 13%). Of the respondents, 352 (58%) work with a team (including junior medical staff) of junior doctors, 218

(36%) work in a clinical team (including junior medical staff), of whom 90 do not have patients under their direct care.

There was near unanimous agreement that medical notes are an important component of clinical care (97%) and that consultants have a responsibility to ensure that what they write in the medical notes is clear, accurate and legible (98%) (Table 2, questions 2 and 5). Several people commented that good quality notes do not necessarily equate with good medical care, and there were also a number of comments about the availability of notes and the quality of the information recorded.

A majority agreed that they had a responsibility for the entries of the junior doctors under their supervision, made in notes of patients under their care (79%) and in the notes of patients under the care of another consultant (71%) (Table 2, questions 6 and 7). A number of people stated that they found this difficult when junior doctors write in notes, for example, on a busy ward round, and in particular when this was in the notes of other patients whose notes they would never see.

Table 2 Responses to questions on responsibility for what is written in the medical notes

Question/topic	Strongly agree (%)	Agree (%)	Neither agree nor disagree (%)	Disagree (%)	Strongly disagree (%)
Do you agree that medical notes are an important component of good quality medical care? (question 2)	66.6	30.7	1.3	0.8	0.3
Do you agree that you have a responsibility to ensure that what you write in the medical notes is clear, accurate and legible? (question 5)	76.7	21.5	0.8	0.0	0.5
Do you agree that you have a responsibility for the clarity, accuracy and legibility of notes written about patients under your care by your team? (question 6)	33.0	45.9	9.0	4.9	1.8
Do you agree that you have a responsibility for the clarity, accuracy and legibility of notes written by your team about patients under the care of another consultant? (question 7)	27.5	43.8	11.6	7.4	3.0
Do you agree that you have a responsibility for the clarity, accuracy and legibility of what other clinicians write in the notes of your patients? (question 8)	8.0	18.0	22.0	34.1	14.1
Do you agree you should be able to use supporting information from medical notes in appraisal? (question 11)	13.0	41.0	30.5	10.2	3.6

When responding to questions about what other clinicians write in the notes of patients under their care, only 26% agreed that this was part of their overall responsibility for the care of their patients (Table 2, question 8). As many as 48% felt that this was not part of their responsibility, as all

clinicians have their own responsibility to ensure that what they write is clear, accurate and legible (Table 2, question 8). However, when asked what they would do if note entries were not legible, only 8% said that they would do nothing. Over 80% of all respondents said that they would let the individual know, irrespective of the extent to which they felt what was written was part of their responsibilities (Table 3, questions 9 and 10). One in five would inform the individual's manager (or consultant in the case of a doctor) if a problem persisted. A number of respondents stated that this can be an awkward subject to raise with another person, especially if that person is another consultant.

Table 3 If what is written in the medical notes of a patient under your care by a clinician who is not part of your team is not accurate clear and legible, what would you do?

	Let them know (%)	Let their manager know (%)	Let trust management know (%)	Do nothing, not my responsibility (%)
A doctor (question 9)	87.9	16.7	1.5	7.0
Person from a different clinical discipline (question 10)	83.8	23.1	1.6	8.5

Of the respondents, 54% agreed that information from medical notes could be used as supporting information at appraisal, with 30% neither agreeing nor disagreeing (Table 2, question 11). The range of reasons given by those who disagreed were echoed among those who did agree with the proposal. A frequently made comment throughout was that the quality of the medical notes did not necessarily reflect the quality and outcome of clinical care, which was regarded as being more relevant. Concerns expressed included that this could be time-consuming, in what was already perceived as a time-consuming and complex process (revalidation appraisal); that it could be used to target unpopular colleagues; or it could become very trite and appear to be the equivalent of a handwriting test. Four people thought there may be issues of confidentiality requiring patient consent.

Nearly two-thirds said that it should be included only as one option among many at appraisal, with just under 10% saying that notes audit is not appropriate for revalidation appraisals (Question 13). One-third of respondents said that there should be information from at least one medical notes audit in a five-year appraisal cycle, 15% that an audit should only be included if indicated for some reason.

A majority agreed that information from audits could be included, with no particular preference for who conducted the audits. Around two-thirds of all respondents said that audits conducted by themselves, by members of their clinical team (including junior medical staff) or by trust clinical audit staff would be acceptable. There was no overall preference for method of selection of notes for audit; 63% said that quality of record medical note keeping would be an appropriate item for 360^{o} feedback, though this would be unlikely to be information from an audit. A number of respondents stated that an audit could be requested where there are concerns about record keeping reported in 360^{o} feedback (Table 4, questions 12 and 14).

Table 4 Views on information from audits of medical notes

	Responses	%
How information from an audit of medical notes of patients treated or cared for can be used as supporting information at appraisal (Question 13)	At least one medical notes audit (undertaken by anyone) in a five-year cycle	33
	Information from medical notes audits (undertaken by anyone) should be only one of several options	63
	Information from medical notes audits should only be required if it has been suggested there is a problem with medical notes of my patients	15
	Information from medical notes audits should not be used in appraisal	9
Other options for using information from medical notes relevant as supporting information for appraisal (Question 14)	A selection of notes of your patients chosen at random (by someone else) could be brought as supporting evidence to an appraisal	44
	A selection of your medical note entries (selected by someone else) could be brought as supporting evidence to an appraisal	42
	Quality of record keeping should be a specific question in 360 degree feedback	63
	Information about record keeping is not relevant at appraisal	8

5.2 Selected representative comments made by respondents

The overall agreement (97% of clinicians) that medical notes are an important component of providing good medical care was further reinforced through the clinicians' comments. These highlighted the importance of accurately communicating patients' medical history, and providing good quality continuity of care. Clinicians also expressed frustration and concerns at the lack of control they were able to exert over the organisation of notes.

''*Disorganised medical notes are a major problem for which all doctors take some responsibility, though they cannot individually be held to account for failure of NHS management. The move to electronic notes is seen as the solution, but appears some way off*''

''*There is also no real ownership of the notes as a whole*''

''*Personally filed loose notes, rectified ERRONEOUS filings of results, also alarmed the Governance Team – MORE IMPORTANTLY patients are dying because when they are admitted they can have five different hospital numbers and the attending doctor fails to know the underlying illness for which the patient attends the OPC*''

When commenting on who has responsibility for the clarity, accuracy and legibility of medical notes, clinicians agreed that what they write themselves is their responsibility (99%). There was also agreement that they have responsibility for what junior doctors under their supervision write (79%). This includes what the junior doctors under their supervision write in the notes of patients under the care of another doctor (72% of respondents agreed). Where clinicians expressed concerns, these were in relation to the fact that medical notes are completed by a variety of team members shared within and between teams; the concept of clinical teams is changing and teams may be multidisciplinary in composition.

''The GMC makes it clear that each doctor has this individual responsibility''

''The VAST majority of my clinical team are NOT doctors'' and *''the notes are also written in by other disciplines who form a critical part of the clinical team eg Allied health professionals, specialist nurses and so on''*

''The concept of a 'team' is part of the problem here. There is no responsible hierarchy, juniors are pulled by different bodies (deanery, foundation school,) and are not the same cohesive band with a definite team leader that they used to be... It is therefore very difficult, unless one takes over all the responsibilities of the team, to exert control over its activities''

''I may have no control of this - my team may even be acting on behalf of another consultant when they are on call for them, not me''

''The killer question is who constitutes your team – in days gone by you appointed juniors who worked to you. Nowadays, you have no say in the appointment of trainees you may see every now and again. The team is large, but is it your team?''

''It is difficult to check the accuracy of entries by all junior doctors relating to my patients both on the ward and in outpatients''

Most clinicians expressed disagreement with taking responsibility for what others, not part of their clinical team, write in the notes of patients under their care (48% disagreement versus 26% agreement). Above all, clinicians described the barrier of not being able to monitor or police the actions of other clinicians.

''It's important but you cannot be responsible for another, working with someone you don't know''

''In reality, in the post-take setting, for example, this may not come to light immediately, or ever. There is precious little time to devote to chasing juniors who often have moved on by the time I get to see any problem''

''It is difficult to be held responsible for the actions of staff you do not manage''

''I do not think I should police other clinicians [other consultants'] *entries''*

''How would you police this or change the way another consultant writes?!''

''What someone else writes may not come to your notice until some time later (if at all). [This is] *outside your control''*

The majority of clinicians, however, stated they would let the practitioner know what they had done if the medical notes of their patient, by a doctor, nurse, midwife or an allied health professional (AHP) who was *not* a member of their clinical team, were not accurate, clear and legible (90% for doctors and 87% for nurses, midwives and AHPs).

> *''Responsibility lies with the person making the notes regarding accuracy and legibility. As a senior clinician I would bring deficiencies in record keeping to the attention of the individual. If errors are present I would ask for these to be corrected, ideally by the person who made the error, or to be followed by a qualifying statement by myself within the notes, and then communicate the correct version to the other team members (and patient if appropriate). For persistent problems, I would refer them to the guidelines and then feedback to their supervisor/manager if they did not change practice''*

Those few who felt that this was not their responsibility to pursue in any way (9%) felt it best to ''*do nothing, not because it is not my responsibility, but because it is time-consuming, and difficult to broach this with a colleague.* [I] *would probably write an accurate summary in notes instead*'' or ''*do nothing because it would be considered astonishing behaviour to go to another consultant and say ''I think you wrote a poor note on my patient.'' ''This is analogous to hand washing - a culture of cross-checking has developed which did not previously exist*''

More neutral responses were framed in the context that the action to be taken would ''*depend[s] on the importance of these notes* [and the fact that] *legibility could be hugely improved by typed electronic notes*''

Regarding views on whether supporting information from medical notes should be used in appraisal (54% agreement versus 13% disagreement), clinicians were concerned that many people write in the notes (not just the person to be appraised), and that therefore selected excerpts from notes or documents such as letters, written by the subject of appraisal, or immediate team, might be more appropriate for appraisal.

> *''For notes made by me personally definitely. For team's notes, possibly, as measure of team quality''*

> *''For a consultation speciality it would be more appropriate to review the clinic letter rather than the notes made during the consultation in order to produce that report. Otherwise we are going to need much longer consultations in order to provide clear prose, and would have to rewrite drafts as the history does not necessarily come from the patient in sequence''*

> *''The letters filed in the medical notes must be taken into account because they usually are full text and more detailed than hand-written notes''*

Clinicians who disagreed with this suggestion did so because of concerns that notes could be manipulated, either to a person's advantage or disadvantage:

> *''I think evidence of poor performance may be found in the notes, but it is likely that a poor performer would not present that evidence themselves, and it is more likely to arise in an investigation. Evidence of good performance may be found, but I'm sure we could all cherry pick the good bits to present, so it doesn't really serve any purpose unless it is random selection, which would be difficult''*

There were also observations that good quality notes would mistakenly be taken to equal good quality of care.

''*Although good notes usually reflect good care, they may not – the care could be excellent, but the notes poor in some areas, or care poor, but notes very good*'' and ''*Medical notes are merely a record of care. Not all care is necessarily good no matter how good the notes are*''

Regarding whether or not information from audits should be used in appraisal, concerns were raised about how this information could be used negatively.

''There is a real danger that the revalidating doctor takes the rap for poor records. In my experience nearly all doctors wish to keep good records but are constrained by over booked clinics and other issues'' and *''Audits of medical notes in the past have produced grossly inaccurate conclusions due to the state of the notes, for example that an entry was not made in the notes, when in fact an entry* had *been made but had been missed by the person auditing the notes due to misfiling. There are several other ways in which audits can produce inaccurate conclusions''*

In addition, it was thought that information from audits would need to be used carefully, maintaining patient confidentiality, and that the audit information should be used as one of the many tools for appraisal (not in isolation).

''It should be accepted that team audits such as a notes audit are an important aspect of clinical governance for a variety of reasons, only one of which is revalidation. Poor results of an audit do not necessarily reflect the quality of the individual consultants work, but he/she should be able to discuss measures being taken to improve the team's activity in this area''

5.3 Responses from lay respondents

Responses to the questionnaire given by the lay respondents were very similar to those given by the doctors. Comments made were also broadly similar, though some expressed surprise that this should be an issue at all with regard to consultant responsibility for their own entries and the entries of their team.

''In nearly every adverse incident I have seen in eight years' involvement with the NHS as a lay rep, patient records have been implicated. I believe it is imperative to include record keeping in revalidation''

Two lay people mentioned data protection and consent as potential issues. The overall tone was that it was a major issue for revalidation, but responsibility for what others wrote may not be straightforward. However, there was a consensus that if notes were of an insufficient standard then the consultant would be expected to let the person or their manager know.

''If the patient is under your care you accept ultimate responsibility for accuracy of their record. If not the Doctor in charge who?''

''The fact that the person is not a fellow doctor does not alter the essential nature of the responsibility, nor the pathways for tackling the issue''

5.4 Other points arising from the consultation

There are occasions when a consultant sees little of junior doctors nominally working under their supervision. These situations may arise when cover for patients is provided by juniors from another hospital on a shift basis, and also with locums, who may work for short periods. In some specialties and in some hospitals, these situations are common occurrences. It is difficult in these circumstances for consultants to exercise any form of control over the quality of note writing of juniors 'within their clinical team'.

6 Discussion

The analysis of the consultation questionnaire broadly reflects the pattern that was emerging from the first contacts with revalidation leads and the workshop discussions. Consultants are clear about the importance of medical notes and their own responsibility for what they write. This extends to those for whom they have a management responsibility within teams (including junior medical staff). There is a clear message that responsibility for what others write is not theirs, but the great majority would take action if the entries of others were found wanting. There was also a general consensus that information from medical notes could be brought as *a part* of the supporting evidence at appraisal, and that information from audits was acceptable.

There were a number of provisos. The concept of clinical teams and patterns of working are changing, so lines of responsibility are far less clear than they once were. Where junior doctors provide cover from another hospital, or where there is frequent use of locums, a consultant may rarely see junior doctors nominally under their supervision. This places a boundary on the extent of a consultant's direct responsibility, in that monitoring of what team members write is not customary, and would be difficult in many circumstances. This is particularly problematic where 'teams' are not consultant-based. In these circumstances, junior doctors for whom a consultant has a role as educational or clinical supervisor would be more appropriate and practicable, when note keeping would be included in the performance review processes. There were concerns that revalidation appraisals could form part of a witch hunt in trying to deal with 'unpopular' consultants who were being challenged for other reasons.

It is notable that patients and their carers are astonished that there should be any doubt about responsibility for the content of medical notes. They believe that the medical record is so fundamental to continuity and quality of care that overall responsibility for their content must rest with the consultant providing their care, irrespective of who writes in the notes.

An additional point, in this context, is the recommendation that an audit of the quality of medical records *could* be required once every five years in the revalidation cycle. While this appears to be in conflict with the majority view that an audit should be optional for appraisal, patients believe that an audit *should* be required. This implies that an audit of the quality of medical notes should be a required audit in addition to or as a part of requirements for another audit(s).

There were many statements of frustration at the inability to improve the overall management of medical notes, which were reported as being frequently poor. Some respondents also reported that financial constraints within hospitals were resulting in reduced numbers of ward clerks, for example, who would have previously been responsible for filing of papers and results.

Limitations include the unbalanced representation from some specialties. This led to a systematic check on whether the responses varied between specialties, but there was no evidence for this.

From the findings of the consultations and meetings, we have produced guidance which reflects the pattern of responses and the tenor of the comments.

7 Summary of findings

Responsibilities regarding good clinical practice in relation to medical note keeping

- What people write in clinical notes is their own explicit responsibility.
- Medical notes are an important component of clinical care, and consultants have a responsibility to ensure that what they write in the medical notes is clear, accurate and legible.
- Consultants have a responsibility for the entries made by their clinical team (including junior medical staff) in notes of patients under their care and in notes of patients under the care of another consultant. There may be external constraints on the extent to which consultants are able to meet this responsibility (eg locums and some forms of shift working).
- What other clinicians write in the notes of a patients under a consultant's care is not part of the consultant's responsibility, as all clinicians have their own responsibility to ensure that what they write is clear, accurate and legible.
- However, individuals should be informed if their note entries are illegible, irrespective of the extent to which consultants feel that what is written is part of their responsibilities.

Views on the use of medical notes information at appraisal

- Information on the quality of medical note keeping can be used as supporting information at appraisal.
- Information from a medical notes audit should be included only as one option amongst many at appraisal.
- Information from audits can be included; with audits conducted by consultants themselves, by members of their clinical team (including junior medical staff), or by trust clinical audit staff deemed acceptable.
- Information from an audit of medical note keeping could be included in appraisal at least once every five years.
- The quality of record medical note keeping is an appropriate item for 360° feedback (multisource feedback (MSF)), though this would be unlikely to be information from an audit.

8 Appendices

Appendix 1 – organisations contacted regarding interest in the project (51)

Box A1.1 Organisations that confirmed interest (44 organisations)

Association of Surgeons of Great Britain and Ireland
Association for Palliative Medicine of Great Britain and Ireland
Association of British Clinical Diabetologists
Association of British Neurologists
Association of Cancer Physicians
British Association for Sexual Health and HIV
British Association of Audiological Physicians
British Association of Dermatologists
British Association of Oral and Maxillofacial Surgeons
British Association of Paediatric Surgeons
British Association of Stroke Physicians
British Association of Urological Surgeons
British Cardiovascular Society
British Geriatrics Society
British Nuclear Medicine Society
British Orthopaedic Association
British Society for Allergy and Clinical Immunology
British Society for Clinical Neurophysiology
British Society for Gastroenterology
British Society for Haematology
British Society for Rheumatology
British Society of Rehabilitation Medicine
British Thoracic Society
Clinical Genetics Society
College of Emergency Medicine
ENT – UK
Faculty of Sport and Exercise Medicine
Intensive Care Society
Renal Association
Royal College of Anaesthetists
Royal College of Obstetrics and Gynaecology
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal College of Physicians and Surgeons Glasgow
Royal College of Physicians Edinburgh
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons Edinburgh
Royal Colleges of Surgeons England
Society for Acute Medicine
Society for Cardiothoracic Surgery in Great Britain and Ireland
Society for Endocrinology
Society of British Neurological Surgeons

Box A1.2 Organisations that did not respond or who stated that the project was not relevant to their organisation (seven organisations)

British Association of Plastic, Reconstructive and Aesthetic Surgeons
British Pharmalogical Society
Faculty of Occupation Medicine‡
Faculty of Pharmaceutical Medicine‡
Faculty of Public Health
Medical Ophthalmological Society‡
Royal College of General Practitioners

‡ Was not relevant to their organisation

Appendix 2 – Organisations contacted to request signoff of the report and guidance (42 organisations)

Organisations that provided sign off (42)	
Association of Surgeons of Great Britain and Ireland	British Thoracic Society
Association for Palliative Medicine of Great Britain and Ireland	Clinical Genetics Society
Association of British Neurologists	College of Emergency Medicine
Association of Cancer Physicians	Faculty of Sport and Exercise Medicine
British Association for Sexual Health and HIV	Intensive Care Society
British Association of Audiological Physicians	Renal Association
British Association of Dermatologists	Royal College of Anaesthetists
British Association of Oral and Maxillofacial Surgeons	Royal College of Obstetrics and Gynaecology
British Association of Paediatric Surgeons	Royal College of Ophthalmologists
British Association of Stroke Physicians	Royal College of Paediatrics and Child Health
British Association of Urological Surgeons	Royal College of Physicians
British Cardiovascular Society	Royal College of Physicians and Surgeons Glasgow
British Geriatrics Society	Royal College of Physicians Edinburgh
British Nuclear Medicine Society	Royal College of Psychiatrists
British Orthopaedic Association	Royal College of Radiologists
British Society for Allergy and Clinical Immunology	Royal College of Surgeons Edinburgh
British Society for Clinical Neurophysiology	Royal Colleges of Surgeons England
British Society for Gastroenterology	Society for Acute Medicine
British Society for Haematology	Society for Cardiothoracic Surgery in Great Britain and Ireland
British Society for Rheumatology	Society for Endocrinology
British Society of Rehabilitation Medicine	Society of British Neurological Surgeons

Appendix 3 – Initial email inviting revalidation leads for their initial thoughts

In relation to each of these attributes – of the GMC Good Medical Practice Appraisal Framework – we are asking the questions: 'what will be the source of the information?' and 'how should that information be used in appraisal for revalidation?'.[6]

Attribute 2 Adequately assess a patient's condition to take account of history and patient views, and investigate and treat accordingly.

Attribute 3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible

Attribute 8 (in relation to medical notes only) Provide effective leadership including supervision of a clinical team, teaching and training, appraising and assessing, and ensuring that staff perform to acceptable standards of practice.

Please give us your initial thoughts on the following questions. Your responses will be used to formulate the agenda for a workshop to draft the guidelines:

1 Do you agree with our proposal to use audit data and the source of the audit data? (See attached tested audit tool) The record keeping standards are available at: http://www.rcplondon.ac.uk/sites/default/files/clinicians-guide-part-2-standards_0.pdf

2 Is information from the audits on the standards sufficient?

3 Are there specialty-specific matters that might be included for your specialty?

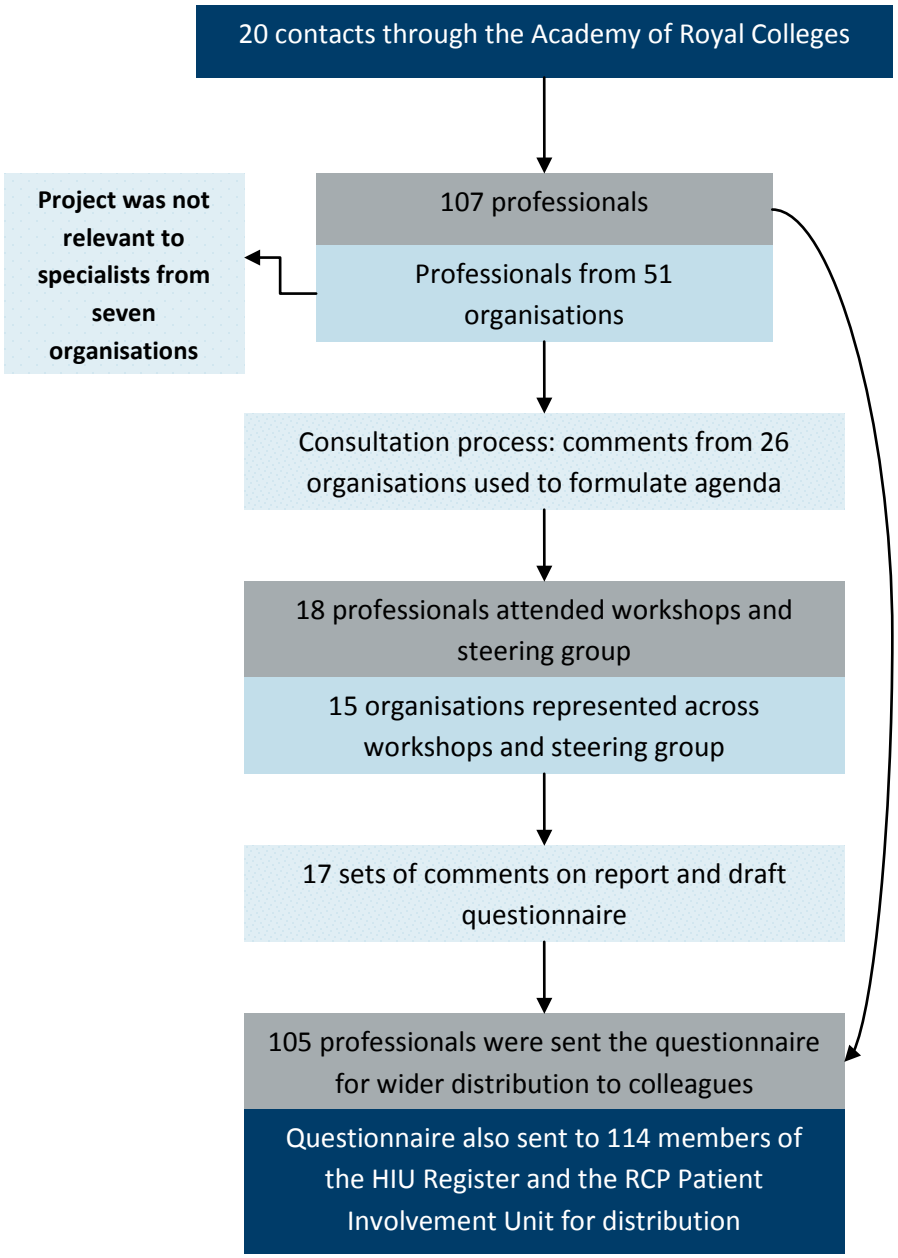
4 What are your thoughts about information/audit of electronic records?

5 What are your thoughts on how the medical notes information should be used in the appraisal?

6 Should a doctor include information from notes audits in their portfolio and specifically discuss this in the appraisal?

7 Are you available to attend a workshop at the RCP on Thursday 8 April?

Appendix 4 –Flow diagram of consultation and workshop attendance



9 References

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6 General Medical Council. *Revalidation: The Way Ahead. Annex 1 – Good Medical Practice Framework for Appraisal and Assessment*. 2010. http://www.gmc-uk.org/static/documents/content/Revalidation_way_ahead_annex1.pdf