Royal College of Physicians | Health Informatics Unit

Evidence on the quality of medical note keeping: Guidance for use at appraisal and revalidation

April 2011

Funded by:

ACADEMY OF MEDICAL ROYAL COLLEGES

Acknowledgements
This project was funded by the Academy of Medical Royal Colleges.

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Contents ♠

♠ The content of this guidance is structured in accordance with the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument: www.agreetrust.org/resource-centre/the-original-agree-instrument

1 Objective

1 To produce consensus-based guidance on how information on quality of medical note keeping can be used in supporting information at appraisal for revalidation.

2 There are two features of medical notes that are relevant for appraisal and revalidation. The quality of the written entries (are they legible, accurate, dated, signed etc) and the clinical content of those entries (do they show appropriate levels of care or clinical outcome).

3 This guidance addresses the quality of written entries; it does not address matters of clinical content.

4 This guidance does not address specialty-specific matters, which are covered by the relevant professional organisations. Examples of specialty-specific standards include Good psychiatric practice (Royal College of Psychiatrists),[1] Good surgical practice (Royal College of Surgeons of England),[2] and Good practice: a guide for departments of anaesthesia, critical care and pain management (Royal College of Anaesthetists).[3] The guidance has not been designed to apply to General Practice.

2 Methodology

5 The guidance is the product of a consultation project led by the Health Informatics Unit of the Royal College of Physicians, and funded by the Academy of Medical Royal Colleges.[4] Revalidation leads for the medical royal colleges and specialist societies took part in email consultation and workshop participation, to help define the contents of a consultation questionnaire. The final questionnaire was emailed by revalidation leads to doctors in the professional organisation they represented. The responses to the questionnaire were analysed and formed the basis of the guidance, which was then distributed, via the revalidation leads, to their professional organisation for approval (see Appendix 1 and related report for more detail).[5]

3 Background

6 Medical notes are an important part of clinical practice. They are the record of information about a patient's condition, investigation and treatment upon which decisions about their care are made. They are the essential permanent records that form the basis of communication between healthcare professionals, supporting patient safety and continuity of care. Errors and omissions in clinical records are frequently related to clinical incidents, in particular those that come to litigation and also to GMC fitness to practice panels. Patients expect them to be accurate and complete.

7 Clinicians who have responsibility for the care of patients have a responsibility for what they write in medical notes, and also for reviewing what is written in the notes of patients for whom they are the responsible clinician.

8 There is a difference in the expression of this responsibility, depending on the relationship between the consultant and the clinicians who make entries in the notes of their patients.

9 Where the consultant has a management responsibility for another clinician (as a team member or as educational or clinical supervisor), even though the individual has a specific responsibility for

what they write, the consultant also has a responsibility for the quality assurance of what he or she has written.

10 A consultant should have some means of determining whether the notes made by members of their clinical team for whom they have a management responsibility are up to standard. This may be by raising the matter at a supervision meeting for example. Where they have no management responsibility for the person making the entry, then they can be expected to inform that individual or their supervisor when an entry does not meet acceptable standards.

11 Typed letters form the bulk of the clinical communications in outpatient clinics, and they should be regarded as the primary source of clinical information. This guidance applies only to the written record. Where the typed letter is the full record of the outpatient encounter, the written record is of less importance.

4 Definitions

12 The standards for determining the quality of medical record keeping are the generic medical record-keeping standards approved by the Academy of Medical Royal Colleges (see Appendix 2).[5] The relevant standards are standards 2, 5, 6, 7, 8, 9, 10 and 12 (see Box 1). Standards 1, 3, 4 and 11 are not relevant in this context.

Box 1 Standards that should be included in appraisal for revalidation

Standard	Description
2	Every page in the medical record should include the patient's name, identification number (NHS number) and location in the hospital
5	Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma
6	Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed
7	Entries to the medical record should be made as soon as possible after the event to be documented (eg change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded
8	Every entry in medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made
9	On each occasion the consultant responsible for the patient's care changes, the name of the new responsible consultant and the date and time of the agreed transfer of care, should be recorded
10	An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why

12	Advanced Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified eg Lasting Power of Attorney

13 Audits of the quality of record keeping referred to in the guidance can be conducted using the 'stand-alone' *Generic medical record standards audit tool*,[6] or an audit tool which will be available on the Health Quality Improvement Partnership (HQIP) website in 2011. Audit of the most recent admission in ten sets of average sized medical notes takes 1.5 to 2 hours. An example of a suitable audit tool is shown in Appendix 3.

5 Recommendations

R1 All clinicians have a degree of responsibility for the overall state of medical records. However, this is limited where, for example, the medical notes folders are in poor condition, disorganised or unavailable. In these situations, trust management must hold responsibility, and a consultant may reasonably be expected to inform trust management when these situations arise. Only in this way will the general standard of medical notes folders be improved.

R2 Appraisal for revalidation may include information on the quality of medical note keeping in support of the appraisal process.

R3 Information from an audit against professional standards, such as those approved by the Academy of Medical Royal Colleges, can be used as appropriate evidence, irrespective of who conducts the audit.

R4 Information from an audit should not be required information; rather it should be an option, unless concern has been expressed about the medical notes entries of a consultant or the notes of patients under their care.

R5 A general question about medical record keeping is a legitimate component of 360^{o} feedback. This should be a general question and not a specific question about performance against specific standards or results of audits.

R6 Revalidation is intended to be a non-onerous process. However, inclusion of information from at least one audit of the medical notes could be available as supporting evidence at appraisal in any one five-year period. Patients and carers believe that this should be a *required* audit, irrespective of other audit requirements.

R7 ***For consultants who have responsibility for hospital inpatients, either under their name or as part of a clinical team.***

Information from an audit of the notes, against the Academy of Medical Royal Colleges' generic medical record standards, should be from patients who have been under the care of the consultant or their clinical team (including junior medical staff). The information can come from an audit undertaken by the consultant themselves, a member of their clinical team, or the trust audit department.

A consultant should have some means of determining that the notes made by members of their clinical team for whom they have a management responsibility (as a team member or as educational or clinical supervisor) are up to standard. This may be by raising the matter at a supervision meeting for example. Where they have no management responsibility for the person making the entry, then they can be expected to inform that individual or their supervisor when an entry does not meet acceptable standards.

Where a consultant has no management responsibility, or there are constraints on the extent to which they are able to exercise their responsibility for clinicians who have made entries that do not meet the standards, then it is reasonable to expect that the consultant would have informed the individual(s) concerned or that person's supervisor.

R8 ***For consultants who see primarily outpatients only***

Typed letters form the bulk of the clinical communications in outpatient clinics, and they should be regarded as the primary source of clinical information. An audit of the notes of outpatients made by a consultant should be quality of the written information only. Generic Medical Record Keeping Standards 2 and 6 are the only standards that currently apply to outpatient records. Where the typed letter is the full record of the outpatient encounter, the written record is of less importance (eg entries should be dated but need not be timed or completely legible).

R9 ***For consultants who do not have patients specifically under their care (eg anaesthetics, haematology)***

For specialties that contribute to the care of patients under other consultants and clinical teams (including junior medical staff), the consultant may bring a sample of entries selected by another clinician from their specialty.

R10 ***For consultants who work in multidisciplinary teams where there is no clear identification of lead responsibility***

An audit against the Academy of Medical Royal Colleges generic medical standards of the notes of patients who have been cared for by the team (including junior medical staff) may be used as evidence. Interpretation of the information in the notes should form the basis of a discussion. As a team member, the consultant will have a role, in so far as they feed back to members of the team on the performance of the whole team, and possibly to some individual members.

6 Appendices

Appendix 1 – organisations that provided sign off of the report and guidance

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 2 – generic record keeping standards

Standard	Description
1	The patient's complete medical record should be available at all times during their stay in hospital
2	Every page in the medical record should include the patient's name, identification number (NHS number)[1] and location in the hospital
3	The contents of the medical record should have a standardised structure and layout
4	Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order
5	Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma[2]
6	Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed
7	Entries to the medical record should be made as soon as possible after the event to be documented (eg change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded
8	Every entry in medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made
9	On each occasion the consultant responsible for the patient's care changes, the name of the new responsible consultant and the date and time of the agreed transfer of care, should be recorded
10	An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why[3]
11	The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital
12	Advanced Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified eg Lasting Power of Attorney

[1] The NHS number is being introduced as the required patient identifier

[2] This standard is not intended to mean that handover proforma should be used for every handover of every patient rather that any patient handover information should have a standardised structure

[3] The maximum interval between entries in the record would in normal circumstances be one (1) day or less. The maximum interval that would cover a bank holiday weekend, however, should be four (4) days

Web address: http://www.rcplondon.ac.uk/sites/default/files/clinicians-guide-part-2-standards_0.pdf

Appendix 3 – Audit Tool for RCP Generic Record Keeping Standards (Medical)

Instructions to Auditor

Contact your information department to identify all patients who were discharged last month. Randomly select 30 patients and request the records department to go down the list and pull out the notes. They should stop when they have retrieved 10. Label the sets from 1-10. Go through each set of notes and answer the questions below. Audit the most recent admission in the medical notes. The audit begins at the point in the notes when the medical team takes responsibility for the patient ie not A&E. Every subsequent entry in the notes should be audited, up to and including the final entry prior to discharge or death, including entries written by other disciplines The audit should not include entries made outside the main body of the written medical notes for the most recent admission. For this audit to be effective, it should be presented at an appropriate meeting where decisions to change practice can be made. The audit should be repeated regularly, at an agreed interval, on an ongoing basis.

Name:	**Job Title:**
Date:	**Ward / Clinical Team / Department:**

		Record Number										
		1	2	3	4	5	6	7	8	9	10	Average
2 Every page in medical record should include the patient's name, identification number (NHS number) and location in the hospital												
Q1	How many pages of the medical notes relate to this admission? **[NB: audit all pages ie both sides of each sheet; this question only applies to the written clerking and continuation notes from admission to discharge]**											
Q2	How many pages for this admission have both the patient's first and last name?											#DIV/0!
	Q2 Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Q3	How many pages have the patient's unique identifying number? e.g. NHS Number (or Hospital Number)											#DIV/0!

		1	2	3	4	5	6	7	8	9	10	Average
3 The contents of the medical record should have a standardised structure and layout												
Q4	Does the WARD/CLINICAL TEAM/DEPARTMENT have a standardised protocol for the organisation of DOCUMENTS WITHIN THE medical notes? **(Yes/No)** **[NB: If you answer 'No' to this question leave Q5 blank]**	Yes / No IF YOU ANSWERED 'NO' TO THIS QUESTION, GOOD PRACTICE SUGGESTS THAT YOU SHOULD USE A PROFORMA AND THIS IS SOMETHING THAT YOU/YOUR WARD/TEAM/DEPARTMENT/TRUST SHOULD CONSIDER IMPLEMENTING										
Q5	Do the notes in the record comply with the trusts standardised protocol for organisation of medical notes? (Yes/No)											
4 Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order												
Q6	Are the doctors' admission clerking and subsequent continuation notes filed in chronological order ? **(Yes/No)**											
5 Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma												
Q7	Does your trust have a standardised doctor's admission clerking proforma? **(Yes/No)**	Yes / No										
Q8	Is the data recorded using this standardised proforma? **(Yes/No)**											
Q9	Does your trust have a standardised discharge summary? **(Yes/No)**	Yes / No										
Q10	Is the data recorded using this discharge summary? (exclude death) **(Yes/No)**											
9 On each occasion the consultant responsible for the patient's care changes, the name of the new responsible consultant and the date and the time of the agreed transfer of care should be recorded												
Q11	How many times, during this admission, was it recorded that there was a change of consultant responsible for the patient's care?											
Q12	For how many changes of responsible consultant was the date recorded?											#DIV/0!
	Q12 Percentage											#DIV/0!

		1	2	3	4	5	6	7	8	9	10	Average
Q13	For how many changes of responsible consultant was the time recorded?											#DIV/0!
	Q13 Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
6 Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed												
Q14	How many written entries are there on the medical record for this admission? (The audit begins at the point in the notes when the medical team takes responsibility for the patient ie not A&E. Every subsequent entry in the notes should be audited, up to and including the final entry prior to discharge or death, including entries written by all disciplines. Do not include entries made outside the main body of the written medical notes for the most recent admission)											
Q15	How many written entries on the record have the date recorded?											#DIV/0!
	Q15 Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Q16	How many written entries on the record have the time recorded?											#DIV/0!
	Q16 Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Q17	How many written entries on the record have a signature?											#DIV/0!
	Q17 Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Q18	How many written entries on the record have a legible printed name?											#DIV/0!
	Q18 Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Q19	How many deletions or alterations are there?											#DIV/0!
Q20	How many deletions or alterations are countersigned?											#DIV/0!
	Q20 Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

		1	2	3	4	5	6	7	8	9	10	Average
Q21	For how many deletions or alterations was the date recorded?											
	Q21 Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Q22	For how many deletions or alterations was the time recorded?											
	Q22 Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
		1	2	3	4	5	6	7	8	9	10	Average
8 Every entry in the medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made												
Q23	How many written entries on the record indicate the most senior clinician present? (see help notes)											#DIV/0!
	Q23 Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
10 An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7 days) for long stay continuing care, the next entry should explain why												
Q24	On how many occasions is there a gap of more than four days between entries?											
Q25	How many entries with a gap of more than 4 days have an explanation provided?											#DIV/0!
	Q25 Percentage	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
12 Advance Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney												
Q26	Is there a decision regarding 'not for resuscitation' NOTED ? **(Yes/No)**											
Q27	Where there is a 'not for resuscitation' decision, is it clearly recorded? **(Yes/No)**											
Q28	Where there are statements in relation to Advance Decisions, Consent or Cardio-Pulmonary Resuscitation, has the decision maker been clearly identified? **(Yes/No)**											

List the five main areas, in the medical record keeping, that need improvement:	
1	
2	
3	
4	
5	

Identify three action points to improve the quality of medical record keeping:	
1	
2	
3	
4	
5	

Date for follow-up audit (complete the audit cycle within 3-6 months):

For copies of this Audit Tool contact us directly at:

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Tel: +44 (0)20 3075 1578

Email: informatics@rcplondon.ac.uk

7 References

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