Defensible Record Keeping

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ABSTRACT

INTRODUCTION: Patients records are among the most fundamental of clinical tools and are involved in almost every consultation. It is essential in evaluation the patient's progress & in a variety of legal contexts including defensive malpractices claims. Way of keeping the records may vary from institute to institute.

METHODS: Seven departments having the inpatient were included in the study on November 2013. Thirty files from each department were randomly collected and studied for the complete and proper documentation in (a) admission notes (b) daily progress notes (c) investigation form filling on the basis of inclusion criteria as laid down in the protocol by the Royal College of Surgeons.

RESULTS: Record keeping of the patient's documents was not satisfactory in all departments. However, entry of date and entry of ward and bed number in an investigations form were filled in all departments.

CONCLUSION: All the departments must know of the proper record keeping in their respective ward. Conducting a regular rolling audits and implementation of the recommendations made in rolling audits may help in the improvement of proper record keeping.

KEY WORDS: Audit; Defensible record keeping.

INTRODUCTION

Patient's records are among the most fundamental of clinical tools and are involved in almost every consultation[1]. Proper record keeping is of increasing importance in the medical field[2]. The quality standard of the record is desirable for the purpose of evaluating the patient's progress, and essential from the legal point of view if arguments should arise about competence. They are there to give a clear and accurate picture of the care and treatment of patients and to assist in making sure they receive the best possible clinical care. Good records do more than support good patient care; they are essential to it. It is critical in a variety of legal contexts, including defensive malpractice claims. Risk of litigation can be reduced by adopting practices that include keeping thorough medical records[3]. It is also important in peer review, in providing data for public health purposes and may be used for the purposes of teaching.

Way of keeping the records may vary from institute to institute. One definite universal protocol may not be followed. The Royal College of Surgeon has laid down the protocol for proper medical record keeping which was followed in the present study[4]. Thus, the present study were conducted to evaluate the maintenance of records of the inpatient in National Academy of Medical Sciences, Bir Hospital. After the evaluation of record keeping the deficit part and overlooked aspect in the record keeping process were identified. Recommendations were made for the proper filling of the medical records and the implementation of the recommendations will be assessed by considering the regular rolling audits.

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METHODS

The study was conducted in Bir Hospital, National Academy of Medical Sciences on November 2013 where seven departments with the inpatient wards were included. Files were collected by us from the record keeping section of Bir Hospital, NAMS. Thirty files from each department stored in bundles in a medical record section were randomly collected from among overall records to minimize the biasness and studied. So, total number of files studied were two hundred and ten. The departments included were Medicine, ENT-HNS, Orthopedics, Surgery, Radio-oncology, Dermatology, and Dental. The files were studied for the complete and proper documentation in (a) admission notes (b) daily progress notes (c) investigation form filling. In this study we had followed the mentioned by Wallace MJ. protocol for the analysis of the records[4]. The protocols laid down by the Royal College of Surgeon are as follows:

1. The name, unit number, date of birth should be mentioned in every sheet of medical record.
2. The method of admission should be stated.
3. The date and time of consultation should be mentioned.
4. All entries should be clear and legible.
5. All entries should be signed with printed name, grade and contact number.
6. The request form should be complete with adequate clinical details.
7. Every request form should be seen, evaluated and initiated by the clinician before filing.
8. The abnormal records should be noted in the clinical records and appropriate action (if any) should be documented. The dictated notes should be checked, assessed and signed by the doctors who dictate them.
9. The prescriptions must be legible, dated and signed.

RESULTS

The study was conducted by analyzing thirty files from each of the seven departments. Regarding the admission note filling; the use of capital letters were specifically asked for, the entry of full department that included unit and unit in charge, provisional diagnoses, final diagnoses, date of admission and the full address of the patient were analyzed as shown in table I.

Table I: Analysis of the admission notes in the percentage out of 30 sample files from each faculty (total two hundreds and ten files).

	ENT %	ORTHO %	MEDICINE %	SURGERY %	SKIN %	ONCO %	DENTAL %
Use of capital letters	10	0	16.66	3.33	76.66	0	46.66
Entry of unit & unit in charge	86.66	63	63.33	53.33	100	56.66	63.33
Entry of provisional diagnoses	100	83.33	100	100	100	93.33	93.33
Entry of final diagnoses	93.33	56.66	80	100	53.33	56.66	10
Entry of full address	3.33	50	16.66	20	20	0	3.33
Signature of the Doctor (understandable)	0	16.66	20	3.33	33.33	13.33	3.33
Entry of the admission date	96.66	96.66	96.66	96.66	100	100	100

Regarding the analysis of progress notes, the data was analyzed regarding the subjective complains of the patients, objective evaluations of the doctors, assessment and plan regarding the patients as shown in the table II.

Table II: Analysis of the daily progress notes in the percentage out of 30 sample files from each faculty (total two hundreds and ten files).

	ENT %	ORTHO %	MEDICINE %	SURGERY %	SKIN %	ONCOLOGY %	DENTAL %
Entry of subjective complains	40	60	63.33	36.66	100	6.66	13.33
Entry of objective data	43.33	56.66	80	26.66	100	20	6.66
Assessment and plan	16.66	66.66	70	30	100	0	0
Entry of signature (understandable)	16.66	0	0	13.33	3.33	0	0
Written over, erased or notes	0	0	0	0	0	0	0

Regarding the filling of the investigation form, the data were analyzed regarding the entry of date, ward and the bed number and the diagnoses as shown in table III.

Table III: Analysis of the investigation form filling in the percentage out of 30 sample files from each faculty (total two hundreds and ten files).

	ENT %	ORTHO %	MEDICINE %	SURGERY %	RADIO-ONCO %	SKIN %	DENTAL %
Entry of date	100	100	100	100	100	100	100
Entry of Ward and bed number	100	100	100	100	100	100	100
Entry of diagnoses	13.33	3.33	16.66	3.33	3.33	0	23.33

DISCUSSION

Health record keeping is an integral part of clinical practice and good record keeping is the mark of a safe and skilled practitioner since lawsuits against medical personal are increasing nowadays. There is a growing need of accurate, legible and understandable maintenance of records[2]. It is essential to make a record, at the time of clinical examinations, clinical decisions, treatments and advice given, complete with dates, times, names and address of individuals concerned and drugs or tests used. According to General Medical Council we must work with colleagues to monitor and maintain the quality of the care we provide and maintain a high awareness of patient safety. In particular, we must part in regular and systemic medical and clinical audit, recording data honestly. According to NHS, defensible documentation policy board, 2005 poor record keeping is the major factor in litigation cases which hinder the defense of defensible cases. So, failure of proper record keeping results in reduced quality of care, increase chances of litigation and defensible cases becomes indefensible. According to Panting[2] and Meyers et al[5] there is a growing need to keep records in medical fields since doctors have to justify their patient management in malpractice claims. Hutchinson et al[6] mention the practical implications of proper record keeping. They have highlighted the importance of proper record in peer reviews, audit and research. According to Colon[7], communicating with patients, keeping accurate records and actually taking time to examine patients are three of the top 10 ways to avoid a lawsuit. In addition health records are a valuable resource because of the information they contain. Records should also be available where unscheduled care is provided. In the present study, medical records regarding the proper admission form, the daily progress notes and the investigation form was undertaken with the aim to bring change and improve in record keeping in this hospital. We have expected improvement in patient's record keeping in future with the proper implementation of recommendations in this study. Similar study conducted by Rayamajhi and Guragain[8] in their hospital observed some improvement in patients record keeping in rolling audit. For the significant improvement regular rolling audit with recommendations must be carried in every six month.

Only seven departments were included for the study as these were the departments having the inpatient wards. The files were studied on a random basis so as to decrease biasness. Record keeping of the patients' documents was seemed to be not satisfactory in all departments. However, entry of date and entry of ward and bed number in an investigation form were filled in all departments which is positive aspect of record keeping.

CONCLUSION

Defensible record keeping is not satisfactory in all of our departments. All the departments must be aware of the proper record keeping in their respective ward. It can play an important role when legal issues rise about the negligence and compensation for malpractice along with proper management sequence of the disease. So, all the concerned doctors should consider good record keeping a crucial task which needs to be carried out for future legal use if required and in providing data for public health purposes. Although the policy and practice of National Academy of Medical Science requires good record keeping of each and every patient, our findings suggest that a mandatory course will be helpful to achieve the purpose. Regular rolling audits of attainment of this practice will further

reinforce the task of adequate record keeping. Proper implementation of the recommendations may help in the rapid improvement of proper record keeping.

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