Original article

Defensible record keeping

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Background: This retrospective study was conducted by the department of ENT and Head & Neck Surgery, TU Teaching Hospital to evaluate the maintainance of records of the inpatients in TU Teaching Hospital. The rolling audit was performed to evaluate the implementation of the recommendations made.

Material and Methods: Total of twenty files from each of the eight departments with the inpatient wards was reviewed retrospectively on January 2004. Similarly, other twenty files from each department were studied for the rolling audit on October 2006. The notes were reviewed for completeness and inclusion of the criteria as laid down in the protocol by the Royal College of Surgeon.

Results: The admission notes were adequately filled in the department of Psychiatry. The progress notes were adequately filled in the department of Psychiatry and ENT-HNS. The investigation form filling was comparable in all the departments. The discharge summaries were complete and understandable in the department of Psychiatry followed by ENT-HNS. Significant improvement was seen in the department of Obstetrics and Gynecology during the rolling audit.

Conclusion: The rolling audit can be done every 6 month to assess the maintainance of the records and the implementation of the recommendations.

Key Words: Audit; Defensible record keeping; Royal College of Surgeons

Introduction

Proper record keeping is of increasing importance in the medical field also. There is a growing need of accurate, legible and understandable maintainance of records[1]. Record keeping is essential for audit and research. It is also important in peer review, in providing data for public health purposes, and may be used for the purposes of teaching. 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.[1-2]

It is understood that styles for keeping the records may vary from practitioner to practitioner or in different institutions. One definite universal protocol is not followed.

The Royal College of Surgeon has laid down the protocol for proper medical record keeping which was followed in the present study[3]. Thus, the present study was conducted to evaluate the maintainance of records of the inpatient in T.U. Teaching Hospital.

Material and Methods

The study was conducted in TU Teaching Hospital, January 2004 where eight departments with the inpatient wards were included. Randomly, ten files from each department were studied by resident from ENT-HNS and other ten files by resident Pathology, total of twenty files from each department. The departments included were Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, Orthopedics, Ophthalmology, Psychiatry and ENT-HNS.

The files were studied for the complete and proper documentation in (a) admission notes (b) daily progress notes (c) investigation form filling and (d) discharge summary.

The rolling audit was performed in October 2006 where again twenty files from each of the eight departments were analysed. The implementation of the recommendations made in the first audit was also analysed.

Results

The study was conducted in two phases. First the study was done analyzing ten files from each of the eight departments. The rolling audit was done in the second phase to analyze the implementation of the recommendations made.

Regarding the admission note filling; the use of capital letters when specifically asked for, the entry of full department, provisional diagnoses, final diagnoses, date of admission and the full address of the patient were analysed as shown in table I.

Table 1: Analysis of the admission notes.

	Med (%)	Surg (%)	Obg (%)	Ped (%)	Orth (%)	Oph (%)	Psy (%)	ENT (%)
Use of capital letters	30	60	80	70	100	60	90	80
Entry of full department	70	70	70	80	70	80	80	100
Avoidance of initials	0	0	0	0	0	0	60	0
Entry of provisional diagnoses	100	100	100	100	100	100	100	100
Entry of final diagnoses	60	30	40	60	50	30	60	30
Entry of full address	30	30	20	30	30	30	100	60
Signature of the doctor (understandable)	40	30	30	30	40	30	80	50
Entry of the admission date	100	100	100	100	100	100	100	100

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

Table 2: Analysis of the daily progress notes.

	Med (%)	Surg (%)	Obg (%)	Ped (%)	Orth (%)	Oph (%)	Psy (%)	ENT (%)
Entry of subjective complain	30	40	30	40	60	80	100	90
Entry of objective data	60	60	70	70	60	70	100	80
Assessment and plan	30	40	60	60	40	60	90	80
Entry of understandable signature	40	30	30	30	40	30	80	50
Written over, erased or tippexed notes	20	20	30	30	20	30	30	20

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

Table 3: Analysis of the investigation form filling

	Med (%)	Surg (%)	Obg (%)	Ped (%)	Ortho (%)	Oph (%)	Psy (%)	ENT (%)
Entry of date	30	40	100	100	100	100	100	100
Entry of ward and bed number	70	70	60	70	60	80	100	80
Entry of diagnoses	70	70	70	70	70	70	90	80

Regarding the analyses of the discharge form, 30% of the files of the ENT-HNS were typed. All the other forms were handwritten. The entire discharge summaries were dated. The follow up of the patients was properly mentioned in the department of Psychiatry followed by the department of ENT-HNS.

The rolling audit was done after thirty-two months of the first audit. Again twenty files from each department were analysed. The results were as shown in Table IV, V and VI.

Table 4: Analysis of the admission notes on rolling audit

	Med (%)	Surg (%)	Obg (%)	Ped (%)	Orth (%)	Oph (%)	Psy (%)	ENT (%)
Use of capital letters	80	80	60	70	70	80	90	90
Entry of full department	70	70	70	80	70	80	80	80
Avoidance of initials	20	10	30	40	40	10	90	60
Entry of provisional diagnoses	100	100	100	100	100	100	100	100
Entry of final diagnoses	10	30	30	30	10	10	20	20
Entry of full address	30	50	80	60	30	60	80	80
Signature of the doctor (understandable)	40	30	30	30	40	30	80	50
Entry of the admission date	100	100	100	100	100	100	100	100

Table 5: Analysis of the daily progress notes on rolling audit

	Med	Surg	Obg	Ped	Orth	Oph	Psy	ENT
Entry of subjective complain	40	40	30	40	30	30	60	60
Entry of objective data	40	40	70	40	40	40	70	80
Assessment and plan	30	40	60	60	40	40	60	70
Entry of understandable signature	20	30	30	40	20	30	60	60
Written over, erased or tippexed notes	20	20	30	30	20	30	30	20

Table 6: Analyses of the investigation form filling on rolling audit

	Med	Surg	Obg	Ped	Orth	Oph	Psy	ENT
Entry of date	90	90	100	90	80	80	100	100
Entry of ward and bed number	70	70	60	70	60	80	80	80
Entry of diagnoses	70	70	70	70	70	70	90	80

Regarding the analyses of the discharge form, 80% of the files of the ENT-HNS were typed. All the other forms were handwritten. The entire discharge summaries were dated. The follow up of the patients was properly mentioned in the department of Psychiatry followed by the department of ENT-HNS. The avoidance of initials was 100% in the department of Psychiatry and ENT-HNS, 80% in the department of Obstetrics & Gynecology and Ophthalmology, 30-40% in the other departments.

Few recommendations were made in the first audit like avoidance of initials, entry of full address of the patients, entry of final diagnoses, properly written daily progress notes and writing understandable signatures. The implementation of the above recommendations was analysed in the rolling audit. The avoidance of initials and entry of full address showed improvement. The entry of final diagnoses and proper filling of daily progress notes showed no improvement and further recommended. Understandable signatures were lacking in the rolling audit also.

Discussion

Proper maintenance of record is very important in the medical field also since lawsuits against medical personal are increasing nowadays. It is also important for audit. According to Panting[1] 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. According to Colon[4], communicating with patients, keeping accurate records and actually taking time to examine patients are three of the top 10 ways to avoid a lawsuit. 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.

In the present study, medical records regarding the proper filling of the admission form, the daily progress notes, the investigation form and the discharge summary was undertaken. We had followed the Royal College of Surgeon's protocol for the analysis of the records[3]. 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 initialed 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.

Only eight departments were included for the study as these were the departments having the inpatient wards. The files were studied on a random basis by the resident Pathology and the resident ENT-HNS so as to decrease bias. The rolling audit was done to analyse the implementation of the recommendations in the same departments.

Record keeping of the patients' documents was appreciable in the department of Psychiatry and ENT-HNS in both the first and the rolling audit. The implementation of the recommendations made in the first audit did not show significant improvements. Some improvement was noticed in the admission note filling only. No improvement was seen in the proper filling of the progress notes and the investigation form filling. Significant improvement in filling the discharge summary was seen in the department of Obstetrics & Gynecology. We think that all the departments

must be aware of the proper record keeping in their respective wards. Rolling audit must be done in a regular basis to see for the changes made. Though in the present study the rolling audit was done after thirty-two months, it is advisable to do the rolling audit every six monthly.

Conclusion

Recommendations are made for the proper filling of the medical records. The rolling audit can be considered every six monthly for assessing the implementation of the recommendations.

References

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