Good medical records: a guide for the foundation year doctor

Introduction

Maintaining good medical records is essential for providing safe and effective patient care. The General Medical Council (2006), in *Good Medical Practice*, suggests that doctors should 'keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'. While good medical practice is necessary throughout one's medical career it is important to develop good qualities early in the training.

Most people consider medical records to be electronic, typed or handwritten patient notes, but they also include investigation reports, images such as X-rays and clinical photographs.

Why keep good medical records?

Maintaining good medical records provides information about patient care to colleagues, both doctors and other health professionals. It is essential for effective communication and thus a requirement for good team work. With increasing number of doctors and nurses working in shifts, accurate documentation in patient notes is essential for continuity of any form of treatment. A meticulous handover is not an alternative to good documentation, especially when there are multiple handovers in a single day. Errors and mistakes in medical practice often relate to poor communication.

Clear written or typed patient notes are important in pursuing medicolegal issues such as claims and complaints. Complaints investigation often takes place a long time after the event and it is difficult to remember the exact sequence of a patient's care. A well-written clinical note will relay the information correctly and is useful during a coroner's inquest or court proceedings.

Clinical audit depends on good documentation to assess the present care and decide on processes which may improve patient care.

Medical records contain confidential information and it is important to store them efficiently and safely to avoid any breach of patient confidentiality.

How to keep good medical records

Clear handwriting is important to make written notes easily understandable. A black ink pen is recommended for writing in patients' notes. Abbreviations should be avoided wherever possible. If your handwriting is not clear, then try writing in upper case. Any corrections to clinical notes should be clearly marked and signed. Electronic records could be considered for use in most clinical tasks but the limitations of confidentiality, computer literacy and flexibility have been debated (Laerum et al, 2001). For now, however, written patient notes will continue to be an important part of the patient care record.

Good documentation includes a clear, concise and objective record of events in the notes, which everyone can understand with minimal effort. The popular belief among doctors is that documentation is necessary for communication with other doctors, leading to limited or no recording of other aspects such as discussions with patient. However, it is important to record all aspects of communication with the patient and relatives to avoid any malpractice claims later. It is particularly important in surgical practice to record discussions with patients about risk factors, complications and success rates of operations.

Discharge summaries should be comprehensive and cover all significant events regarding patient care. The information should allow colleagues including the GP to manage patient care in your absence.

Investigation reports should be signed and filed in patient notes regularly. While in many hospitals the X-rays and laboratory tests are computerized, reports continue to be printed off for clinicians to review. Where the X-ray films are hard copies, it is important to file them properly and return the file to the radiology department promptly. All electronic patient records should be held safely with due consideration for confidentiality and data protection.

While keeping good medical records is essential, maintaining them safely is equally important. All the necessary paperwork should be filed carefully in the notes and all records should be stored in cabinets. Safe medical record keeping requires good team work with ward clerks, nurses, secretaries and medical records personnel.

Conclusions

Maintaining good medical records is part of good medical practice and it is beneficial for doctors develop this quality early in their training. BJHM

Conflict of interest: none.

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KEY POINTS

- Clear and legible handwriting is essential.
- Date, time and sign all entries in medical notes.
- Record all forms of communication with patients and relatives.