Keeping documents and electronical reports of the patient

Dr. Hasan Fatih Çakmaklı

MD, Lecturer, Specialist in Pediatric Hematology and Oncology

Ankara University, Department of Pediatrics

20.05.2021

What are **the documents and electronical reports** of the patients?

- Documents that in medical facilities about the patient for the purpose of treating.
  - Includes records by physicians, nurses, pharmacists, physiotherapists, psychologists, administrators or students.

Types of medical records

- Hand-written records
- Electronical records (Computer-based)
- Some organisations or employers will use a combination of both.

Documents of the patients

- Physician notes and anamnesis, progress notes
- Nursing records/progress notes
- Medication charts
- Prescriptions
- Laboratory orders and reports
- Radiologic scans and reports
- Photos
- Vital signs observation charts
- Handover sheets and admission
- Discharge and transfer checklists/ letters
- Patient’s assessment forms, such as nutrition or pressure area care assessment.

Mathioudakis A, Rousalova I, Gagnat AA, et al. How to keep good clinical records. Breathe 2016; 12: 371–375.

Table 2 *Structured information which needs to be included in clinical records*

Clinical notes should include
Patient demographics
Reasons for the current visit
The scope of examination
Positive exam findings
Pertinent negative exam findings
Key abnormal test findings
Diagnosis or impression
Clear management plan and agreed actions
Treatment details and future treatment recommendations
Medication administered, prescribed or renewed and any drug allergies
Written (or oral) instructions and/or educational information given to the patient
Clear documentation and justification for resuscitation status and ceiling of care (if inpatient)
Documentation of communications with patient and family/friends (level of awareness of the situation and acceptance of the plans)
Recommended return visit date

Mathioudakis A, Rousalova I, Gagnat AA, et al. How to keep good clinical records. Breathe 2016; 12: 371–375.

What are the musts in a good clinical record?

- Factual, consistent and accurate
- Consecutive and accurately dated, timed
- Legible
- All entries signed (including any alterations)
  - Draw a clear line through any changes and sign and date;
  - Never use whitener, never scratch out
- Do not use abbreviations or jargon because it may cause errors.
  - PID abrevation
    - in neurosurgery dept; prolapsed intervertebral disc or in gynecology dept; pelvic inflammatory disease.
- Avoid speculation and offensive subjective statements/insulting language

https://www.ausmed.com/cpd/articles/record-keeping-documentation

What are the musts in a good clinical record?

- Updated
  - by all members of the multidisciplinary team that are involved in a patient's care
  - After any recordable event
  - Provide current information about the care and condition of the patient
  - Don't change them. If you realise later that they are factually inaccurate, add an amendment.
- Must be appropriately stored, secured, and maintained.
  - Poor records management also leaves hospitals, medical practices and other providers vulnerable to costly fines and lawsuits, as well as criminal charges.
  - They should be stored out of public view and access at all times. Staff should not disclose their contents to anyone other than authorised personnel.
- Must be private.
  - 87% of patients are unwilling to share their full medical histories, citing concerns about privacy protections.
  - Information from medical records should not be disclosed without a patient's consent unless permitted as a matter of law.

Mathioudakis A, Rousalova I, Gagnat AA, et al. How to keep good clinical records. Breathe 2016; 12: 371–375.

Common deficiencies in record keeping

Poor records dangers the patient, care-givers and health system.

Most common mistakes during keeping records are;

- An absence of clarity
- Inaccuracies
- Spelling mistakes
- Missing information
- Failure to record action taken when a problem has been identified.

https://www.ausmed.com/cpd/articles/record-keeping-documentation

What is the aim of clinical records?

- Helps our understanding the patient and solving the problem.
- Continuity of care
- Communication between different healthcare professionals
  - Benefit of patient; through less time lost on repeating tests and by averting inaccurate diagnoses or the prescription of inappropriate treatments
  - Benefit of the healthcare givers
  - Benefit of the security system and health economics
- The quality of healthcare services
- Investigating serious incidents, patient complaints and medicolegal issues.
  - Medical errors are the third leading cause of death in the United States, after heart disease and cancer.

Mathioudakis A, Rousalova I, Gagnat AA, et al. How to keep good clinical records. Breathe 2016; 12: 371–375.

Table 1 *Advantages of keeping good clinical records and the disadvantages of poor clinical records*

Good clinical records	Poor clinical records
Aid the sharing of relevant information and multidisciplinary team communication	Misinform healthcare professionals and patients
Aid coordination of care	Increase medico-legal risks
Aid continuity of care	Lead to unnecessary repetition of tests or other investigations
Aid informed decision making for patient management	Prolong hospital admission
Improve availability of data for risk assessment	Jeopardise patient care
Improve availability of data for route cause analysis in the investigation of serious incidents	Lead to serious incidents
Improve audit capabilities	
Provide informative evidence in a court of law	
Aid targeting of diagnostics and treatment plans without unnecessary repetition	
Improve time management	

Mathioudakis A, Rousalova I, Gagnat AA, et al. How to keep good clinical records. Breathe 2016; 12: 371–375.

Legal issues in record keeping

- Different laws in different countries
- Dynamic area
- Medical records rarely required for legal issues
- A patient or authorities have right of access medical records.
  - Must be a written request
- Confidentiality and data protection.
  - Sharing the data with patients consent
  - Sharing the data with other health professionals in emergency situations
    - In case of terorism, severe communcable diseases…
  - In Germany; clinicians can disclose confidential data without consent in order to safeguard a higher ranking legally protected interest.
  - About electronical records;
    - Strictly forbidden to share pictures with identifiable patients' data on Facebook, Twitter or other social media platforms.
    - Not permitted to share patients' data via Gmail, Dropbox, iCloud or personal nonencoded flash drives
- Patients' access to their medical records.
- If you did not write it down, it did not happen.
  - The courts generally; if amedical decision, treatment or procedure is not recorded in the clinical notes then it has not been performed.

Mathioudakis A, Rousalova I, Gagnat AA, et al. How to keep good clinical records. Breathe 2016; 12: 371–375.

- “Verba volant, scripta manent”

  (spoken words fly away, written words remain)

  Caius Titus

References

1. Mathioudakis A, Rousalova I, Gagnat AA, et al. How to keep good clinical records. Breathe 2016; 12: 371–375.
2. https://www.ausmed.com/cpd/articles/record-keeping-documentation
3. https://www.medicalprotection.org/southafrica/junior-doctor/volume-7-issue-1/the-importance-of-keeping-good-medical-records
4. https://www.avant.org.au/practicemanager/improve-your-practice/operations/pcehr/