Medical Case Note-Keeping & Documentation Practices

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Citation

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Abstract

An attempt has been made to analyse documentation of case notes and suggest changes. This retrospective study included 96 patient hospital visits of 5 randomly picked up case notes of patients who attended Eye clinic between 1st January 2005 to 30th June 2005. Appropriate paperwork and correct addressograph labels were found in more than 95 % cases. We found that maximum improvement was required in doctors signing their entries legibly, printing their names and writing the date and time of consultation. Pinpointing the clinical provisional diagnosis/diagnoses or impression(s) in the notes at the time of consultation specially before ordering investigations also needs to be given more importance.

This study was presented in the Royal College of Ophthalmologists Congress,UK, 2006.

INTRODUCTION

Well documented case records are essential for preserving and communicating information, for the continuity of care & for medicolegal purposes. An attempt has been made to analyse medical case note-keeping & documentation practices.

METHODS

This involved a retrospective study of 96 patient hospital visits of 5 randomly picked up case notes of patients who attended Eye care centre between 1st January 2005 to 30th June 2005.

The purpose was to assess the quality of note keeping , the quality of documentation of doctor's notes and whether correct paperwork has been used.

RESULTS

A total of 96 patient visits to eye centre were studied. Appropriate paperwork was used in 92.8% cases. 3 (0.07%) out of 39 sheets used were wasted. Addressograph labels were attached on each sheet in 97.2%. Date and time of each visit was recorded in 98.3% and 17.5 % cases respectively. Frequency of signing their entries, printing their names and writing their designation was 56.3%, 25% and 7.3 %. Diagnoses or impression were written in 28.1%, only dictated in 12.5% and both written and dictated in 33.3%.

DISCUSSION

Maintaining good standards of clinical documentation remains a problem in the health service despite continued and consistent advice from protection organisations and professional bodies over many years[1]. Incomplete documentation & illegible handwriting in notes is a major problem[2,3]. All clinical departments and hospitals should carry out detailed studies into the contents of their medical notes[4], and suggest changes and reaudit locally. Liyanage et al did four cycles of audit on note keeping in eye casualty and showed improvement in their record keeping[5].

The importance of using appropriate paper work with securely attached addressograph labels needs to be emphasised. We found that improvement was required in doctors signing their entries , printing their names and writing the date and time of consultation. It is suggested that doctors must date and time their entries in 24 hour clock. Each entry should be signed followed by printing surname in block capital letters and if appropriate, writing the respective designation and department. Another possible suggestion is to issue stamps to all doctors and nurse practitioners..

Although clinical findings were entered, a clinical provisional diagnosis or impression was not mentioned. Mentioning provisional diagnosis can be beneficial in case of ordering investigations like CT, MRI, blood tests. Retrospectively, this is useful to analyse as to how many of these investigations were actually indicated & the proportion of cases in which the investigation result matched with the clinical provisional impression. This helps in preventing a

shotgun approach to ordering investigations without complete clinical examination & helps optimal use of resources by avoiding unnecessary investigations.

Poor standards of clinical documentation plague all specialities. We emphasise and highlight the need for carrying out such audits regularly and implementing changes locally.

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