Abstract

New medical record keeping obligations are implemented by the Medical Practitioners Act (2007), effective July 2009. This audit, comprising review of 347 medical entries in 257 charts on one day, investigated compliance with the Act together with the general standard of medical record keeping. The Medical Council requirement was absent in all of 3 (8.6%) of entries; there was no unique identifier or signature in 28 (8%) and 135 (39%) of entries respectively. The case for change is discussed.

Introduction

The Medical Practitioners Act 2007 (Section 43(8)) introduced new record keeping obligations for medical practitioners; effective from July 2009. Medical practitioners are now obliged to include their Medical Council record number, together with their name, when recording clinical details pertaining to each patient. This is in addition to any local requirements. At renewal of annual registration, the Medical Council requires, by letter, each practitioner of their new obligations; the specific requirements are available on the Medical Council website.

Methods

We identified and examined at our institution charts from the 13 wards that care for acutely ill medical and surgical patients. All entries from the 14th of August were examined. Medical entries were scrutinised for the following: 1) Name of attending Service, 2) Name of attending Doctor, 3) Irish Medical Council registration number, and 4) valid contact [bleep] number. The entries were collected and collated on Excel and basic descriptive statistics were generated.

Results

A total of 257 charts were reviewed yielding 347 medical entries, an average of 1.36 per chart. Figure 1 summarises the functional characteristics of the records. Only 52% had a legible signature, and the service was not clearly identified for 48% of all records. We identified only 3 practitioners who were compliant, with the new Medical Council registration number obligation. It was not possible to discriminate any identifying feature for 28 (8%) of the total entries reviewed.

Discussion

There is clearly a compliance problem with this simple, unambiguous Medical Council directive. The problem may lie with poor communication of the change in legislation by the Medical Council. The adequacy of the communication plan and lack of broad dissemination could be questioned. Alternatively one could speculate that doctors have simply misunderstood the directive, or have chosen to ignore it. Irrespective of the root cause, there are significant deficiencies in medical record keeping highlighted in this study. A simple extrapolation of our findings would equate to over 300,000 hand written chart entries per annum for this institution. Given the increasing importance of electronic methods of data management it is worth considering whether paper based records are prudent. Consider that written entries into medical charts are not backed up in any meaningful fashion and are subject to the risk of fire, water or pest damage.

In Ontario, Canada there is electronic record keeping for paediatric patients. This accounts for three million children throughout the province of whom physicians have real time access to medical records. In this audit we could not identify the originators of 8% of entries, a potential problem if clinical or medicolegal questions arise. An audit from an Italian teaching hospital found that 2.3% of entries were untraceable. This strongly argues the case for improved record keeping systems, perhaps incorporating methods such as the electronic patient record. Hillis et al. proposed the potential benefits of electronic medical record keeping would include safeguarding of patient information, reduction in medical and clinical errors, improved efficiency and satisfaction for medical professionals as well as significant long term financial savings. Handwritten electronic medical record keeping was studied for a group of 78 orthopaedic patients; there was an improvement in comparison with paper documentation. In this study the medical record required additional training to utilize the electronic equipment optimally, in addition to the underlying cost overheads. Hillis suggested that the initial investment would be recouped over time through improvements in efficiency and resource utilisation.

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The results of our audit are interesting and raise questions firstly about an appropriate standard for clinical documentation. Second there is the question as to whether regulatory dictates, without a supporting active information campaign, to include rationale and persuasion, can be effectively translated into current practice. Given the surfeit of information technologies available perhaps we should consider moving to a comprehensive electronic patient record, sooner rather than later, in the interest of data security, clinical governance and patient care.

Key: ID- identity; Sig- signature; MCRN- Medical Council Registration Number.

References