Sticking to the rules: are you documenting your Irish Medical Council Registration Number?

Abstract:

Sir,

The latest Medical Practitioners Act added a requirement of documenting a medical registration number to aid in practitioner identification. Our study investigated whether this policy has been successfully implemented in a tertiary level Dublin hospital and it examined the effects of a simple adhesive note including an interns name, Medical Council Registration Number (MCRN), and bleep number on adherence to this policy. Medical record keeping is an increasingly complex area due to the medico-legal ramifications of the written medical record. The most recent Medical Practitioners Act added the requirement of documenting the MCRN to aid in practitioner identification. This identifier should be included on all medical prescriptions and all other documentation and records, whether in paper or electronic format, relating to that practitioner's practice...

The National Hospitals Office Code of Practice for Healthcare Records Management is one of many interlocking guidelines for record keeping in Ireland. There is however a large gap between the multiple policies and their implementation at the ward level in Ireland. It can be postulated that factors such as ineffective information about policies, high staff turnover, and time constraints have significant effects on policy implementation. For our study an initial questionnaire was distributed containing questions in relation the MCRN. This was followed up with an audit of MCRN documentation and after the initial audit was complete an adhesive note was designed that included the surgical interns name, MCRN, and bleep number. These were distributed across a number of surgical teams and charts were again audited post-intervention.

Questionnaire results (n=33) illustrated that 82% (27) of respondents had memorized their MCN. Of these respondents only 5(15%) always recorded their MCRN in chart notes. The majority of ward round notes were written by interns. The initial audit of 74 ward round notes found that only 5(7%) of the notes documented the MCRN. In terms of other identifiers, only 10(14%) of notes had the name of the person writing the note legibly printed. The most commonly legible identifier was the bleep number which was legible in 52(70%) of the notes examined. The recorded health professional data standards remarkably improved with the implementation of the adhesive ward round note. A total of 198 ward round notes were assessed in the 8 day review of charts post-intervention. Only 1(0.01%) of the control group notes examined had the health professional name printed and legible compared with 69(100%) in the study group. The MCRN was present in 1(0.1%) of the control group and 69(100%) of the study group. Finally the bleep number which was 69(100%) in the study group was followed in the control group with 120(93%) documentation. Poor compliance with current policy standards was illustrated in both the initial audit of ward round notes and in the control group of the intervention arm of the study.

We know there is a problem with this new legal requirement in regards to the MCRN; but what is the solution? There are certain to be many; the cheapest being simply taking time to write required information in a legible manner. Our intervention, however demonstrates that a simple adhesive based ward round note can significantly improve documentation standards in relation to core health professional data that is now a legal requirement. In addition, it allows for timely and accurate identification of teams and persons involved in decision making and patient care without increasing the work load on the clinician or the cost of care.

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References