Hospital Topics

The new Aberdeen medical record

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The bulk and disarray of many hospital medical records make it impossible to review and retrieve information easily, hamper the proper care of patients, and cause much time to be wasted. We describe a system which is convenient to use with traditional or problem-orientated medical records, and is easy to edit for destruction of documents or for transfer to microfilm or computer.

Background

Until 1955 each ward in the Aberdeen Hospitals Group was responsible for its own records, the notes of separate inpatient admissions being filed in chronological sequence. Outpatient records were kept in the outpatient department. With the introduction in 1955 of "unit filing" in a central records department the assorted notes of individual patients were assembled in a single case folder with a unique number. Unfortunately, the advantages of making records easily available to the whole hospital complex were soon offset by the disorganised growth of many of the case folders. In 1972 the medical staff committee foresaw that a clutter of dossiers of little help to current hospital practice would accumulate, which were too voluminous to store and whose disorder would make it impossible even to select particular documents to destroy, retain, or store in microfiche, computer, or peripheral buildings. In addition, a solitary summary sheet could not replace the case record to permit later destruction of the entire case record contents.

Some of our recommendations for a redesigned record are based on the work of national committees on the standardisation of hospital medical records[1-3] and a former local liaison committee on medical records.

The new Aberdeen medical record

The principle of the record, which has four sections, is that "like" documents are grouped together. This has the advantage that records may be read quickly with more confidence that information will be retrieved. In addition, editing selected documents is facilitated and

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adaptable to changes in policy by successive records committees. The sequence of arrangement of the new record is: group A—correspondence (letters and discharge summaries); group B—written case records; group C—investigation reports; group D—miscellaneous. Each document has an instruction printed at the bottom left-hand corner—for example, "file in section A."

DESCRIPTION

The *master registration card* (which contains the index of contents on the reverse side) is always the first document visible when the record is opened.

Group A—The filing instructions are that *irrespective of specialty* one copy of all letters and discharge summaries is filed in strict chronological order, with the most recent document uppermost. All papers relating to each specialty are identified by a colour flash—for example, accident and emergency has a black and blue flash.

Group B—The written case records are filed in alphabetical order of specialty. Each specialty has its own facing sheet, again with its own identifying colour flash, which is used for first referrals to that specialty only. Behind each facing sheet continuation sheets (also with coloured flash) are grouped in chronological sequence, irrespective of whether the attendance is inpatient or outpatient. Before outpatient consultations a bookmark is inserted by the records staff to indicate the section of the record the doctor must write in.

Group C—"Like" laboratory reports are filed alphabetically in strict chronological order for the following seven departments, each of which has a separate mount sheet: bacteriology; chemical pathology (continuous reporting); electrocardiography; haematology (continuous reporting being implemented) and blood transfusion; pathology, radioisotope studies, and electroencephalography; radiology, including computerised axial tomography and ultrasonic scans; side-room tests and miscellaneous. Reports are attached to mount sheets (the danger of hepatitis from licking gummed edges is emphasised). On these report forms the department and the nature and date of the examination appear at the top of the form to allow them to be easily read in the narrow space above the ensuing report. The grouping of all "like" laboratory reports, inpatient and outpatient, means that results can be found quickly in a predictable section of the record. It also aids rapid editing or transfer to microfilm or computer at a later date.

Group D—The miscellaneous groups of "like" documents are filed alphabetically in strict chronological order as follows: anaesthetic record; nursing records; prescription sheet—main; prescription sheet—fluid; prescription sheet—diabetic; prescription sheet—oral anticoagulant; prescription sheet—topical applications; any other documents marked "retain."

THE CASE RECORD FOLDER

A colour coding that depends on the terminal digit number is used, to identify misfilings in the central records department. The contents are held together by a plastic Zippel fastener (Scotia Office Machines, Edinburgh), which permits papers to be rapidly and easily inserted or removed at any part of the record. Folders with single and double spines are available. No clinical information is recorded on the case record folder so that it can be renewed if damaged, or if a larger folder is needed later. Because no information needs to be transcribed to the

new folder and the contents are easy to transfer, the staff of a busy records department have been able to replace damaged folders regularly. The space on the folder is used to print general instructions about the filing sequences to be followed in the record. The folder is divided into the four sections (A, B, C, D) by dividers on which the filing sequence for the subsequent section are printed. All new patients are issued with the new folder and all the earlier disordered notes are being converted to the new system as the records come into use, either at outpatient departments or in the wards. Help from the job creation programme has been invaluable.

EDITING

Legal points relating to destruction of medical records are set out in the appendix.

Initial editing—In the Aberdeen hospitals the following are discarded, unless marked "retain," after an inpatient admission: patient's identification labels and backing; unused anaesthetic forms and unused consent forms; fluid intake and output charts; four-hourly temperature charts; morning and evening temperature charts of afebrile patients; check lists of investigations requested; blood-pressure charts; weight charts; medication on discharge sheet; drug recording sheets (which go to secondary storage, a copy of the main prescription sheet remaining in the record); and duplicate or unused papers and forms.

Later editing—The grouping of "like" documents allows for flexibility in the choice of documents for editing and in the timescale of such editing. Changes in policy by successive records committees can also be implemented without undue difficulty. The present policy is that group A papers are microfilmed 15 years after the last contact of the patient with hospital or six years after death, and group B, C, and D papers are destroyed 15 years after the last contact or six years after death.

RESPONSIBILITY

The responsibility for implementing the system is shared by the clinical consultants and the area and district records officers. Some departments (for example, diabetic and oncology) retain their own filing systems, but copies of their correspondence, letters, and summaries are included in the main record.

Progress

The new records system was introduced early in 1975. We feared that despite the approval of the hospitals' medical staff committee, junior staff might not co-operate in implementing the detailed parts of the system and that consultants might be lukewarm in their approach. But in the last three years the recommendations have been carried out and the greatly improved record has been a source of satisfaction to most clinicians. Staff in the medical records department have also co-operated wholeheartedly and have themselves gained advantages from the ordered record. For example, they find that they can extract data for the national morbidity scheme much more easily, and that the quality of the submissions from the available clerical resources is enhanced. Other developments, such as producing clinical summaries, microfilming, a master patient index for the area, problem-orientated medical records, and computerisation of aspects of the record, are progressing well.[6] [7]

Discussion

Unless they are suitably modified, conventional records tend to come to grief in the avalanche of paperwork released by medical technology and specialisation; and they are ill adapted to changes in clinical practice that have brought more periods of off-duty and more frequent transfer of responsibility to colleagues. When papers accumulate chaotically in the folders much time is wasted in clumsy attempts to retrieve information;

important facts about patients and their problems and drug treatment are obscured; and the records, nearly impossible to edit, become voluminous and outrun storage space.

New record systems such as problem-orientated medical records will not solve these problems by themselves. Their success depends on the prior ordering and arrangement of the record so that clinical data can be found readily and reliably. In addition, editing or microfilming ordered, selected, "like" documents is infinitely more useful than uncritically and non-selectively destroying or microfilming disordered papers; and similar considerations apply to computers, continuous reporting in the laboratory, and problem-orientated medical records. Our new Aberdeen record has facilitated all these developments and has been well received throughout the Aberdeen hospitals.

Appendix

LEGAL POINTS RELATING TO EDITING[1] [5]

Medical records and allied documents in hospitals other than mental hospitals and mental deficiency institutions may be destroyed after the following periods:

Medical records and allied documents:	Period after which documents may be destroyed:
(a) Medical records, including: clinical notes (such as reports from pathological, radiological, and other special departments; x-ray pictures; electrocardio-graphic and electroencephalo-graphic records); records of all types of special departments (including almoners' records); consent forms of all types; operation books; casualty notes; appliance order forms Nos 1, 2, and 3; day and night nursing report books.	Six years after the patient's treatment at the hospital has ended. (When the patient dies in hospital the records may be destroyed three years after death.) Destruction of any clinical notes is subject to the overriding provisions of paragraph 7 of the prefatory note.[4]
(b) Ancillary records, including prescriptions, departmental registers, appointment sheets, attendance registers, etc.	Three years after the patient's treatment at the hospital has ended.
(c) Four-hourly temperature charts, fluid intake and output charts, and other similar ephemeral records (provided that they reveal no abnormal conditions and that no notes are written on them).	On discharge of the patient, provided that the patient is discharged without incident.

References

[1] Ministry of Health, *The Standardisation of Hospital Medical Records.* London, HMSO, 1965.
[2] Scottish Home and Health Department, *Hospital Medical Records in Scotland.* Edinburgh, HMSO, 1967.
[3] Scottish Home and Health Department, *Standardisation of Hospital Medical Records.* Edinburgh, HMSO, 1973.
[4] *Public Records of Scotland, Eighth Schedule* (SHM 58/60). Edinburgh, Department of Health for Scotland, 1958.
[5] Benjamin, B, *Medical Records.* London, Heinemann, 1977.
[6] Petrie, J C, in *The Problem Orientated Medical Record,* ed J C Petrie and N McIntyre, ch 3. Edinburgh, Churchill Livingstone, 1978.
[7] Lindsey, D C, Meredith, A L, and Petrie, J C, *MedComp,* 1977, 1, 725.