How bad are medical records? A review of the notes received by a practice

BRIAN G. MANSFIELD, MA, MSc, BM
Trainee General Practitioner, Exeter

SUMMARY. One hundred and fifty-five medical records received by a practice as a result of transfer of care were examined. It was found that the marital status was recorded for 30% of patients aged over 16 years and the occupation noted for only 15% of patients of working age. Twenty-three per cent of the notes included a summary of the patient's history and 39% contained an immunization record. Of the notes for women aged between 16 and 60 years 48% contained a recent cervical smear report. This percentage increased to 61% for women aged 35–60 years. Of the entries examined 86.2% were legible. It is concluded that either doctors do not know as much about their patients as they should or they attempt to carry too much information in their heads.

Introduction

IN paragraph 5.6 of the RCGP *Evidence to the Royal Commission on the National Health Service*[1] it is stated 'We have two compatible objectives: first to provide an efficient record for everyday use, and secondly to provide a system whereby simple information relating to a doctor's practice can be collated and compared with information from other practices'. In its policy statement *Quality in practice*[2] the College further asserts that 'This deficiency of data can only be made good by improving the quality of record-keeping in general practice'.

The aims of this study were to assess the standard of medical records received by a practice. The following aspects of medical record-keeping were examined: the recording of basic information about patients (marital status and occupation); the accessibility of important data (the presence of summary cards for history, repeat medication and contraception); the evidence for the performance of preventive care (cervical smears and immunization); and the legibility of the entries.

Method

The study was carried out in an urban practice in Devon with four doctors and a list of approximately 9000 patients. All of the medical records received by the practice from the family practitioner committee were examined until notes from 100 different general practitioners had been received. The notes were reviewed for the following: the patient's age and sex; the patient's marital status (if aged over 16 years); the patient's occupation (if aged 16–60 years for women, or 16–65 years for men); a completed summary card; a separate record for repeat medication; a record of any immunization; a separate record for contraception (for a woman aged 16–50 years); and a report of a cervical smear performed in the last five years (for a woman aged 16–60 years).

The following information was also noted: the legibility of the last four entries (if there were less than four the number of entries was also recorded), the delay between the patient registering with the practice (shown by the date on a loose FP7/8 filed in the practice notes at the time of registration) and receipt of the record, and the name of the last doctor (as recorded on the front of the record envelope).

Results

One hundred and eighty-two records were examined over a 10-week period (equivalent to an annual turnover of just over 10% of the practice list). Of these, 155 notes were from general practitioners outside the practice and of the remaining 27, 13 were for newborn infants and 14 were constructed. Seventy-five of the practitioners transferred only one set of notes to the practice in the study period while 25 transferred 80 sets of notes, each doctor transferring between two and nine records. The doctor transferring nine records had recently retired.

Which items were recorded in the 155 sets of notes are shown in Table 1. Of 586 entries examined 505 (86.2%) were found to be legible (every word could be clearly deciphered). The delay in receiving the records was ascertained in 104 cases and ranged from three to 64 weeks with 49 sets of notes taking more than 10 weeks to arrive. Of the 53 records received from Devon practices 51 were received in less than 10 weeks.

Table 1. Characteristics recorded in the 155 sets of notes examined.

Characteristic	Potential no. of recordings (males, females)	Actual no. of recordings (% of potential no.) All notes	Male patients	Female patients
Sex	155 (72,83)	155 (*100*)	72 (*100*)	83 (*100*)
Age	155 (72,83)	155 (*100*)	72 (*100*)	83 (*100*)
Marital status	125 (55,70)	38 (*30*)	2 (*4*)	36 (*51*)
Occupation	112 (50,62)	17 (*15*)	8 (*16*)	9 (*15*)
History summary	155	36 (*23*)		
Repeat medication record	155	23 (*15*)		
Immunization record	155	60 (*39*)		
Contraception record	56			10 (*18*)
Recent cervical smear	62			30 (*48*)
Recent cervical smear in women aged 35–60 yrs.	18			11 (*61*)

Discussion

The RCGP report *'What sort of doctor?'*[3] suggests that medical records should be 'complete', 'legible' and organized so as to 'convey the key features'. The sample examined in this study, albeit small, reveals a large discrepancy between current practice and this ideal.

In 1972 Dawes[4] carried out a survey of 1628 records from eight different practices and was only able to ascertain the patient's age in 90.6% of cases. In this study the patient's age could be determined from all the notes examined. The figures found by Dawes for the recording of marital status (1.3% for men and 78.5% for women) and occupation (39.5% for men and 22.4%

for women) are fairly similar to the results found here, and certainly this study shows no detectable improvement in the level of recording.

Moulds[5] also reported that the notes received by his practice were in an 'abysmal state'; he found summary cards in only 15 out of 1000 notes and a separate record for repeat medication in only eight. The gradual introduction of summary cards for both history and continued medication is the latest recommendation from the Joint Committee on Postgraduate Training for General Practice for the improvement of record-keeping in training practices. Of the 155 records reviewed here 36 contained summaries of the patient's history and 23 summaries of continuing medication. This gives a measure of the workload facing this practice in keeping all of its records summarized. The usefulness of summaries is widely recognized, particularly when a patient is seen by more than one doctor or is transferring to the care of another doctor, during out-of-hours visits and in the preparation of insurance reports. Stuart[6] suggested the inclusion of a summary as a possible objective for record improvement. Indeed, the *What sort of doctor?* report[3] emphasized that entries should be retrievable and suggested a completed summary sheet (in addition to the date of birth, marital status, occupation and a record of continued medication) as a guide to the quality of record-keeping in a practice.

In the area of preventive care *What sort of doctor?* suggests that doctors should 'Consistently give evidence of a willingness and ability to give both opportunistic and anticipatory care.' In this study there was no record of any immunizations in 61% of records. It is also disappointing that less than 50% of women aged over 16 years had had a cervical smear performed in the preceeding five years.

For any record to be of value it must be both legible and accessible. It was reassuring to find that 86.2% of the entries examined were totally legible. However, there is still some room for improvement. The long delays involved in the transfer of records are worrying. This study does not attempt to identify the source of the delay, but it is of note that 51 of the 53 notes from other practices in Devon, an area served by a family practitioner committee which is computerized, arrived in less than 10 weeks.

Taylor[7] asserted that 'Doctors who claim that they can carry in their heads all the information needed to deal with each of their patients usually have low standards of both need and performance.' It can be concluded that either doctors do not know their patients as they should or they attempt to carry too much information about patients in their heads.

References

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Address for correspondence

Dr B.G. Mansfield, 9 Greenacres, Wrefords Lane, Exeter EX4 5BS.