Hospital Practice

Notes: a suitable case for audit

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Summary: The increasing emphasis on management responsibilities and audit led us to investigate the state of surgical notes in our hospital. Twelve criteria were evaluated regarding information that should be contained in the notes and the absence of this important information was documented. Deficiencies were revealed in all criteria selected. Until hospital patients files are well kept and maintained, retrospective audit whether financial or medical will not be valid. A significant injection of resources is required to redress the situation. Hospitals which have not carried out detailed studies into the contents of their notes need to do so as a matter of urgency.

Introduction

As a result of the recent Government white paper¹ there has been a radical change in the management role of the hospital consultant. Consultants are now held responsible for the correct medical coding of diagnoses and operations and for auditing the performance of their clinical practice. These responsibilities have been imposed against a background of progressive secretarial and clinical cuts which have eroded the administrative mechanism for producing such data.

In 1988, Duncan *et al.*² clearly showed the problems of missing patients files and data and their impact on outpatient services in our hospital. Although storage and retrieval of hospital notes poses a vast problem for the National Health Service,³ we were concerned about the content, quality and appropriateness of hospital notes for medical audit. This stimulated us to evaluate the notes in the surgical departments of our hospital.

Method

The study was carried out during April 1991 by 11 consultant surgeons at the Whittington Hospital (two urologists, one ear, nose and throat surgeon, two orthopaedic surgeons and six general surgeons). The first 10 consecutive sets of hospital patient files were selected from the consultant outpatient clinics, of patients who had been in-patients under their care within the last year. In some general surgical clinics it was not possible to collect ten sets of notes. Table I shows the criteria

that were evaluated in the questionnaire. This was completed by consultants for each patient file analysed. Twelve criteria were selected for their importance in surgical audit, not all of these were appropriate for each case. For example, some cases did not attend the accident and emergency department. If a particular record should have been in the patient's records (that is, the histology report) but was not, then this was recorded as a 'missing criterion'. Each consultant evaluated his own notes, to mark whether each criterion was present or absent and whether it was filed or loose in the notes (that is, unfiled). Criterion 12 was included to allow the consultants to evaluate other data which might be missing but would only be apparent to specialists in their own fields. The condition of medical notes was examined to see whether all the reports were in the correct section of the notes and that all this information was properly bound with the plastic binder. Although this criterion was not directly related to the contents of the notes it would explain why some information was not present (Criterion 11 – Table I).

Results

The specialty breakdown of patients records were 20 urology, 10 ear, nose and throat, 20 orthopaedic and 54 general surgery. The results were divided into four phases: preoperative, operative, investigative and postoperative. These are tabulated in Table I. In each of the 12 categories, if a result was absent from the notes which should have been present then that information was regarded as appropriately missing.

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Table I Shows the contents of the notes that were examined and those that were appropriately missing

	<i>No. of missing criteria</i>	<i>No. that should have been present</i>	<i>% missing</i>
<i>Preoperative phase</i>			
1. Casualty record	22	53	42
2. Letter from outpatients	12	70	17
3. GP referral letter	24	75	32
<i>Operative phase</i>			
4. Anaesthetic record	8	86	9
5. Operation notes	11	97	11
6. Postoperative note	37	100	37
<i>Investigations</i>			
7. Blood results	21	74	28
8. X-ray reports	31	68	46
9. Histopathology	28	70	40
<i>Postoperative phase</i>			
10. Discharge summary to GP	27	104	26
11. Files bound	53	104	51
12. Other significant data missing	5	104	5

GP = general practitioner.

Discussion

Missing data have medical, financial, managerial and medico-legal implications. Ideally no data should be missing and therefore any data which are missing are significant. The Department of Health has laid down guidelines on how long hospital records should be retained for but also advises the health authority to determine in consultation with the health professionals their policy with regard to elements of the patients' records which may be discarded as their value ceases.⁴

Missing records are a great problem in hospitals⁵ but this study was more concerned with the contents of the patients' notes, and in particular the availability of results and procedure records to the doctor managing that patient.

Although the study could be criticized for allowing the consultants to evaluate their own notes, it was felt that they would be able to evaluate their own notes far more accurately than a consultant from a different specialty and the results support this decision. Thirty-two per cent of referral letters from general practitioners were not in the notes and 46% of X-ray reports were missing from the records.

It was alarming that 37% of postoperative notes on our surgical wards were lost or never actually existed and the histopathology report was missing, in 40% of cases which may have medico-legal implications.

An audit of the quality of medical records in a district general medical unit⁶ also found many deficiencies in the hospital notes. In one hospital

only 44% had correct filing of the discharge summaries and correspondence. They also found that only on 24% of the occasions when diagnostic radiology had been performed was a report present in the case notes and even some of these had been filed in the wrong areas of the notes.

There were two possible explanations for the missing data. Either data have been lost or they were never entered in the first place. Reference to missing operation and anaesthetic records suggest the former as patients are not allowed to pass through the theatre recovery room without this information attached to the notes. Mackay⁷ has discussed the anaesthetic record and concluded that medico-legal protection is better guaranteed if a detailed anaesthetic record is available. In the present study 9% of the anaesthetic records were missing completely. It is not difficult to imagine these vital pieces falling out of the hospital notes in transit as 51% of the hospital notes were unbound.

Reference to the data on discharge summaries to general practitioners shows that 26% are missing. This corresponds with the frequent complaints received from general practitioners that they do not receive this information. It is again unclear if these letters were lost or never actually completed.

The format of hospital notes may not be conducive to easy filing as the notes have to be dismantled to add or remove a single sheet of paper. Hutchison⁸ describes the poor state of the structure of the case record and how debulking the notes, compartmentalizing and using the gazebo mediclip in the folder may improve storage access

and use of hospital notes. The gazebo mediclip allows documents to be inserted and removed without dismantling the whole set of notes. The most important feature of hospital notes is the ease of access to the information they contain. This information must be compartmentalized and securely fastened in the notes or it will be lost.

Medical audit is laudable and indeed initiated this study. Well-completed, readily accessible medical records are the foundation of medical

audit.⁹ This is not a problem confined to our hospital or even just surgical units. Foubister¹⁰ carried out a prospective and retrospective study on femoral neck fractures. The data from the retrospective study were collected from theatre records and medical notes and were shown to be unreliable for clinical reviews. We suggest hospitals who have not reviewed their hospital notes do so with some urgency.

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