ESSENTIAL GUIDE SERIES | PART 1

MORE THAN DEFENCE

Medical Protection

AN ESSENTIAL GUIDE TO MEDICAL RECORDS

ADVICE FOR THE UNITED KINGDOM

medicalprotection.org

INTRODUCTION

This Essential Guide was produced as a resource for MPS members in the UK. It is intended as general guidance only.

In this guide:

- **Introduction**
- **What makes good clinical records?**
- **Confidentiality**
- **Retention of medical records**
- **Relevant legislation**
- **Cases**

MPS members are always welcome to telephone our medicolegal advice line – **0800 561 9090** – for more specific practical advice and support with medicolegal issues that may arise.

Alternatively, members may submit a medicolegal query online.

Good clinical records are a prerequisite of delivering high-quality, evidence-based healthcare, particularly where a number of different clinicians are contributing simultaneously to patient care. Unless everyone involved in clinical management has access to the information they require, duplication of work, delays and mistakes are inevitable. Records may be held electronically or manually, or a mixture of both.

If essential information is missing, found to be inaccurate or indecipherable, cases may be lost when they could otherwise have been won.

The main purpose of any clinical record is to provide continuity of care, but medical records are also used for other purposes:

- Administrative and managerial decision-making within the NHS
- Meeting current legal requirements, including enabling patients to access their records
- Assisting in clinical audit
- Supporting improvements in clinical effectiveness through research.
- Providing the necessary factual base for responding to complaints and clinical negligence claims

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In the event of a complaint, clinical negligence claim or disciplinary proceedings, the doctor's defence will in large part depend upon the evidence available in the clinical records. If essential information is missing, found to be inaccurate or indecipherable, cases may be lost when they could otherwise have been won.

Clinical records include a wide variety of documents generated on, or on behalf of, all the health professionals involved in patient care. This includes:

- Handwritten clinical notes
- Computerised/electronic clinical records
- Emails
- Scanned records

- Text messages (both outgoing from the NHS/professional and incoming from patients)
- Correspondence between health professionals
- Laboratory results
- X-ray films and other imaging records
- Photographs
- Videos and audio recordings
- Printouts from monitoring equipment, particularly in anaesthesia and obstetrics, A&E and ICU
- Consent forms

WHAT MAKES GOOD CLINICAL RECORDS?

CONTENT

Good clinical records will allow a clinician to reconstruct a consultation or patient contact without relying on memory. This will include:

- History – relevant to the condition including any positive and negative answers to direct questions
- Examination of the patient
- All systems examined
- All important findings, both positive and negative, with details of any objective measurement such as blood pressure, peak flow, etc
- Differential diagnosis
- Investigations – details of any investigations arranged
- Referral – details of any referral made
- Information – information given to the patient concerning risks and benefits of proposed treatments
- Capacity and consent – details of the patient's capacity to consent (or lack of capacity) and their consent to proposed investigations, treatments or procedures

- Treatment – details of the main doses of drugs, total amount prescribed, any other treatment organised with batch number and expiry date of any medications personally administered
- Follow-up – arrangements for follow-up tests, future appointments and referrals made
- Progress – any further consultations, how the patient's condition has progressed.
- Discharge plans – details of information provided about when and where to seek medical advice in future

> If the records are unclear, inaccurate or written in such a way that they're difficult to follow, it could cause errors and misunderstandings.

PRESENTATION

Presentation is also important. If the records are unclear, inaccurate or written in such a way that they're difficult to follow, this could cause errors and misunderstandings. Good notes have the following attributes:

- Clear – both legible and understandable when handwritten. Each entry should be legibly signed with the date and time
- Objective – clinical records should be factual and free from subjective comments about patients or their relatives. Always assume that patients will read their clinical records at some stage
- Contemporaneous – clinical records should be written up at the time to ensure accuracy
- Attributable – if information has been given to you by someone other than the patient, then you should record who provided the information as well as what they said
- Original – sometimes it is necessary to amend or alter medical records, for example if a factual error has been made. Any correction must be clearly shown as an alteration, complete with the date the amendment was made and the name of the person who made it so there can be no allegation that the alteration was an attempt to deceive anyone into thinking that it is part of the original record

CONFIDENTIALITY

There is a common-law duty to preserve professional confidence

Confidentiality may seem a very straightforward principle, but translating principle into practice can be problematic. There are all sorts of situations where it is difficult to know if patient information should be shared or not – with the police, for example, or Social Services.

Confidentiality is a legal principle and the following should be noted:

- NHS employees will find a confidentiality clause in their contract;
- There is a common-law duty to preserve professional confidence;
- There are requirements under the Data Protection Act 1998 to keep personal data, including medical records, secure;
- It is a condition of registration to abide by GMC guidance, which includes a requirement to respect patient confidentiality;
- The Information Commissioner can impose a Civil Monetary Penalty on an organisation of a maximum of £500,000 if there is a serious breach of the Data Protection Act and the data controller acted deliberately, or was reckless, and the breach was of a kind likely to cause substantial distress or damages to an individual;
- The duty of confidentiality goes beyond undertaking not to divulge confidential information; it includes a responsibility to make sure that written patient information is kept securely. Confidential records should not be left where other people may have casual access to them and information about patients should be sent under private and confidential cover, with appropriate measures to ensure that it does not go astray.

Confidentiality is not an absolute principle – there are several exceptions, and these are listed below. You can find more comprehensive information by following the provided links to the relevant GMC guidance.

> The duty of confidentiality goes beyond undertaking not to divulge confidential information; it includes a responsibility to make sure that written patient information is kept securely.

- **Disclosure with patient consent**
  GMC, *Confidentiality* (2009), paras 24-35
- **Disclosure without patient consent**
  Information can be disclosed without the patient's consent in two instances:
  - If required by the law – see GMC, *Confidentiality* (2009), paras 17-23
  - If it is in the public interest – see GMC, *Confidentiality* (2009), paras 36-39
- **Members of the clinical team**
  GMC, *Confidentiality* (2009), paras 25-29
- **Publishing case reports, photographs and recordings**
  GMC, *Making and Using Visual and Audio Recordings of Patients* (2011)
- **Relatives**
  GMC, *Confidentiality* (2009), paras 64-66
- **Reports to the DVLA/DVA**
  GMC, *Confidentiality: Reporting Concerns about Patients to the DVLA or the DVA* (2009)
- **Child protection**
  GMC, *Protecting Children and Young People: the Responsibilities of all Doctors* (2012), paras 28-51
  GMC, *0-18 Years: Guidance for All Doctors* (2007), paras 42-52
- **Communicable diseases**
  GMC, *Confidentiality: Disclosing Information about Serious Communicable Diseases* (2009)
- **Confidentiality after death**
  GMC, *Confidentiality* (2009), paras 70-72
- **Insurance and employment purposes**
  GMC, *Confidentiality: Disclosing Information for Insurance, Employment and Similar Purposes* (2009)
  GMC, *Disclosing Records for Financial and Administrative Purposes* (2009)
  GMC, *Disclosing information for Education and Training Purposes* (2009)

RETENTION OF MEDICAL RECORDS

The following national guidelines should be adhered to: *Department of Health, Records Management: NHS Code of Practice* (2006).

- www.gov.uk/government/publications/records-management-nhs-code-of-practice

RELEVANT LEGISLATION

You should be familiar with the principles of the following pieces of legislation.

The laws affecting healthcare can be complex; remember that a call to an MPS medicolegal adviser can help to clarify any areas of uncertainty.

- Data Protection Act 1998
- Access to Medical Reports Act 1988
- Access to Health Records Act 1990

CASES

ILLUSTRATIVE CASES

Case 1
At six months old, a boy suffered with diarrhoea and vomiting. His GP was called and treatment provided at home. Due to severe dehydration, he became both physically and mentally handicapped. When he was in his 20s, a solicitor suggested investigating the circumstances surrounding the illness and a claim of negligence arose. By this time, the GP had died, leaving only brief medical records of his consultations. In the absence of any robust evidence to the contrary, the claim against the doctor's estate had to be settled.

Case 2
A 26-year-old single woman went to see her GP complaining of blackouts. He referred her to a neurologist, giving a detailed account of the blackouts but not disclosing the medication she was on, which included the oral contraceptive pill. The neurologist started the patient on anticonvulsants. Three months later she conceived.

Her claim against both doctors succeeded. As the GP had failed to alert the neurologist to the fact the patient was taking the oral contraceptive pill, and the neurologist had not asked about medication, both had been in breach of their duty of care, causing the unwanted pregnancy.

Case 3
A 38-year-old woman phoned her GP surgery complaining of back pain and difficulty passing urine. The GP checked her notes and saw a reference to PID, which he interpreted as pelvic inflammatory disease. He concluded that she had another urinary tract infection and wrote a prescription for antibiotics for the patient to collect.

In fact PID referred to her recurring problems with a prolapsed intervertebral disc which had now given rise to a cauda equina syndrome and associated pain and urinary symptoms.

> In fact PID referred to her recurring problems with a prolapsed intervertebral disc

Case 4
A 56-year-old man saw a printout of his clinical records in connection with a claim following a road traffic accident. He was surprised to see in his records a reference to the local GUM clinic and asked that this be removed. Further investigation confirmed that he had never been to a GUM clinic so the record was clearly incorrect.

The computerised record was amended with a note stating that the relevant data was deleted by his GP on the basis of it being inaccurate; the archived paper records were retrieved and the reference to the GUM clinic blocked out in black ink with a signed and dated note explaining that an incorrect entry had been deleted.

> Unhappy with its contents, she asked the GP to change it. He declined, saying that it was factually accurate and the details given were relevant

Case 5
Following a road traffic accident, a patient claimed compensation for a whiplash injury.

Her insurers requested a report from her GP, but the patient exercised her right under the Access to Medical Reports Act 1988 to view the report before it was despatched.

Unhappy with its contents, she asked the GP to change it. He declined, saying that it was factually accurate and the details given were relevant so it was inappropriate for him to make the requested alterations. He explained that her options were:

- (a) to refuse to allow the report to be sent to the insurance company,
- (b) to allow the report to be sent but to add a statement of her own to it, or
- (c) to allow the report to be sent as it was.

NOTES

ABOUT MPS

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Membership provides access to expert advice and support as well as the right to request indemnity for any complaints or claims arising from professional practice. Highly qualified advisers are on hand to talk through a question or concern at any time.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

HOW TO CONTACT US

THE MEDICAL PROTECTION SOCIETY
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Please direct all comments, questions or suggestions about MPS service, policy and operations to:

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In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

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