# The Management of Patient Records in the Practice

Dr. Illona Duffy & Mr. Dermot Folan

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# Patient Records

- Practice Management
- Access: external access to patient records and practice's response!

# Practice Management Issues

- **CONFIDENTIALITY**
  - A defined approach
  - Implicit/Explicit **term of employment contract**, clarity with employees about repercussions of any breach of confidentiality.
  - **Staff training/documentation** e.g. discussing patient information externally**.**
  - **Protocols** responding to requests for access to records/ responding to requests for information e.g. parent ringing to see if child attended practice that day.

# Practice Management Issues

- ACCESS – INTERNAL

  - What constitutes appropriate access to records?
    e.g. staff aware that patient notes and files are absolutely private and should never be read (consider: family members of staff).

  - + / - of defined levels of access e.g.: clinical notes only available to doctors and nurses.

# External requests and practice response

- **PATIENT**
  - Who owns records?
  - What rights has patient to their records?
  - Transfer of files to another GP
  - Patient moving abroad and requesting records?
  - Legal implications – Data Protection Act, FOI etc.

# External requests and practice response

- **OTHERS**
  - Solicitors as part of litigation/claim
  - Solicitors as part of litigation against GP
  - PMA
  - Court requests
  - Informed consent by patient – **who informs**?

# Quality of the Patient Record

# Quality

- PRACTICE PROTOCOLS REGARDING RECORD KEEPING
  - ‘Quality’ of notes
  - Policy re: note keeping of telephone consultations, home visits and out-lying clinics.
  - Policy re: locums and notes and identification.

# Different Note-Taking Standards

(A) Dr. Keats

20/2, Headache. Flu-like? Reassure.

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(B) Dr. Gogarty

20/2/07. Frontal headache. Complaining of occasional flu-like symptoms.

On examination: Temp normal. BP 120/80. No photophobia. Pupils equal, reactive to light. Fundoscopy normal. Alert. No vomiting. No rash.

Impression: Possible viral infect. No evidence of hypertension, meningitis or intracranial lesion. Reassured but to return if symptoms persist.

# Good written clinical records

- the permanent contemporaneous record of consultation. Not tainted with hindsight, not subject to any other vagaries of the human memory.

- Clarity in clinical records: insurance against the passage of time and against misunderstandings on the part of those reading the notes, whether for medical or legal purposes.

Dr. S. Mills Clinical Practice & the Law, 2nd ed. 2007 pg. 112

# Good written records (2)

- If a practitioner keeps no notes of a consultation, it will be difficult for her to defend herself against allegations of malpractice, even if those allegations are dubious or unfounded.
- Clinical records should be both **accurate** and **adequate** – conclusions reached and decisions taken and the context of any decision or conclusion.
- If abbreviations are to be used in clinical notes they should be as far as possible **standard** abbreviations. Whether standard or not, they should be **consistent**.

# Practice Management Issues

- MAINTENANCE OF RECORDS
  - Safety both of paper and computer files.
  - Paper files – storage, fire and theft proof.
  - Computerised – backup, virus protection, laptops, audit trails.
  - How long to keep records.

# Practice Policies

- Defined policies clarifies matters for you & practice personnel.
- Ensures consistency of response to requests.
- Ensures professional response.

# To find out more:

- Online information in Practice Management section www.icgp.ie

- Library and Publications www.icgp.ie/library

This presentation will be available online www.icgp.ie