



The Royal College of Surgeons of England

Guidelines for Clinicians on Medical Records and Notes

The *Guidelines to Clinical Audit in Surgical Practice* issued in June 1995 by The Royal College of Surgeons of England comprised an outline of the underlying principles of clinical audit and the basic components of a surgical audit programme.

The *Guidelines for Clinicians on Medical Records and Notes* have been prepared to assist clinicians with the medical records which are fundamental for clinical care and the audit of surgical services.

The College's Hospital Recognition Committee (HRC), as part of its quinquennial inspection of accredited hospitals, will scrutinise hospital records to ensure that optimum standards of surgical care are being provided. Where surgical notes are produced by computer a paper copy should always be made and filed in the hospital record.

The Royal College of Surgeons (RCS), emphasises to units and hospitals the importance of maintaining and securely storing medical records. Accessible medical records are essential to clinical care, follow up and audit.

Clinicians are reminded that an accurate record should be made of the regular clinical review and surgical audit. The maintenance of this record is the responsibility of the Royal College of Surgeons' tutor. The records should include the names of all consultants and trainees attending each meeting, the topics discussed and the decisions reached.

Trainees are also reminded that log books are now required for higher examinations. Accurate clinical records are essential for the preparation of log books.

Guidelines produced 1990 and revised 1994

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1. THE HOSPITAL RECORD

A hospital record must be maintained for every patient. Each record should contain the following identification data:

- (i) a unique medical record number or reference on every page,
- (ii) name in full on every page,
- (iii) address and postcode,
- (iv) telephone number,
- (v) date of birth,
- (vi) sex,
- (vii) person to notify in an emergency (next of kin),
- (viii) occupation and marital status, and
- (ix) the patient's registered general practitioner.

2. THE CLINICAL RECORD

A. The notes should contain the following details:

- (i) an initial patient history with details of previous illnesses, the social and environmental context of the illness when appropriate and details of medication,
- (ii) details of the initial physical examination, including the patient's height and weight, and
- (iii) a working diagnosis and medical care plan should be written down.

B. These notes should be supplemented and updated regularly to include details and reports of all investigations, treatments and verbal advice given to the patient and his or her relatives.

C. An entry must be made on discharge recording the clinician responsible for the decision to discharge, the status and destination of the patient, and arrangements for follow up. A copy of the preliminary discharge letter (section 6A) should be filed in the notes.

3. THE NURSING RECORD AND CARE PLAN

The nursing record is an important part of the hospital record and should be filed in a clearly designated part of the clinical record.

4. PATIENTS UNDERGOING SURGERY

A. For patients undergoing surgery, records should include details of the following:

- (i) signed evidence that informed consent has been obtained by a doctor or an appropriately trained nurse practitioner,
- (ii) signed evidence that the correct procedure was followed when obtaining consent for children under the age of 16 years, and
- (iii) the medical care plan should include the site and side of any operative procedure. Sites and sides must be written out in full and not abbreviated.

- B. A record of the operation should be made immediately following surgery and should include:
- (i) the name of the operation surgeon(s) and the name of the consultant responsible,
 - (ii) the diagnosis made and the procedure performed,
 - (iii) description of the findings,
 - (iv) details of tissue removed, altered or added,
 - (v) details of serial numbers of prosthetics used,
 - (vi) details of sutures used,
 - (vii) an accurate description of any difficulties or complications encountered and how these were overcome,
 - (viii) immediate post-operative instructions, and
 - (ix) the surgeon's signature.
- C. The record should also contain information relating to anaesthesia including:
- (i) the name of the anaesthetist and, where relevant, the name of the consultant anaesthetist responsible,
 - (ii) pre-operative assessment by the anaesthetist,
 - (iii) drugs and doses given during anaesthesia and route of administration,
 - (iv) monitoring data,
 - (v) intravenous fluid therapy, if given,
 - (vi) post-anaesthetic instructions, and
 - (vii) name and signature of anaesthetist.
- D. The anaesthetic record should be filed with the clinical record, NOT separately in another place.

5. PATIENTS IN INTENSIVE THERAPY UNITS

- A. The record should include:
- (i) a clear statement why the patient was admitted to the ITU,
 - (ii) an accurate record of monitoring of the physiological state while the patient was in ITU, and
 - (iii) contemporaneous details of all therapeutic manoeuvres performed.
- B. When the patient is moved from the ITU, a description of the patient's clinical status must be written down and the reason for transfer adequately described in the notes.

6. DETAILS ON DISCHARGE

- A. On discharge all patients should take with them a brief summary notes containing the name of the consultant in charge, operation(s), diagnoses, current ongoing medication and arrangements for wound management.
- B. For each patient there should be a discharge summary/letter which is completed within 14 days of the patient's discharge. This should include a précis of the clinical notes, the full diagnosis and the name of the consultant(s) in charge. This should be sent to the general practitioner, hospital of institution to which the patient is discharged.

- C. The front sheet must be completed at the time of discharge or as soon as the relevant information is available. It should contain details of all diagnoses and procedures and significant complications. Read coding using the terms developed by the Clinical Terms Project is recommended as the recognised standard because it is intelligible to clinicians and allows easy mapping to the current revision of the *International Classification of Disease (ICD 9)* and *OPCS 4 Classification of Operative Procedures*. Consultants in charge are responsible for entering a diagnosis and ensuring that the coding process is correct.
- D. When a patient dies a similar documentation should be completed and sent to the patient's general practitioner.
- E. Details of the death certificate entry should be written into the patient's notes.

7. POST-MORTEM REPORT

- A. When a post-mortem is performed a provisional anatomical diagnosis should be noted in the medical record within 72 hours and the medical record should be completed within one month following the death. A copy of the post-mortem report must be filed in the medical record.
- B. A review of the clinical diagnosis and the findings of the post-mortem examinations are an important part of clinical process and should be contained in the notes.

8. THE MANAGEMENT OF HOSPITAL RECORDS

- A. The methods by which hospital records are managed and maintained should be discussed and developed locally. The hospital should maintain a good diagnostic index. It should be possible to locate records quickly and resources must be made available to ensure that the records service is adequately staffed and equipped to do this. Hospital records must be maintained in a tidy condition and proper maintenance ensured; adequate arrangements should be made by hospitals for support staffing.

Policies should be established locally with regard to the following:

- (i) Safeguarding information in the records against loss, damage, or use by unauthorised persons. Where computerised records are maintained specific measures should be taken to ensure confidentiality in accordance with the Data Protection Act 1984, Department of Health Guidance, and the Professional Code of Ethics.
- (ii) Confidentiality and release of information which takes into account the Data Protection Act 1984 and the Access to Medical Records Act 1988.
- (iii) Retention, destruction and microfilming of medical records (in accordance with *British Standards Guidelines and Health Circular (89) 20* and *Guidelines for the Appropriate Storage of Active and Inactive Records*).
- (iv) Storage of records stored separately from the main record, eg accident and emergency records.

9. SECRETARIAL SUPPORT

It is essential that consultant staff are supported by appropriately trained secretarial staff in sufficient numbers to allow the clinician to follow these guidelines.