Medical records

MPS

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Advice correct as of September 2013

Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should therefore be comprehensive enough to allow a colleague to carry on where you left off.

Why good records are important

The main reason for maintaining medical records is to ensure continuity of care for the patient. They may also be required for legal purposes if, for example, the patient pursues a claim following a road traffic accident or an injury at work. For health professionals, good medical records are vital for defending a complaint or clinical negligence claim; they provide a window on the clinical judgment being exercised at the time.

What should they include?

Good medical records summarise the key details of every patient contact. On the first occasion a patient is seen, records should include:

- Relevant details of the history, including important negatives
- Examination findings, including important negatives
- Differential diagnosis
- Details of any investigations requested and any treatment provided
- Follow-up arrangements
- What you have told/discussed with the patient.

On subsequent occasions, you should also note the patient's progress, findings on examination, monitoring and follow-up arrangements, details of telephone consultations, details about chaperones present, and any instance in which the patient has refused to be examined or comply with treatment. It is also important to record your opinion at the time regarding, for example, diagnosis.

Medical records must be:

- Objective recordings of what you have been told or discovered through investigation or examination
- Clear and legible
- Made contemporaneously, signed and dated
- Kept securely.

Medical records should contain all the pertinent information about a patient's care and can cover a wide range of material including:

- Handwritten notes
- Computerised records
- Correspondence between health professionals
- Laboratory reports
- Imaging records, including x-rays
- Photographs
- Video and other recordings
- Printouts from monitoring equipment.

Entries to be avoided

In preparing medical records, you should keep in mind that you are generating a document which, while reflecting your personal findings and management of a patient's illness, can be demanded by the patient and the courts of law in matters of litigation. Therefore, they must be complete, objective and comprehensive.

Abbreviations

These should generally be avoided, as unfamiliar or unconventional abbreviations may lead to untoward incidents in the management of patients. When used at all, they should be those abbreviations that are traditionally accepted and recognised. Never use abbreviations for making derogatory comments about a patient.

Additions or alterations

If you need to add something to a medical record or make a correction, make sure you enter the date of the amendment and include your name, so no one can accuse you of trying to pass off the amended entry as contemporaneous. Do not erase an entry that you wish to correct – run a single line through it so it can still be read. You should avoid leaving blank spaces in between entries in the continuation sheet, so that retrospective notes cannot be made.

Patients have the right to access their medical records, eg, for a second opinion for treatment elsewhere, or for litigation. Generally, you are expected to co-operate with any such request, unless to do so would be detrimental to the patient or harm their physical or mental health.

Patients have the right to inform healthcare professionals of any factual errors in their personal information, but they should not seek to change any entries made in the course of consultation, diagnosis and management, as these are made by the practitioner based on their clinical judgment.

Security and storage

Medical records should be kept secure and inaccessible to unauthorised people. Adequate procedures should be in place to prevent improper disclosure or amendment; medical records should be kept in such circumstances for as long as required.

Upon transfer/cessation of practice

If you are ceasing practice, either to move elsewhere or leave medicine entirely, it is your responsibility to ensure that your patients' records are suitably handled and preserved. The Medical Council of Hong Kong says that this can be done by either transferring the records to a suitably competent doctor, or by giving the record, or a copy of it, to the relevant patient. Affected patients should be notified of this change in circumstances and the new arrangements. If you are taking over the records from another doctor, you must inform and seek the consent of affected patients upon enquiry or attendance at the practice.

Further information

- Medical Council of Hong Kong, *Code of Professional Conduct* – www.mchk.org.hk
- Personal Data (Privacy) Ordinance (Cap 486) – www.pcpd.org.hk

Medicolegal and membership enquiries

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This factsheet provides only a general overview of the topic and should not be relied upon as definitive guidance. If you are an MPS member, and you are facing an ethical or legal dilemma, call and ask to speak to a medicolegal adviser, who will give you specific advice.

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MPS1325: