

Medical Records



MPS



Advice correct as of January 2016

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 reliance on memory. The Singapore Medical Council (SMC) advises that 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.

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.

The manner in which medical records are kept can also reveal whether a doctor is careful and diligent as opposed to someone who is likely to be disorganised or careless.

What should medical records 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 (including details of all drugs) provided
- Follow-up arrangements
- What you have told/discussed with the patient
- You should also record discussions surrounding consent including details of any warnings that you have given of the potential risks and alternative options.

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. If a patient is transferred to another healthcare facility, you should provide a full clinical summary of the patient's management, to allow treatment to continue without undue delay.

Consent to share the patient's records with other HCPs involved in the patient's treatment may be implied (for example if the patient agrees to a referral being made). Information should not be disclosed, however, if the patient refuses consent – though the patient should be warned of any potential detrimental effect on care.

Medical records must be:

- clear
- legible
- accurate
- objective recordings of what you have been told or discovered through investigation or examination
- made contemporaneously, signed and dated
- kept securely.

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 factually complete and accurate.

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 – for paper records, 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. Amendments to electronic records can be tracked by audit trail and should be clearly marked on the file.

Access to records

Whilst it is usual practice to provide a patient with a medical report in response to a request for information, the patient does have the right to access medical records under common law, should they wish to do so. Patients also have a statutory right to access under the Personal Data Protection Act (PDPA). This right may be curtailed only where there are reasonable grounds for the belief that disclosure of the patient's medical records and reports to the patient would be detrimental to the patient's physical or mental health.

Generally, you are expected to co-operate with requests for medical records, unless to do so would be seriously detrimental to the patient's physical or mental wellbeing.

Patients have the right to have any factual errors in their personal information corrected, but they cannot require a healthcare professional to change any entries made in the course of consultation, diagnosis and management, that are made by the practitioner based on their clinical judgment.

In the case of incapacitated patients the holder of a Lasting Power of Attorney (LPA) may request access to records to enable the LPA to discharge his obligations to the patient. In the absence of an LPA, the doctor should make the decision based on the patient's best interests and in determining those interests it would be good practice to consult with next of kin.

Who do the records belong to?

- Medical records are the property of the healthcare professional (or hospital in the government or public sector) and can only be disclosed to third parties with the patient's consent, or the administrator or trustee when the patient is deceased, or in response to a court order.
- Personal information, eg, name, address etc, belongs to the patient.
- Test results, eg, blood tests, imaging and scans belong to the patient and may be released when requested.
- Unless imaging records have been retained for medicolegal reasons or continuing patient care, they should be returned to the patient.

Security and storage

Medical records should be classified "confidential". They must be stored in secure rooms when not in use and, as a general rule, must not be taken out of the healthcare facility. If they are requested by a court order, a copy should be retained by the healthcare facility and any originals returned at the end of the proceedings.

Electronic records must be kept secure to protect patient confidentiality and safe from loss or damage. All confidential patient data files must be password and PIN protected, and where possible laptops and memory sticks should be protected by encryption. There must also be an audit trail to allow checks on unauthorised access or any breach of confidentiality. The records must be stored in a safe place with safeguards including backup systems to prevent loss.

Further information

- Singapore Medical Council – www.smc.gov.sg/html/SMC_Home.html
- SMC, *Ethical Code and Ethical Guidelines* – www.healthprofessionals.gov.sg/content/hprof/smc/en.html
- SMC, *Medical Records: Making and Retaining Them* (Nov 22, 2000) – www.smc.gov.sg/html/SMC_Home.html
- *R v Mid-Glamorgan Family Health Services* 1995 1 WLR 110

For medicolegal advice please call us on:

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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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