Record keeping

Part 2

In the second of two articles looking at record keeping, Professor Nizar K Hirji discusses how best to record information, and then store or transfer this material. Module C12404, one general CET point, suitable for optometrists and DOs.

Good record keeping is not just important for good patient care, it is fundamental to it. All other reasons, though worthy, are secondary to this principal reason is good patient care. The first article in this two part series, covered issues of confidentiality, disclosure, the legal framework that impacts on patient information, and gave some generic tips on good practice in record writing/keeping. This article deals with the format of good optometric records, the use of abbreviations, ownership of records, their retention and destruction and whether ‘if it’s not written down it was not done’ in the light of recent research evidence, is still a valid view.

Format

A very useful format for effective clinical record keeping was proposed by Weed1 when he published his proposals of the Problem Oriented Medical Record (POMR) in 1968.1 Subsequently he published the Subjective Objective Assessment and Plan (SOAP) approach to clinical record keeping in 1969.2 These proposals were designed to improve the structure of the medical record. The idea was to encourage logical thought process and approach to record keeping with the aim of generating clearer records for communicating information about a patient to other clinical professionals. Today, the SOAP format and variations of it (eg SOAP-F,3 SOAP-F,4 SOAP-F,5) are used around the world by a variety of healthcare professionals and is effectively applied to optometry3 to structure record keeping, analysis and clinical decision making. The acronym SOAP-F, a variation developed by the author stands for the following:

S = Subjective (the patient’s perspective) – everything that the patient tells the practice/practitioner. This includes the patient’s demographics/profile data, presenting complaint(s), symptoms, and any secondary concerns. Including frequency, location, onset, association, duration, severity; aggravating and relieving factors of symptoms; ocular history, medical history, a review of systems (necessary to establish any correlation/connection with systemic disease), social history, and family ocular and medical history. The practitioner will with most patients, have to elicit much of this by careful questioning because patients often do not associate some of this information or its importance, to ocular and/or visual problems. In some optometric practices especially in the United States, it is normal practice for the patient to fill out demographic details on a pre-attendance form which also includes a screening of history and symptoms, and review of systems. Such forms3 are in some cases downloadable from practice/clinics websites for patients to complete and bring along to the practice when attending. They begin with patient identifiers (giving an opportunity to update changes for returning patients) and go on questions relating to personal history, social history, family history, review of systems etc. They do not however absolve the practitioner from history and symptoms questioning during the consultation, but do allow the practitioner to identify pertinent issues and related aspects quickly while also allowing for a standard comparable core review of the patient’s history and symptoms at every visit.

O = Objective (the practitioner’s perspective) – the practitioner’s observations and tests: including vision, visual acuity, ocular muscle balance, pupils, motility, near point of convergence, examination of the external eye and adnexa, internal eye exam, objective and subjective refraction, accommodation, supplementary tests/data (eg Amsler, colour vision, slit lamp, fixation disparity, visual field analysis, tonometry, stereopsis, cycloplegic exam etc). These should be recorded with details of times, instrumentation and the techniques utilised where appropriate/applicable.

A = Assessment (the analysis) – This is the optometrists’ understanding of the problem: the diagnosis(es) and differentials where appropriate for the patient ie conclusions reached, based on the collected information from the subjective and the objective perspectives, and possible secondary problems that need to be considered. This is not something that optometrists in the UK are used to doing explicitly and an implicit diagnosis from the patient’s and practitioner’s perspectives is often taken for granted when it is something simple like say myopia or presbyopia. However, it is good practice to be explicit about diagnoses other than the most basic refractive ones, although here too it is good practice to record these explicitly at least once at the outset where possible.

P = Plans – The practitioner’s goals, actions, advice or counselling etc. in the best interest of patient care. This would include details of any interventions e.g. therapeutic measures or interventions, dispensing of optical appliances, orthoptic exercises, additional diagnostic tests or procedures, patient (and family, if applicable) education, handouts given, referral letters sent, etc as applicable based on the assessment.

F = Follow-up – What is done to monitor the plan, and recall/review appointments. After all, one would not know how successful the clinical decisions and plans were without follow up and feedback.

Abbreviations

Though not uncommon in optometry, abbreviations generally...
in recordkeeping are to be avoided. However they are considered helpful in instances where writing in full would result in disproportionately extra time being spent, arguably inefficiently, during a consultation especially if the abbreviations used are very well recognised. A list of ‘approved’ optometric abbreviations is available on the College of Optometrists website for members, and these are recognised and well understood by most eye care professionals. It does mean, however, that should a record be scrutinised or access to this information be requested by any authorised lay persons or agencies, an explanation/interpretation as to the exact meaning in lay terms of any abbreviations or acronyms used, will need to be provided as well.

Ownership
Ownership of optometric records belongs to the practice where the patient attends for their optometric care. It is normal to transfer this ownership, eg by sale, to another practice should the original practice have to close down for whatever reason. Patients may choose to attend a different practice and it is also normal for practices to transfer copies of the records at the patients’ request to the new practice that they wish to attend (the original records remain with, and are still owned, by the original practice). There is an obligation on the practice owner to ensure that care continues at the practice at which the patient attends and that the record keeping complies with the common law duty of confidentiality and with the Data Protection Act 1998.

Retention
The Department of Health publishes a Code of Practice for Records Management.6 This sets out the minimum recommended periods for which different types of health records must be kept, either due to legal requirements or because they may be needed for the patients’ future care. Legally required periods are:

- Seven years for NHS patients, being agreed in the NHS contract, three years for contractual matters, three years for personal injury, but the three years starts from when the patient becomes aware that they may bring a claim, which means that it could start at any time, so periods for retaining records such as 10 years (recommended by the AOP), or 11 years (recommended by the NHS) are simply recommendations.8

- Ownership of optometric records may be an imperfect representation of the eye exam

- Optometric clinical records

- children until they reach 25th birthday or 26th birthday if the young person was 17 at conclusion of treatment; or eight years after death if sooner.

  Once this period has expired, all health records are dealt with in one of three ways:

  1 The organisation that created the records may keep them for longer than the minimum period. However, the organisation must ensure that keeping the records does not contravene the Data Protection Act 1998, which says that personal data should not be retained longer than is necessary.

  2 The records may be transferred to an archive. This will happen if the records no longer need to be kept for patient care or as a legal requirement, but have some long-term historical or research value.

  The Data Protection Act 1998 allows for personal data identified as being of historical or statistical research value to be kept as archives – with reasonable review periods.

  3 The records are destroyed. This will happen if the records no longer need to be kept for patient care or as a legal requirement, and they have no long-term historical or research value. Destruction should be by a foolproof method, such as shredding or burning, or undertaken by a firm which offers foolproof methods of destroying confidential documents. Shredding, it should be remembered, has various security levels (DIN 32757) ranging from level 1 which is regarded suitable for home use to level 6 which is recognised as shredding for the very highest security level (eg for the military). DIN Level 4 is recommended for shredding of healthcare records.

- Simply throwing old records in a bin for the dustman to collect is not acceptable and would be in contravention of the Data Protection Act 1998.

Final thoughts
Finally some interesting questions with respect to clinical record keeping have emerged from the recent work by Shah et al10 who used a well accepted method of Standardised Patients (SPs) to gauge how well optometric clinical records can be used to abstract (from volunteer practitioners in the South East of the UK who consented to be visited by unannounced actors – trained in reporting of the content of the eye examinations, via an audio recording and a checklist completed for each clinical encounter), the actual content of an eye exam conducted.

Their findings were, not withstanding some of the limitations of their study, that optometric clinical records are an imperfect representation of the content of an optometric eye examination. They found that the records they examined and compared to the SPs’ experience/observations presented both under- and over-estimations of the clinical consultation/optometric care. Thus some practitioners did not record what they had actually done/advised, whilst there were other practitioners who recorded items/actions that could not be corroborated by the SPs. This finding is apparently not just confined to optometric practice and similar over- and under-estimations of patient care has been noted in other healthcare disciplines.10 This raises the question of the validity of the adage ‘if it’s not written down it wasn’t done’, and places serious reservations on the reliance on optometric patient records alone, when a practitioner’s clinical practice is scrutinised.

Good record keeping is essential for good patient care. Good records will facilitate good defence, whilst poor records, a poor defence, and no records, no defence at all, when a clinician’s professional practice is under scrutiny by a judicial body. •

References
1 Wee L. Medical records that guide and teach. NEJM, 1968; 278: 593-599.
4 Dziegielewski SF, Leon A. Social work practice and psychopharmacology, Springer
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1. The principal reason for good record keeping is:
   A. Legal defence
   B. Provide statistical data to the DoH
   C. Comply with The DPA 1998
   D. Good patient care

2. In the SOAP-F acronym S represents:
   A. The subjective refraction
   B. All details of the patients' symptoms
   C. The information provided on a pre-exam questionnaire
   D. All information provided by the patient

3. Records belong to:
   A. The patient
   B. The general medical practitioner
   C. The optometrist who examines the patient
   D. The practice owner where the patient attends

4. NHS records for minors are recommended to be kept for:
   A. Seven years
   B. 10 years
   C. Until they are 21 years old
   D. Until their 25th or 26th birthday

5. The DPA 1998 does not impact on the issue of:
   A. The destruction of records
   B. The retention of records
   C. Records generated as a result of research
   D. None of the above

6. Research using standardised patients in optometry has revealed:
   A. That optometric record keeping is a perfectly reliable way of gauging optometric practice
   B. Under recording in optometric practice
   C. Under and over recording in optometric practice
   D. Over-recording in optometric practice

Professor Nizar Hirji is a consultant optometrist, Hirji Associates – Consulting in Optometry, Birmingham, www.hirji.co.uk

A visual recognition and interpretation of clinical signs CET exercise relating to this topic will be published in Optician and online next February.

Successful participation in this module counts as one credit towards the GOC CET scheme administered by Vantage and one towards the Association of Optometrists Ireland's scheme.

The deadline for responses is November 26 2009