GPSA
GENERAL PRACTICE SUPERVISION AUSTRALIA

SKILLS
CONSULTATION SKILLS

Quality medical records

'Medical record' is a general term for a wide range of health data, including a patient's progress notes, specialist reports, discharge summaries, pathology and imaging reports, clinical images and medico-legal reports. The primary purpose of medical records is to support safe, continuing and high-quality healthcare for individual patients and practice populations, but they also can be used for other reasons – research, audit, and as evidence in criminal, coronial or other legal proceedings. Maintaining good quality medical records is therefore a core aspect of good quality practice, and supervisors can play a vital role in assessing and teaching this skill to their registrars.

TEACHING AND LEARNING AREAS		• Primary and secondary purposes of medical records • Essential attributes of high-quality medical records - completeness, consistency, legibility, accuracy, relevance, accessibility and timeliness • Practice-based systems approach to high-quality medical records, including processes for incoming reports and actioning according to urgency • Practice software – recalls, reminders, templates etc. • My Health Record
PRE- SESSION ACTIVITIES		• Read AVANT Mutual - Medical records: the essentials
ACTIVITIES		• Assessment and teaching on quality medical records is best done by either 1. role play with notes review, or 2. random case analysis • See over page for activities
TEACHING TIPS AND TRAPS		• Update and 'tidy' the past history and medication list at every encounter to remove redundant entries e.g. previous URTIs, old antibiotic prescriptions • Avoid non-standardised or ambiguous terminology • Avoid disrespectful, offensive or humorous language • Include relevant negative findings and a differential diagnosis as a routine part of medical record keeping – this is also good for clinical reasoning development • Always document informed consent and any refusal of treatment • Always document telephone or other brief encounters • There should be an expectation that medical records will be shared with colleagues and patients, and documentation should reflect this
RESOURCES	**Read**	• RACGP Quality health records in Australian Health Care: A guide • 2016 paper How to keep good clinical records • Top 10 tips for effective use of electronic health records
FOLLOW UP & EXTENSION ACTIVITIES		• Undertake the My Health Record online training

GPSA
GENERAL PRACTICE SUPERVISION AUSTRALIA

SKILLS

CONSULTATION SKILLS

Activities

ROLE PLAY WITH NOTES REVIEW

1. Role play the following case with the registrar
2. Registrar to document the encounter as per usual practice
3. Supervisor to review the notes and discuss the quality of the record taking, using the criteria below

ROLE PLAY CASE SCENARIO

You are Sam, a 44-year-old university lecturer, and you present with a three week history of vague right-sided intermittent lower abdominal pain. There are no associated GI and GU symptoms, and no red flags for serious disease. You are a new patient to the practice. You have a PMHx of GORD (gastroscopy 2 years previously) and take intermittent Nexium when it flares up. Otherwise, you have no other PMHx , take no other medications, do not smoke, drink 50g ETOH/week and have no allergies.

Examination is entirely normal.

GPSA
GENERAL PRACTICE SUPERVISION AUSTRALIA

SKILLS

CONSULTATION SKILLS

Activities

RANDOM CASE ANALYSIS

1. Review the medical records from a few recent registrar encounters
2. Use the following schema to assess the medical record

CRITERIA FOR ASSESSING MEDICAL RECORDS

A medical record should include:

- demographic data, including Aboriginal and Torres Strait Islander health status
- lifestyle risk factors
- up to date past medical history and medications
- reason for the visit and history of the presenting illness (including relevant red flags and negative findings)
- physical examination findings (including relevant negative findings)
- diagnostic impression
- management plan and agreed actions
- treatment details, including warnings or advice given to the patient in relation to any proposed medical treatment
- medication administered, prescribed or renewed and any drug allergies
- written (or oral) instructions and/or educational information given to the patient
- any follow up instructions given to the patient.

General requirements:

- A record must include sufficient information allow another medical practitioner to continue to appropriately manage the patient's care
- All entries must be accurate statements of fact or statements of clinical judgement. Personal (non-medical) opinions should not be included.
- Details of significant discussions or correspondence including telephone calls with the patient or other health professionals should be included
- Only abbreviations or expressions which are generally understood in the medical community should be used. All records need to be legible.
- Notes should be entered at the time of the encounter or as soon as possible thereafter
- A record should not be altered in any way that obliterates, obscures or renders illegible information that is already contained in the record

Based on Medical Board of Australia's Good Medical Practice: A Code of Conduct for Doctors in Australia

GPSA is supported by funding from the Australian Government under the Australian General Practice Training Program 24/06/2023