

DRAFT RCP record keeping standards – inpatients

Version 5.0

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Purpose of Document

1. To explain why evidence-based standards for inpatient record keeping are needed
2. To describe the review of the evidence
3. To describe the standards for inpatient record keeping
4. To provide a conformance test to allow physicians to monitor their record keeping

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Background

Medical records serve many functions in the modern healthcare environment. These can be broadly divided into *primary* and *secondary* functions (table 1).

Primary functions	Supporting direct patient care <ul style="list-style-type: none"> • Aide memoire • Support clinical decision making • Communication
Secondary functions	Medico-legal record Source of information for: <ul style="list-style-type: none"> • Clinical audit and research • Resource allocation • Epidemiology • Service planning

Table 1 – Primary and secondary functions of medical records

Why standards are needed

In 1995 the Audit Commission examined 200 casenotes from 8 hospitals and found many different structures to the records, some having no structure at all. There were no index of contents in 55%; 50% were fat and disorganised; they were focussed on episodes (out-patient, day-case or in-patient) rather than the continuum of the patient's care and were diagnosis or procedure led rather than problem orientated. They criticised that the records were not integrated, with medical, nursing and other components kept separate.¹ The Commission repeated the audit in 1999, finding improvement in some areas but continued inconsistency.²

The Kennedy report from the Bristol Inquiry criticised current record-keeping practices and standards.³

In 2002, we audited 149 casenotes in 5 hospitals in England and Wales as part of the evaluation of a training package for junior doctors. We looked at the completeness of the notes for completed admissions, various features of individual entries and markers for quality of printed discharge summaries. We found that 35% of the casenotes did not have a problem list and 29% and 22% had pages without patient ID and name respectively. 9% of all entries were not completely legible, 10% unsigned and 11% undated. 83% of all entries did not identify the lead clinician present (presumed to be the decision maker).

Of 87 printed discharge summaries present in the notes 17% had no diagnosis, 19% no procedure, 21% had no follow-up arrangements, and 75% provided the GP with no information on what the patient had been told.

Two hospitals had 16% and 24% of printed summaries without dates.

The delay to produce the printed summary was variable. For those summaries that were dated the longest average delay was 26 days, the shortest was zero. The site that produced a printed discharge summary on the day of discharge had an electronic system (fig 1).

We also examined inter-auditor variability and found that there were considerable differences in opinion between senior and junior doctors and nursing and audit staff as to what constitutes a 'problem list', and even large discrepancies in counting number of procedures in some sites.

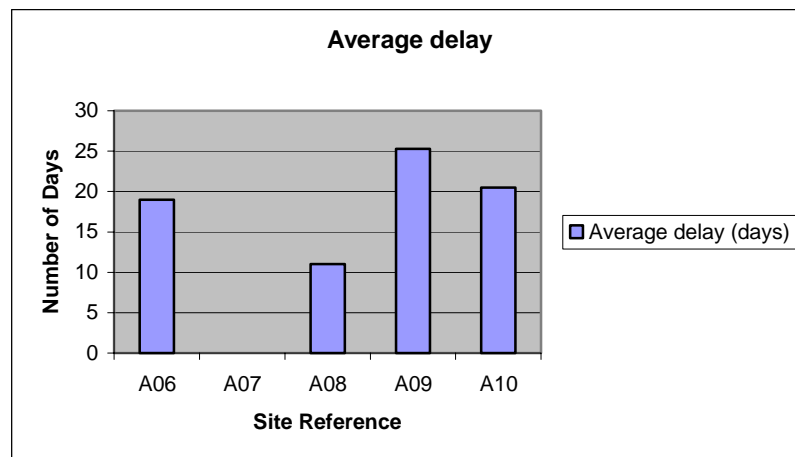


Fig 1 - Average delay to produce printed discharge summary (from HIU medical records audit)

In 'Good Medical Practice', the General Medical Council (GMC) has stated the need for doctors to keep 'clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'⁴. 'Good Medical Practice' also requires keeping colleagues well informed when sharing the care of patients, and taking part in regular and systematic medical and clinical audit. The GMC has published guidance on confidentiality and consent for disclosure of patient information.⁵

The Federation of Royal Colleges of Physicians of the United Kingdom has produced guidance for physicians preparing for revalidation⁶. Good Medical Practice for Physicians consists of around 50 paragraphs and bullet points offering specific guidance on what constitutes good medical practice. Half of these either directly relate to medical record keeping, or require the recording of information that would be best placed in patients' medical records.

The European Working Times Directive will cause a change in working patterns for SHOs.⁷ Often this means a shift system is imposed rather than the more traditional rota. Shifts require handovers of information. The medical record is the key to successful information exchange, and quality standards of record keeping such as maintaining structured problem lists will be an essential component of ensuring continuity of care.

The NHS Information Authority (NHSIA) produced draft Headings for Communicating Clinical Information⁸. These were intended to convey clinical information in a structured way across the NHS and across professional and organisational boundaries. The headings chosen, though, were not intuitive and subsequent multiprofessional evaluation of the headings showed that the terms and definitions were

confusing across professions. The project has since been discontinued. However, the need for standards in the heading structure of clinical records and communication is still acknowledged⁹.

The national context

There is currently a major drive to develop electronic records systems across the UK.^{10;11;11;12;12} The NHS Information Authority has been in place for 5 years to implement the strategy in England. There are many facets to this process, but there remains an objective to replace existing paper records with electronic records by 2008.

The problem is that computerising medical records in their current state will create more problems than it solves. A mess computerised is a computerised mess.

Evidence-based standards for record keeping

Part of the solution is to develop evidence-based standards for record-keeping. The potential benefits are summarised in Table 5.

<ul style="list-style-type: none">• Improved quality of records<ul style="list-style-type: none">○ Improved completeness of information○ Improved accuracy of information• Better patient information<ul style="list-style-type: none">○ Improved communication○ Informed patients○ Greater patient involvement in decision-making• Improved patient outcomes• Improved data validity for secondary purposes<ul style="list-style-type: none">○ Improved central returns○ Accurate performance data○ Better research data○ Better NHS management information• More efficient health services• Improved public health

Table 5 – Benefits of adopting evidence-based standards for record keeping

This document contains the RCP Health Informatics Unit's draft standards for in-patient record-keeping. These are based on the best available evidence and take into account existing standards for paper and electronic records as well as definitions held in the NHS data dictionary.

The standards address the admission clerking, the discharge or transfer summary, and the entries made between admission and discharge. They allow for local variation in practice without compromising the benefits.

The draft standards are released for consultation. Formal piloting and evaluation in situ is planned.

Implementation of standards

We acknowledge that introducing any innovation into clinical practice requires organisational change as well as changes in ways of working for clinicians. It has been found that providing education and support for staff can ease the introduction of structured proformas in the hospital setting.¹³ This should start at induction,^{14, 15;16} and be maintained by reinforcement and monitoring.

The standards are supported by a comprehensive portfolio of educational exercises *Laying the Foundations for Good Medical Practice – A generic training programme for SHOs*.¹⁷ The resource also contains an audit tool. Junior doctors are encouraged to regularly audit records against the standards.

Review of evidence for record-keeping standards

Objectives

- To identify any evidence relating to clinical record-keeping practice
- To identify existing standards for medical records
- To collate evidence to produce professional standards for clinical record-keeping practice

Questions for review

- Should records be structured?
- Is there an evidence base for individual record entries?

Search strategies

Medline and Cochrane databases were searched for published articles. Broad searches were conducted using the terms 'record', 'chart', 'admission', 'discharge', 'summary', 'structure' 'headings' and 'pro forma'. Suggested articles were initially short-listed by title, then by abstract. Full text articles were retrieved using the Royal College of Physicians information service. Reference lists of retrieved articles were hand searched for further publications. Personal contacts were used to identify unpublished information and other standards including CEN, ISO, ASTM, BSI and Professional Bodies

Inclusion criteria

Articles were considered for inclusion if they described studies providing evidence relating to record-keeping. All specialties are included. Evidence from countries outside the UK has also been included. Evidence including quantitative and qualitative methods is included. Expert opinions are included.

Exclusion criteria

Articles were excluded if they did not describe evidence relating to standards for record-keeping.

Description of studies

Studies are described within the standards documentation.

Limitations

Our primary interest in searching for articles was to identify research that demonstrated an effect of record-keeping practice on patient care or delivery of care. Database searches were limited to Medline and Cochrane to enable time to be spent reviewing other standards and chasing contacts. A formal systematic review would need to include other databases and non-medical sources.

Layout of full standards

The full standards have been laid out in the structured, colour-coded format, shown below’:

Standard	Description of Draft RCP record-keeping standard
Notes	Accompanying notes to further define the standard
Evidence Base	A description of the evidence-basis for the standard. Tables of articles are found in a separate document
Other standards	Extracted standards from other standards and guidelines

References to standards documents

In the UK, the NHS Litigation Authority has a Clinical Negligence Scheme for Trusts, which has produced Clinical Risk Management Standards.¹⁸ These stipulate that the health record contains a designated place for the recording of hyper-sensitivity reactions, and other information relevant to all healthcare professionals.

In the United States, more detailed documentation standards have been produced. This is probably due to the highly legislative nature of the US healthcare system. American terms are different from those in used in the UK, so they are not immediately transferable. The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) stipulates essential elements of the discharge resume.¹⁹ For electronic records, ASTM International (formerly known as the American Society for Testing and Materials) have produced a standard specification for healthcare document formats,²⁰ which provides ‘section headings’ for capturing clinical information.

The Federation of Royal Colleges of Physicians has produced ‘Good Medical Practice for Physicians’, which outlines requirements for revalidation.⁶ This suggests that the patients history must be carefully recorded, clear records must be kept of diagnoses and actions, including ‘do not attempt resuscitation’ statements, and the reasons for them and that clinical notes should always enable a colleague to understand the current needs of the patient.

The Royal College of Surgeons has guidelines for clinical documentation.²¹ It provides guidance on admission information, discharge summaries, and clinical coding

The Scottish Intercollegiate Guidelines Network (SIGN) has produced evidence-based guidelines for the ‘immediate discharge document’.²² This is based on a review of publications from 1993, so misses any research from before that period. They have produced guidance for content.

RCP Standard	Notes	Evidence-Base	Other Standards
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Patient/Medical Records

Standard 1	When a patient is admitted to hospital with an acute medical or social problem, or for rehabilitation, a complete record should be available at all times.		
Notes	Hospital includes teaching, district general, community, or geriatric long stay hospital and any environment utilised for the care of patients with medical (acute and/or rehabilitative) needs		
Evidence Base	No specific evidence to support the need to have a record available at all times was identified. However, it would probably be unethical to study the effects of not having a medical record for a patient.		
Other standards	<p>GMP for Physicians: Physicians must keep clear, legible and contemporaneous patient records as an essential part of good clinical practice, including care outside the NHS, and must sign and date all entries.</p> <p>GMP for Physicians: Physicians must be honest and accurate in any document or report they prepare.</p> <p>GMP for Physicians: Clinical notes should always enable a colleague to understand the current needs of the patient.</p> <p>CNST Clinical Risk Management Standard 4.1.6: The storage arrangements allow retrieval on a 24 hour / 7 day arrangement.</p>		
Standard 2	Documents within the record should reflect the continuum of patient care.		
Notes	All clinical records should be kept together, ordered chronologically and not separated into different specialties, unless there is a legal requirement (e.g. HIV information).		
Evidence Base	<p>No specific evidence for patient-centred records was identified. However, there are recognised disadvantages to separating documentation by specialty. These include:</p> <ul style="list-style-type: none"> • It is difficult to review a patient's history • Changes in service delivery may result in lost information 		
Other standards	<p>CNST Clinical Risk Management Standard 4.1.1: There is a unified health record which all specialties use.</p> <p>CNST Clinical Risk Management Standard 4.1.3: The health record contains clear instructions regarding filing of documents.</p> <p>CNST Clinical Risk Management Standard 4.2.1: A&E records are contained within the main record for patients who are subsequently admitted.</p> <p>CNST Clinical Risk Management Standard 4.2.3: Nursing, medical and other records</p>		

RCP Standard	Notes	Evidence-Base	Other Standards
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(e.g. physiotherapy notes) are filed together after the patient is discharged.

Standard 3 The clinical record should be structured.

Notes This standard applies to the clinical component of the record.

Evidence Base The evidence indicates that structure can improve patient outcomes and doctors' performance (tables 1 and 2).

Authors	Outcome measured	Results	Comments
Rogers & Haring 1979 ²³	Number of days readmitted	Decreased	Possibly confounded
Humphreys, Shofer et al. 1992 ²⁴	Number of problems at follow-up	No change	RCT
Humphreys, Shofer et al. 1992 ²⁴	Patient satisfaction with treatment	Increased	RCT
Zenni & Robinson 1996 ²⁵	Patient satisfaction with treatment	Increased	Small sample size

Table 1 – Studies assessing how improved structure of medical records affects patient outcomes

Authors	Outcome measured	Results	Comments
Rogers & Haring 1979 ²³	Monitoring and investigations	Improved	Possibly confounded
Adams, Chan, et al. 1986 ²⁶	Junior Doctor correct diagnosis	Improved	
Duggan, Starfield et al. 1990 ²⁷	Recorded & observed performance	Improved	Not randomised
Lilford, Kelly, et al. 1992 ²⁸	Doctors' response to risk factors	Improved	
Humphreys, Shofer, et al. 1992 ²⁴	Completeness of documentation	Increased	RCT
Wallace, Gullan et al. 1994 ²⁹	Completeness of documentation	Increased	Before and after study
Goodyear and Lloyd 1995 ¹⁶	Completeness of documentation	Increased	Retrospective, no control
Teo, Hansen et al. 1995 ³⁰	Completeness of documentation	Increased	Before and after study
Robinson, Harrison et al. 1996 ³¹	Completeness of documentation	Increased	Before and after study
Zenni & Robinson 1996 ²⁵	Doctors conformance to guidelines	Increased	Small sample size
Belmin et al. 1998 ¹⁴	Completeness of documentation	Increased	Before and after study
Belmin et al. 1998 ¹⁴	Accuracy of recorded information	Increased	Before and after study
Johns et al. 1992 ³²	Documentation of counselling	Improved	
Shank et al. 1989 ³³	Screening recommendations	Improved	Before and after study
Cohen et al. 1982 ³⁴	Screening procedures	Improved	RCT
Irtaz-Ali et al. 2001 ³⁵	Documentation of admission history	Improved	Audit reported in letter
Cheney et al. 1987 ³⁶	Screening procedures	Improved	RCT
Wrenn et al. 1993 ³⁷	Completeness of documentation	Improved	High risk of selection bias
Town et al. 1990 ³⁸	Completeness of documentation	Improved	Before and after study

Table 2 – Studies assessing how improved structure of medical records affects doctors' performance

Wyatt (1998) argues that structured records are easier and quicker to search and therefore can improve decision-making, but they have the disadvantage of being more difficult to write.³⁹ There is evidence against the latter, however, since some have found no significant difference in the time taken to complete structured proformas and free text history sheets.^{14;40;40} Wright (1998) described how structuring information could enhance interpretation and therefore limit clinical errors, improving patient outcomes and reducing the costs of healthcare.⁴¹

There is also evidence that structured discharge summaries are preferred by GPs^{13;15;42-46},

RCP Standard	Notes	Evidence-Base	Other Standards
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	^{13;15;43} improve the continuity of care, ¹⁵ and benefit the extraction of information for ‘secondary purposes’ such as audit and performance monitoring. ^{47;48 48}		
Other standards	SIGN 2.5: The IDD should be laid out in a structured format		

Standard 4	The clinical record should consist of entries made by individual doctors and other healthcare professionals. There should be an admission entry (clerking), follow-up entries, and a discharge entry (copy of discharge/transfer communication).		
Notes	<p>An entry includes any set of comments entered into the record by a physician. Entries made by other healthcare professionals are not included, although similar principles should apply.</p> <p>Follow-up entries are considered to be those between admission and discharge. Outpatient entries are not included, although similar principles should apply.</p> <p>In addition to admission, follow-up and discharge entries, there may be special entries (e.g. patient information, consent forms, death) with additional requirements.</p>		
Evidence Base	<p>The discharge transfer communication provides a clinical summary of a patient’s stay in hospital. A copy should be kept in the record to facilitate speedy review of past medical history in the future.</p> <p>One study found that 15% of 569 medical records did not contain a copy of the discharge summary.⁴⁹</p>		
Other standards	None		

RCP Standard	Notes	Evidence-Base	Other Standards
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All entries

Standard 5	Entries should be made as soon as possible after the event.
Notes	None
Evidence Base	No specific evidence was identified. It is unlikely that a study of timeliness of recording of clinical information would be considered ethical.
Other standards	GMP for Physicians: Physicians must keep clear, legible and contemporaneous patient records as an essential part of good clinical practice, including care outside the NHS, and must sign and date all entries.

Standard 6	<p>Every entry should:</p> <ul style="list-style-type: none"> • Be dated • Be timed • Be signed • Have the name of entry author legibly printed against the signature • Be legible • Have any deletions or alterations countersigned • Identify the patient • Locate the patient
Notes	<p>The patient's full name date of birth and identification number must be recorded clearly on every sheet of paper in the record</p> <p>The patient's location can simply be the ward number if the hospital name and address is recorded elsewhere.</p> <p>Abbreviations used in the record should be avoided and, if used, must conform to agreed local protocols</p>
Evidence Base	<p>Clinical information has attributes that help to define clinical meaning.⁵⁰</p> <p>Legibility:</p> <p>Despite reputation, doctors handwriting has been found to be no less legible than other healthcare professionals⁵¹, but this does not alter the findings that 2% –20% of handwritten clinical information and up to 70% of signatures have been found to be completely illegible or partly illegible.⁵²⁻⁵⁶ Patients find doctors handwriting more difficult to read than doctors⁵⁵</p>
Other standards	GMP for Physicians: Physicians must keep clear, legible and contemporaneous patient records as an essential part of good clinical practice, including care outside the NHS, and must sign and date all entries.

RCP Standard	Notes	Evidence-Base	Other Standards
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CNST Clinical Risk Management Standard 4.3.1: An author of an entry in a health record is clearly and easily identifiable.

RCS guideline 1: A hospital record must be maintained for every patient. Each record should contain the following identification data:

1. A unique medical record number or reference on every page
2. Name in full on every page
3. Address and postcode
4. Telephone number
5. Date of birth
6. Sex
7. Person to identify in an emergency
8. General Practitioner

Standard 7	Every record entry should identify the most senior doctor present at the time the entry was made.
Notes	<p>The most senior doctor is sometimes identifiable at the beginning of the record entry, next to the reason for clinical encounter. It may be in the form of ‘ward round Dr X’.</p> <p>If the full name and grade of the most senior doctor is not given it should be possible to determine this from previous entries. (e.g. if ‘ward round SpR’ is used then the full name of the SpR should be identifiable from previous entries)</p>
Evidence Base	None
Other standards	<p>GMP for Physicians: For in-patients there should always be a single physician or clinical team taking responsibility for the patient’s continuing care.</p> <p>GMP for Physicians: Physicians who lead teams must ensure that all members understand their own roles and responsibilities, including that of confidentiality, and know who is responsible and accountable for each aspect of the patient’s care.</p> <p>GMP for Physicians: Physicians may delegate tasks to junior doctors and to other health care professionals provided they are appropriately trained and supervised</p>

Standard 8	There should be an entry in the record at least once every 24 hours for acute medical care, and at least twice a week for rehabilitative care.
Notes	<p>Acute medical care includes medical care given/received whilst on an acute ward or unit regardless of specialty</p> <p>Patients who are receiving acute medical care should be reviewed as frequently at the weekend as during the week.</p>

DRAFT RCP record keeping standards – inpatients

RCP Standard	Notes	Evidence-Base	Other Standards
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Evidence Base	No specific evidence was identified. However it is regarded as common practice for acute patients to be reviewed daily.		
Other standards	<p>GMP for Physicians (supplement for acute physicians): A consultant physicians must carry out a ward round with the on-call team at least once every 24 hours.</p> <p>RCS guideline 2B: The 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.</p>		

RCP Standard	Notes	Evidence-Base	Other Standards
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Admission entry

<p>Standard 9</p>	<p>For acute medical admissions, the record entry on admission should include information under the following headings:</p> <ul style="list-style-type: none"> • Patient’s registered GP details • Admission details (administrative) • Reason for clinical encounter • Presenting problem/complaint • History of presenting problem • Current diagnoses • Allergies • Past illnesses • Procedures and investigations • Medications and diets • Social circumstances • Functional state • Family history • Systems review • Examination findings • Results of investigations • Overall assessment • Problem list • Management plan • Intended outcomes • Information given to patient <p>Other headings may be used locally in addition to those listed.</p>
<p>Notes</p>	<p>GP details include the name, address, telephone number and identification number (if used) of the patient’s general practitioner</p> <p>Admission details (administrative) includes date and time of admission, route of admission, type of admission (e.g. emergency or elective), source of admission, name of referring general practitioner</p> <p>Reason for clinical encounter is the administrative reason for the patient’s contact with the clinician. (e.g. clinical review, referred by GP etc.)</p> <p>The presenting problem/complaint is the sign, symptom or condition that has occasioned the admission of the patient to hospital. In circumstances where this does not apply, the reason for the admission should be recorded.</p> <p>Current diagnoses are disorders, syndromes and diseases that the person currently suffers from, including allergies. Specific professional rules may exist for particular diseases being classified as diagnoses even if they have potentially resolved (e.g. treated cancer).</p>

RCP Standard	Notes	Evidence-Base	Other Standards
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Allergies include any hypersensitivity reactions or other adverse event related to medications.

Past illnesses include previous disorders, syndromes and diseases that are not currently affecting the patient. Dates should be given.

Procedures include any operations, interventions or investigations that the patient has had.

Medications include any substance being taken by the patient on a regular or as-required basis. Dose, frequency and route of administration, and duration should be recorded for each medication.

Social circumstances should include domestic, employment and lifestyle information.

Functional state may be recorded as a validated score if appropriate.

Examination findings includes general observations (e.g. pulse, blood pressure) as well as specific systems (e.g. cardiovascular, respiratory, central nervous) and body areas (e.g. ear nose and throat, abdomen)

Test results include results of investigations, or results of other assessments made of the patients condition (e.g. stairs assessment). Dates should be given.

Problems include any issues that require action from the doctor or team. and may include the patient’s presenting problem, clinical findings, test results, and diagnoses. If there is uncertainty about a diagnosis then the most appropriate problem (symptom, sign or test result) should be used until the diagnosis is confirmed. If there are a number of possible diagnoses that need to be excluded, these should be listed as such within the problem list If there is more than one confirmed diagnosis these should be recorded as a list, in order of importance, in terms of keeping the patient in hospital.

Overall assessment is the clinician’s overall assessment of the patient’s condition.

Management plan includes any procedures or medications that would relate to resolving the identified problems. It also includes plans for review or follow-up.

Intended outcomes includes prognosis.

Information given to patient includes any information the patient has been given. This includes information on any of the items listed above.

Evidence Base The most basic structure involves categorising clinical information under headings (e.g. history of presenting complaint, past medical history). More complex structures break down the basic categories further and may require recording of specific data items (e.g. blood pressure) or ticking check boxes to indicate if a task has been completed (e.g. follow-up arranged).

As we move towards electronic records, agreeing a common structure becomes more

RCP Standard	Notes	Evidence-Base	Other Standards
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important. This is because placing a word into a category provides context. For example, the word ‘Carcinoma’ has a different context if it is placed under the heading ‘Diagnosis’ than under ‘Family History’. Without common categories, this context may be lost as data is transferred between systems, and the risks to patients are increased.

This all seems fairly obvious, after all we have all been using a fairly standard set of headings to structure clinical information since learning how to clerk a patient. However, there are problems. In our audit of 149 casenotes in 5 hospitals in England and Wales⁵⁷, we found that an SpR in one hospital thought that 100% of the casenotes they studied had a problem list whereas the consultant thought only 17% had one. This indicated a difference in opinion of what a problem list is.

The problem is complicated further if multi-professional records are considered. Researchers in Sweden found that different professional groups use different headings at different hierarchical levels.⁵⁸ They identified 6 main headings in common use, but these had different contexts across professions.

The NHS Information Authority developed and piloted *Headings for Communicating Clinical Information* in several hospitals across England and Wales.⁹ These multidisciplinary headings were found illogical and overlapping⁴⁴ and it was found that using a separate set of headings for communicating information between systems with different structures actually caused information to change its context or be lost altogether. The project has since been stopped (http://www.nhsia.nhs.uk/headings/pages/whatsnew_230502.asp).

Electronic messaging standards such Health Level 7, and clinical terminologies such as SNOMED-CT will support communication between systems (e.g.), but problems have been encountered using HL7 to do this,⁵⁹ and SNOMED-CT may be too complex for doctors to use in practice.

A common structure across healthcare systems will go a long way to allowing communication without losing contextual meaning. We have undertaken a literature review to identify evidence to help define how medical records should be structured.

We have made the following assumptions:

1. The benefits to patient care that have been established in different healthcare settings will be retained if a common structure is used.
2. There are generic headings that can be used across specialties

Methods

Review of the evidence

Medline and Cochrane databases were searched for published articles. Broad searches were conducted using the terms ‘record’, ‘chart’, ‘admission’, ‘discharge’, ‘summary’, ‘structure’, ‘headings’ and ‘pro forma’. Suggested articles were initially short-listed by title, then by abstract. Full text articles were retrieved using the Royal College of

RCP Standard	Notes	Evidence-Base	Other Standards
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Physicians information service. Reference lists of retrieved articles were hand searched for further publications. Personal contacts were used to identify unpublished information and other relevant material.

Articles were considered for inclusion if they described studies providing evidence relating to structure. All specialties were included along with evidence from outside the UK. Quantitative and qualitative methods are included.

Articles were excluded if they did not describe evidence relating to structure, or did not include detail about the structure used.

Review of existing standards and guidelines

Personal contacts (experts in electronic records standards) were asked to identify which British, European and American standards were relevant to structuring the record. Suggested standards were retrieved and reviewed in detail. Standards from the professional bodies were also sought.

Determining the headings

The headings from each study were grouped into administrative and clinical themes. These were then given a title, which enveloped the individual headings from the studies.

In determining the final headings, we applied some basic principles:

1. Headings must provide context to clinical information
2. Duplication of recording clinical information should be minimised
3. Headings should be intuitive

The headings were tested against ‘use case scenarios’, which is a form of testing for electronic systems requirements. The headings match the concept of ‘headed groups’ for capturing clinical information.

Summary of evidence

A total of 27 studies were found that fulfilled the inclusion criteria. Headings were derived from:

1. Studies that relate to specific headings (5)⁶⁰⁻⁶⁴
2. Studies that have tested structure against patient outcomes (1)³⁸
3. Studies that have tested structure against measures of doctors performance (1)¹⁶
4. Studies that have identified doctors’ information needs for patient care (12)⁶¹
42;47;65-73
5. Studies that have used structured forms that have been liked by doctors (8)^{13;15;43;45;46;54;55;74}

RCP Standard	Notes	Evidence-Base	Other Standards
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Description of studies

1. Studies that relate to specific headings

A non-randomised comparative study of 55 primary care patient encounters found poor concordance between information in the medical record and information from a taped recording of the encounter.⁶⁴ Information was usually given to the patient but this information was poorly recorded in the notes. The authors suggested that ‘information given to patient’ should become a standard heading for the record.

A randomised study assessed the concordance between recorded admission medications and patients’ own medication history obtained by interview.⁶⁰ They found that at 83% of records had at least one error, and 46% had 3 or more errors. Errors were usually due to a failure to record medications that the patient was taking rather than adding medications that the patient wasn’t. This study demonstrates that medication lists should include non-pharmacy medications and diets, as well as prescription drugs.

A survey of 95 general practitioners’ and 63 consultants’ views on the use of a functional assessment measure (FAM) in discharge summaries of patients with brain injuries found that 89% of the surveyed doctors felt the FAM was very or moderately useful.⁶³ This indicates that functional status should be recorded.

A surveys of 86 general practitioners found that GPs think that discharge letters with problem lists improve continuity of care.⁶² Another survey of 93 GPs found that 90% preferred a discharge summary with a problem list.

A study of the records of 100 discharged patients found that 84% had the name of patient’s GP, but only 47% had the name and complete address and only 40% had the GP’s telephone number.⁶¹ GP details are important for continuity of care.

2. Studies that have tested structure against patient outcomes

A retrospective before and after study found that a clerking proforma for 159 patients with asthma presenting at A&E was associated with a significant increase in use of appropriate medications, but did not reduce readmission rates over 1 month.³⁸ This study was not controlled.

3. Studies that have tested structure against measures of doctors performance

A retrospective before and after study of 200 admission records found that documentation of agreed core clinical details was significantly improved after implementing the proforma.¹⁶ This study was not controlled.

4. Studies that have identified doctors’ information needs for patient care

The bulk of published research into doctors’ information needs relates to GP preference for information within discharge summaries. This is useful because the discharge summary provides information for continuity of care, and can be extrapolated to other

RCP Standard	Notes	Evidence-Base	Other Standards
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areas where care is transferred.

One survey asked 49 GPs to rank suggested information items for importance.⁶¹ Another survey of 30 GPs asked them to identify important aspects of summaries.⁴⁷ A qualitative study of 4 GPs using semi-structured interviews identified 4 groups of information needed for continuity of care.⁶⁶ GPs' views have also been sought on the information needed to support patient care from various specialities.^{67;72;73 42:65;71} Although some have requested detail specific to that specialty (e.g. chemotherapy dose), most of the information required is transferable across all specialties.

Consultants' views of information needed to support patient care have been compared with those of GPs.⁶⁸⁻⁷⁰ In general there is agreement, although differences have been identified in the perceptions that each profession have of the other's psychosocial information needs.⁷⁰

5. Studies that have used structured forms that have been liked by doctors

Eight studies that have shown GP preference for a structured discharge document have also included details on the structure used.^{13;15;43;45;46;54;55;74} Headings can be extracted from these to inform generic headings.

Existing standards and guidelines

In the UK, the NHS Litigation Authority's Clinical Negligence Scheme for Trusts has produced Clinical Risk Management Standards.¹⁸ These stipulate that the health record contains a designated place for the recording of hyper-sensitivity reactions, and other information relevant to all healthcare professionals.

In the United States, more detailed documentation standards have been produced. This is probably due to the highly legislative nature of the US healthcare system. American terms are different from those in used in the UK, so they are not immediately transferable. The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) stipulates essential elements of the discharge resume.¹⁹ For electronic records, ASTM International (formerly known as the American Society for Testing and Materials) have produced a standard specification for healthcare document formats (ASTM E2184-02)²⁰, which provides 'section headings' for capturing clinical information.

The Federation of Royal Colleges of Physicians has produced 'Good Medical Practice for Physicians', which outlines requirements for revalidation.⁶ This suggests that the patients history must be carefully recorded, clear records must be kept of diagnoses and actions, including 'do not attempt resuscitation' statements, and the reasons for them and that clinical notes should always enable a colleague to understand the current needs of the patient.

The Royal College of Surgeons has guidelines for clinical documentation.²¹ It provides guidance on admission information, discharge summaries, and clinical coding

RCP Standard	Notes	Evidence-Base	Other Standards
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The Scottish Intercollegiate Guidelines Network (SIGN) has produced evidence based guidelines for the ‘immediate discharge document’.²² This is based on a review of publications from 1993, so misses any research from before that period. They have produced guidance for content.

For the purpose of this review, only the SIGN guidelines have been included because they are evidence based and specify headings for recording clinical information. Electronic records standards that relate to technical systems architectures have not been included.

Results

Suggested headings for structuring clinical information

Tables 1 and 2 show how the administrative and clinical themes relate to the suggested headings. The number of studies, and the total number of doctors participating in the studies, that have informed each heading has been included for interest. These figures don’t indicate the relative importance of the clinical information, since the studies are not necessarily directly comparable.

Administrative theme	Suggested heading	No. Studies (n=28)	No. Doctors (n=3284)
Details about hospital /ward	Location of patient	2	61
Details about author/user	User/author details	5	221
Date and time entry made	Date and time	8	495
Details about clinician responsible for patient care	Responsible clinician	7	725
Details about patient.	Patient details	11	1019
Details about patient’s GP	Patient’s registered GP details	6	653
Administrative details about admission	Admission details (administrative)	12	1211
Reason for admission /referral /transfer/ hospitalisation	Reason for clinical encounter	4	335
Administrative details about discharge	Discharge details (administrative)	9	835

Table 1. Administrative themes from the 27 studies and 1 guideline are listed against the suggested headings. The number of studies, and number of doctors that have informed the heading have been included for interest.

Clinical theme	Suggested heading	No. Studies (n=28)	No. Doctors (n=3284)
Unstructured information about progress, course, comments	Review of case	13	1361
Presenting problems/complaints	Presenting problem /complaint	5	349

RCP Standard	Notes	Evidence-Base	Other Standards
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History relating to presentation	History of presenting problem	8	1137
Diagnoses – active, main, secondary, coded	Current diagnoses	19	2111
Details on, allergies, adverse reactions	Allergies	6	932
Details of previous medical history	Past illnesses	2	274
Details of investigations undertaken	Procedures and investigations	16	1687
Details of procedures undertaken			
Details about treatment given	-	-	-
Details about medications	Medications and diets	24	2855
Details about diets			
Details about actions	-		
Details about clinical management	-		
Details about social history, accommodation	Social circumstances	4	75
Details about functional status, disabilities, condition	Functional status	4	249
Family history	Family history	1	0
	Systems review	0	0
Details about findings on examination	Examination findings	12	1899
Details of results of laboratory investigations, radiology results	Results of investigations	12	2264
Unstructured information about clinical state, clinical findings, condition, overall assessment	Overall assessment	5	685
List of problems, working diagnoses	Problem list	10	885
Planned events relating to management of patient	Management plan	20	2197
Prognostic information, likely outcome, outcomes	Intended outcomes	6	988
Details of what the patient or relatives have been told about their condition, treatment etc.	Information given to patient	11	1458
Developmental information	-	-	-
Risk factors			

Table 2. Clinical themes from the 27 studies and 1 guideline are listed against the suggested headings. The number of studies, and number of doctors that have informed the heading have been included for interest.

Problem areas

Past medical history

The traditional heading ‘Past Medical History’ (PMH) encompasses any conditions that the patient currently has or has had, as well as any procedures and investigations that the patient has had.

RCP Standard	Notes	Evidence-Base	Other Standards
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The evidence suggests that doctors' want know which diagnoses are currently relevant. We can separate active diagnoses from the PMH, but some conditions may be relevant but not currently active (e.g. conditions in remission, or treated cancers). The heading 'Active Diagnoses' would miss these, so 'Current Diagnoses' is more appropriate. Conditions that occurred in the past and may no longer be relevant to their current health also need to be recorded, and we suggest 'Past illnesses' rather than 'Past Medical History' to avoid confusion.

Procedures and investigations have been grouped together because some procedures are investigations and there is overlap. Duplication of information would be required for separate headings.

Treatment

'Treatment' has been used to convey clinical information, but this term overlaps with procedures and includes medications and diets. The use of 'Treatment' would cause duplication of information, so it is suggested that procedural treatments are placed under procedures, and medications and diets are included under their own heading.

Uncertain diagnoses (e.g. working diagnoses)

Clinical information is complicated by uncertainty. Statistical probabilities provide a scientific measure of uncertainty, and are familiar to us through research publications. But in everyday life we tend to use expressions such as 'likely', 'probable' and 'possible' instead of providing p-values.

The problem with using these expressions in clinical records is that different readers have different understandings of what they mean. There is internal consistency in use of uncertainty expressions, but no such conclusions can be drawn on between subject reliability.⁷⁵

This may not be all that important in face to face communication, but in an electronic environment, the consequences may be dangerous. This is particularly so for decision support. If a diagnosis list contains a *possible* diagnosis, then the system may suggest a management plan based on erroneous information. The risks are higher with expressions of negativity such as 'excluded'. The recommendation therefore is that diagnosis lists should contain only diagnoses that are certain or the highest level of clinical knowledge that is certain (e.g. problems, symptoms, signs, test results etc.). This is in keeping with existing guidance for clinical coding.⁷⁶ If a diagnosis is uncertain (e.g. working diagnoses, clinical impression) then it can be accommodated by the 'overall assessment' and 'problem list'.

When to use the headings

The list provided is intended to be fairly comprehensive. However, not all the headings are appropriate all the time. In our standards for record-keeping we have considered requirements for the admission and discharge entries, as well as those entries that are made whilst in hospital.

RCP Standard	Notes	Evidence-Base	Other Standards
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The headings are not exhaustive. The review threw up 3 examples where clinical information could not be placed under one of the suggested headings. These included developmental information (paediatrics), DNR statements, and risk factors. The first could be included as a separate heading for paediatrics. To minimise duplication of information entry, the second should probably be a ‘flag’ that is attached to other information (e.g. diagnoses), rather than a separate list.

Limitations

Our primary interest in searching for articles was to identify research that demonstrated an effect of structuring the medical record on patient care or delivery of care. Database searches were limited to Medline and Cochrane to enable time to be spent reviewing other standards and chasing contacts. A formal systematic review would need to include other databases and non-medical sources.

These headings are for medical records. The needs of multi-professional records have not been addressed.

Electronic records provide the opportunity for coded data entry, which aide communication of information between systems and data extraction for secondary purposes. This paper does not specify which headed groups should contain coded data, and which should be free text, but recognises that this is work that needs to be done.

These standards have not been tested in practice. They have been published in draft form to allow consultation, feedback and piloting.

Conclusions

Suggesting which headings doctors should use to structure their records will always be controversial. Each doctor will have their own way of doing things that has been developed over years of mentoring and personal experience, so everyone will have an opinion about it. However, studies cited in this article have shown that agreement is possible and practice can change. We hope that this article will stimulate interest and catalyse debate.

Other standards	<p>GMP for Physicians: The patients history must be carefully elicited and recorded</p> <p>CNST Clinical Risk Management Standard 4.2.5: The health record contains a designated place for the recording of hyper-sensitivity reactions, and other information relevant to all healthcare professionals.</p> <p>RCS guideline 2A: The notes should contain the following details:</p> <ol style="list-style-type: none"> 1. An initial patient history with details of previous illnesses, the social and environmental context of the illness when appropriate and details of medication 2. Details of the initial physical examination 3. A working diagnosis and medical care plan should be written down, signed and dated by the appropriate doctor.
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RCP Standard	Notes	Evidence-Base	Other Standards
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Follow-up entries

Standard 10	<p>Every follow-up entry should clearly record what has happened or been done to the patient since the previous entry, the assessment of the patient’s condition, state the new management plan, and document any information given to the patient.</p> <ul style="list-style-type: none"> • Reason for clinical encounter • Review of case • Overall assessment • Management plan • Information given to patient
Notes	<p>Reason for clinical encounter may simply be ‘ward round’ or ‘asked to see patient’</p> <p>Review of case documents any new information that relates to the patient’s care.</p> <p>Overall assessment is the clinician’s overall assessment of the patient’s condition. If there is no change then ‘no change’ can be recorded.</p> <p>If the plan has not changed since the last entry then ‘continue’ can be recorded.</p> <p>New problems, medications, examination findings, test results etc. should be recorded under the relevant headings.</p>
Evidence Base	<p>The rationale for this standard is that any new information placed in the record should be reviewed by a clinician who should assess it in relation to the patient and note any effect that the new information has on the management plan.</p> <p>Several structures of recording information have been proposed including SOAP (Subjective, Objective, Assessment, Plan) and HOAP (History, Observations, Assessment, Plan).⁷⁷ These are based on a problem-orientated medical record (POMR) where each problem is intended to be documented and clarified using the proposed structure.</p> <p>There is limited evidence on this issue, however one small study found that no effect on time to problem identification, diagnosis or therapy after introducing a SOAP structure.⁷⁸ It has been argued that the use of ‘subjective’ and ‘objective’ to indicate the patient’s view and clinician’s view respectively, actually demeans the patients view since subjective implies fallibility whereas ‘objective’ implies scientific rigor.⁷⁹</p> <p>We suggest that follow-up information should be recorded as a minimum under the following headings:</p> <ul style="list-style-type: none"> • Review of case • Overall assessment • Management plan <p>New problems, medications, examination findings, test results etc. should be recorded</p>

RCP Standard	Notes	Evidence-Base	Other Standards
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	under the relevant headings. New diagnoses should only be recorded under current diagnoses if there is clinical certainty.		
Other standards	<p>GMP for Physicians: Physicians must maintain good communication by regular explanations and updating on results and investigations, and on response to treatment.</p> <p>CNST Clinical Risk Management Standard 4.1.4: Operation notes and other key procedures are readily identifiable.</p> <p>RCS guideline 2B: The 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.</p>		

RCP Standard	Notes	Evidence-Base	Other Standards
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Discharge/transfer Communication

Interim discharge documents (IDD, TTO, TTA, TTH) and final discharge summaries/letters are used to convey summary discharge information to the receiving doctor. The former is usually hand written and prepared by a junior doctor. The latter is usually dictated and posted as a typed letter. The rationale for sending two documents must be questioned. This situation probably arose because of delays in receiving the final discharge letter (see standard 16) meant that interim discharge documents were adopted to provide a speedier mechanism of transmission.

There are serious problems with the validity of clinical information in interim discharge documents that may affect patient care (see standard 18), and these problems are passed on to NHS central data returns, affecting resource management, performance indicators and other secondary uses of health information.⁴⁸ However, there is strong evidence that the structured format of interim documents is preferred to narrative letters (see standard 3) and one study suggests that GPs think that one structured document is all that is needed.¹³

We see no rationale for separate standards for interim and final discharge communications. These standards therefore apply to any form of discharge document. If physicians decide to send two communications then the standards should be applied to both.

Standard 11	A clinical communication must be provided for all doctors involved in the care of the patient when care is transferred out of the hospital.
Notes	All doctors involved in the care of a patient includes the general practitioner and any secondary/tertiary care consultant who either regularly cares for the patient or that the patient has been referred to.
Evidence Base	One study found that patients for whom discharge information is available at follow-up are less likely to be readmitted. ⁸⁰ The same study found that only 12.2% of 888 discharge summaries were available at follow-up. Another study found that a summary was available for only 15% of 6619 clinic visits. ⁸¹
Other standards	SIGN 2.6: All relevant members of the primary health care team should have access to the IDD in accordance with the data protection act. GMP for Physicians: When sharing care, colleagues must be kept well informed. GMP for Physicians: Physicians must communicate with the general practitioner and others looking after the patients in primary care GMP for Physicians: Good communication with general practitioners is important.

RCP Standard	Notes	Evidence-Base	Other Standards
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Standard 12	The patient must be informed as to what information will be communicated to which other doctors involved in their care, and given the opportunity to object, in accordance with GMC guidance.		
Notes	Consent should be obtained for disclosure of clinical information and documented.		
Evidence Base	No specific evidence identified.		
Other standards	<p>GMC Confidentiality 7. Where patients have consented to treatment, express consent is not usually needed before relevant personal information is shared to enable the treatment to be provided. For example, express consent would not be needed before general practitioners disclose relevant personal information so that a medical secretary can type a referral letter. Similarly, where a patient has agreed to be referred for an X-ray physicians may make relevant information available to radiologists when requesting an X-ray. Doctors cannot treat patients safely, nor provide the continuity of care, without having relevant information about the patient's condition and medical history.</p> <p>GMC Confidentiality 8. You should make sure that patients are aware that personal information about them will be shared within the health care team, unless they object, and of the reasons for this. It is particularly important to check that patients understand what will be disclosed if it is necessary to share personal information with anyone employed by another organisation or agency providing health or social care. You must respect the wishes of any patient who objects to particular information being shared with others providing care, except where this would put others at risk of death or serious harm.</p>		

Standard 13	A copy of the clinical communication must be kept in the record.		
Notes	None		
Evidence Base	<p>The discharge transfer communication provides a clinical summary of a patient's stay in hospital. A copy should be kept in the record to facilitate speedy review of past medical history in the future.</p> <p>One study found that 15% of 569 medical records did not contain a copy of the discharge summary.⁴⁹</p>		
Other standards	None		

RCP Standard	Notes	Evidence-Base	Other Standards
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Standard 14	The Patient should be given a copy of the clinical communication, unless it is clinically inappropriate to do so. It should be recorded that the patient has been given a copy of the clinical communication unless it is clinically inappropriate to do so, in which case the reason should be documented.		
Notes	None		
Evidence Base	<p>Evidence suggests that most patients like having information and find it helpful. ^{55:82-85}</p> <p>Some studies have had similar findings for dictating a letter in front of the patient. ⁸⁶</p> <p>Doctors are less convinced. One study did find that most GPs think that it is a good idea for their patients to have discharge information, but the patients did not receive diagnostic details or information on problems encountered in hospital or doctors' comments. ⁵⁵ One small qualitative study found that although a majority of GPs liked the idea of patients receiving a copy, many still expressed doubts. ⁸⁵</p> <p>Patient outcomes may be affected. Although one well constructed RCT found no effect on attendance rates at hospital when patients were given a copy of the referral letter, ⁸⁷ another controlled study found that then number of clinically significant discrepancies in post-discharge prescribing was significantly reduced in the group of patients who had received a copy of their hospital medication list to hand over to the community phsrmacist. ⁸⁸</p>		
Other standards	<p>SIGN 2.6: Patient's, and where appropriate, carers, should be offered a copy of the IDD and the opportunity to discuss this with a relevant practitioner.</p> <p>GMC Confidentiality 4: Patients have a right to information about the health care services available to them, presented in a way that is easy to follow and use.</p> <p>GMC Confidentiality 5: Patients also have a right to information about any condition or disease from which they are suffering. This should be presented in a manner easy to follow and use, and include information about diagnosis, prognosis, treatment options, outcomes of treatment, common and/or serious side-effects of treatment, likely time-scale of treatments and costs where relevant. You should always give patients basic information about treatment you propose to provide, but you should respect the wishes of any patient who asks you not to give them detailed information. This places a considerable onus upon health professionals. Yet, without such information, patients cannot make proper choices, as partners in the health care process. Our booklet Seeking Patients' Consent: The Ethical Considerations gives further advice on providing information to patients.</p> <p>GMC Confidentiality 6: It is good practice to give patients information about how anonymised information about them may be used to protect public health, to undertake research and audit, to teach or train medical staff and students and to plan and organise health care services.</p>		

RCP Standard	Notes	Evidence-Base	Other Standards
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GMP for Physicians: Physicians should provide details of the methods and examples of patient information used to inform patients.

RCS guideline 6A: On discharge all patients should take with them a brief summary note containing the name of the consultant in charge, diagnosis, current ongoing medication and arrangements for wound management

Standard 15	If the communication is duplicated using carbon copy paper then the duplicate sheets must be legible.
Notes	None
Evidence Base	<p>The use of carbon copy paper to reduce duplication of information can improve productivity rates of doctors completing discharge information,⁸⁹ however, one study found that 10% of handwritten under-copies were illegible.¹³</p> <p>Modern mechanisms for communication (e.g. electronic) may provide a more reliable mechanism for ensuring that all copies are legible.</p>
Other standards	None

Standard 16	The clinical communication should be dispatched so that it is available to the receiving doctor when the patient is next seen.
Notes	None
Evidence Base	<p>Patient care may be affected if complete discharge information is not available when the patient is next seen. A survey of 145 interim discharge documents showed that 10.3% of discharge summaries were delayed sufficiently to affect patient management.⁹⁰ A descriptive study of hospital discharge and death communications found that 61% of elderly patients were readmitted due to lack of information about home circumstances in the discharge summary.⁹¹ Similarly, a correlational study of 888 acute medical patients indicated that there is a decreased risk of readmission if summary information is available.⁸⁰</p> <p>Most patients see their general practitioner within one week of discharge.⁹² and between 14%-53% of patients see their GP before any information is available.⁹³ In one study GPs felt that 35% of the discharge summaries had not arrive soon enough,⁹⁰ and others have found that 3% -54% of summaries aren't received at all.^{13;49;94-96}</p> <p>GPs like timely discharge summaries: a survey of the quality of communication between hospitals and general practitioners illustrated that GPs rank timeliness of the discharge summary the most important aspect along with information on admission and discharge.⁶¹ A study of 118 GPs attitudes toward discharge summaries showed ..</p>

RCP Standard	Notes	Evidence-Base	Other Standards
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that 57% of GPs felt that the summary should be available on the day of discharge.⁴²

The average time taken for discharge information to reach the receiving doctor has been found to vary from 0 to 28 days,^{53;91;94;95;97-99} with the handwritten interim summary arriving sooner than the formal discharge summary (4.3 days vs. 25.3 days).⁹⁴

Various methods have been used for transmission of discharge communications, including hand delivery by the patient, post, fax and electronic means.

There is conflicting evidence for patient delivery of the summary: different studies have different experiences of the reliability of hand delivery with 66%-94% of summaries reaching the GP.^{13;94;95} Another study found that GPs reported fewer problems for patients who delivered the summary.⁹⁸

Fax transmission may be faster than post,^{52;54} but faxes can be unreliable and difficult to read at the receiving end.

One RCT found that the use of a computer database to generate the summary resulted in more discharge documents being produced within 4 weeks of discharge.⁷⁴ A lesser before and after study found that using an electronic system reduced the delay from 2-4 days to less than 1 hour.⁹⁷

Electronic distribution of the discharge summary appears to be the most effective method of ensuring timely receipt of relevant patient information.

Other standards

SIGN 2.7: If fax transmissions are used they should comply with current Scottish office guidance.

RCS guideline 6B: 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 or institution to which the patient is being discharged

RCP Standard	Notes	Evidence-Base	Other Standards
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Standard 17	<p>The transfer or discharge communication should contain information under the following headings:</p> <ul style="list-style-type: none"> • Validating clinician • Patient’s registered GP details • Admission details (administrative) • Discharge details (administrative) • Review of case • Current diagnoses • Allergies • Procedures and investigations • Medications and diets • Functional state • Systems review • Examination findings • Results of investigations • Problem list • Management plan • Intended outcomes • Information given to patient <p>Other headings may be used locally in addition to those listed.</p>		
Notes	<p>Current diagnoses should include all adverse drug reactions and other problems that developed during the stay in hospital as well as existing diagnoses on admission.</p> <p>Review of case should include progress in hospital and any other clinically important information.</p> <p>Management plan should include specific instructions for the receiving doctor, any services provided, and follow-up requirements.</p>		
Evidence Base	See standard 9		
Other standards	<p>SIGN 2.5: The IDD should be laid out in a structured format.</p> <p>SIGN 3:</p> <ul style="list-style-type: none"> Hospital Patient ID (National ID, Local ID, forname, surname, address, postcode, date of birth) Preferred GP ID Consultant ID Ward/department Date of admission/transfer Date of discharge/transfer Date of death Reason for admission/transfer Mode of admission Source of admission Diagnosis/problems (multiple) 		

RCP Standard	Notes	Evidence-Base	Other Standards
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	<p>Significant operations/procedures (multiple) Relevant investigations Complications (multiple) Medication on discharge (name, formulation, dose, frequency, duration) Adverse reactions Discharge plans Information to patient and/or carer/relative Comment Results awaited Letter to follow Contact Signature and name and rank/position</p> <p>GMP for Physicians: Clear records must be kept of diagnoses and actions, including ‘do not attempt resuscitation’ statements, and the reasons for them</p> <p>GMP for Physicians: Clinical notes should always enable a colleague to understand the current needs of the patient.</p> <p>RCS guideline 6A: On discharge all patients should take with them a brief summary note containing the name of the consultant in charge, diagnosis, current ongoing medication and arrangements for wound management</p> <p>RCS guideline 6B: 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 or institution to which the patient is being discharged.</p> <p>RCS guideline 6C: 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 using the terminology of a current revision of the International Classification of Diseases and OPCS coding for operative procedures. Consultants in charge are responsible for entering a diagnosis and ensuring that the coding process is correct.</p>		
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Standard 18	Discharge summary information should be validated by a senior clinician		
Notes	None		
Evidence Base	<p>In a survey of 100 acute hospitals the SHOs prepared the discharge summaries in 92 and PRHOs in 6; 86 of the SHOs had never had any feedback on their discharge summaries and most did the summaries outside of contracted hours.¹⁰⁰</p> <p>Discharge summaries have been found to be missing diagnostic information in 10% - 12%,^{61;101} with 19% of 200 discharge summaries having incorrect or irrelevant diagnoses according to a senior clinician.¹⁰¹</p>		

RCP Standard	Notes	Evidence-Base	Other Standards
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In a study of SMR data from 52 paediatric and 98 general medical records, 25% of paediatric diagnoses and 18% of medical were considered clinically unacceptable compared with senior clinician’s diagnosis.¹⁰²

Other standards	<p>SIGN 2.4: Senior staff should approve the content of every IDD.</p> <p>RCS guideline 6C: 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 using the terminology of a current revision of the International Classification of Diseases and OPCS coding for operative procedures. Consultants in charge are responsible for entering a diagnosis and ensuring that the coding process is correct.</p>
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Standard 19	Discharge Summaries should be multidisciplinary where multidisciplinary care is to be continued.
Notes	None
Evidence Base	One study indicated that nursing staff were happy with the inclusion of nursing information in the discharge summary. ¹³
Other standards	None

RCP Standard	Notes	Evidence-Base	Other Standards
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Special entries: Patient information

Standard 20	All patients and/or their relatives/carers should be given information about the patient's illness, treatment and further management. The information given, and to whom, should be documented in the record.
Notes	None
Evidence Base	See standard 14 for evidence relating to patient information
Other standards	<p>GMC confidentiality 5: Patients also have a right to information about any condition or disease from which they are suffering. This should be presented in a manner easy to follow and use, and include information about diagnosis, prognosis, treatment options, outcomes of treatment, common and/or serious side-effects of treatment, likely time-scale of treatments and costs where relevant. You should always give patients basic information about treatment you propose to provide, but you should respect the wishes of any patient who asks you not to give them detailed information. This places a considerable onus upon health professionals. Yet, without such information, patients cannot make proper choices, as partners in the health care process. Our booklet Seeking Patients' Consent: The Ethical Considerations gives further advice on providing information to patients.</p> <p>GMP for Physicians: The patient's right to participate fully in decisions on their care is paramount and the physician must ensure that they are sufficiently informed to do so.</p> <p>GMP for Physicians: A record must be kept of information given to patients and their relatives including a summary of all discussions between physicians and patients.</p> <p>GMP for Physicians: Physicians should ensure that all treatment decisions and discussions with the patient and their families are appropriately documented in the notes</p> <p>GMP for Physicians: Physicians must give patients sufficient information in a way they can understand and enable them to accept or decline treatment.</p> <p>GMP for Physicians: Physicians must share information with relatives and carers, unless the patient withholds consent.</p>
Standard 21	Patients have a right to be fully involved in decisions about their care. Their involvement should be documented in the record.
Notes	None
Evidence Base	None identified

RCP Standard	Notes	Evidence-Base	Other Standards
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Other standards	GMP for Physicians: Physicians must respect the right of patients to be fully involved in decisions about their care		
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Standard 22	Advance directives must be clearly recorded in the notes, alongside any resuscitation statements.		
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Notes	None		
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Evidence Base	None identified		
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Other standards	<p>GMP for Physicians: Clear records must be kept of diagnoses and actions, including ‘do not attempt resuscitation’ statements, and the reasons for them</p> <p>GMP for Physicians: Physicians must be aware of their duty of care. Including complying with the wishes expressed in Advance Directives (Living Wills)</p>		
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Standard 23	If information is given to anyone other than the patient, then consent should be obtained from the patient for the disclosure and recorded. If consent has not been given or obtained, then the reason must be documented. The GMC’s guidance on confidentiality must be followed.		
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Notes	None		
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Evidence Base	None identified		
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Other standards	<p>GMC confidentiality 13: Seeking patients' consent to disclosure is part of good communication between doctors and patients, and is an essential part of respect for patients' autonomy and privacy.</p> <p>GMC confidentiality 38: Problems may arise if you consider that a patient is incapable of giving consent to treatment or disclosure because of immaturity, illness or mental incapacity⁵. If such patients ask you not to disclose information to a third party, you should try to persuade them to allow an appropriate person to be involved in the consultation⁶. If they refuse and you are convinced that it is essential, in their medical interests, you may disclose relevant information to an appropriate person or authority. In such cases you must tell the patient before disclosing any information, and, where appropriate, seek and carefully consider the views of an advocate or carer. You should document in the patient's record the steps you have taken to obtain consent and the reasons for deciding to disclose information.</p> <p>GMP for Physicians: Physicians must respect patients’ privacy and dignity</p> <p>GMP for Physicians: Physicians must keep information about patients confidential</p> <p>GMP for Physicians: Physicians must share information with relatives and carers,</p>		
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unless the patient withholds consent.

GMP for Physicians: Physicians must respect the right of patients to decline to take part in research or teaching

Special entries: Consent forms

Standard 24	Consent forms should be included within the record
Notes	None
Evidence Base	None identified
Other standards	<p>RCS guideline 4A: For patients undergoing surgery, records should include details of the following:</p> <ol style="list-style-type: none"> 1. Signed evidence that informed consent has been obtained by a doctor. 2. Signed evidence that the correct procedure was followed when obtaining consent for children under the age of 16 years. 3. The medical care plan should include the site and side of any operative procedure. Sites and sides must be written in full and not abbreviated.

RCP Standard	Notes	Evidence-Base	Other Standards
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Special entries: Death

Standard 25	<p>The entry made when death is confirmed should contain the following information:</p> <ul style="list-style-type: none"> • Date and time of entry • Name of certifying doctor in block capitals • Designation of certifying doctor • Examination made establishing death • Time and date patient certified dead • Signature of certifying doctor, followed by full name in block capitals
Notes	Remember that confirmation of death is very difficult in severely hypothermic patients. Advice should be sought if there is any doubt.
Evidence Base	None identified
Other standards	None identified
Standard 26	<p>When the death certificate is completed, an entry should be made in the record stating: The cause of death as appearing on the death certificate; whether a cremation form has been completed; whether and how the deceased relatives have been or will be informed; and whether and how the general practitioner has been or will be informed.</p>
Notes	<p>The death certificate must be completed according to the guidance provided with the pad of death certificates.</p> <p>Informing the general practitioner is important because it gives them the opportunity to offer counseling and support to the relatives of the deceased.</p>
Evidence Base	None identified
Other standards	<p>RCS guideline 6D: When a patient dies a similar communication [to the discharge summary] should be completed and sent to the patient's general practitioner.</p> <p>RCS guideline 6E: Details of death certificate entry should be written into the patient's notes.</p>

RCP Standard	Notes	Evidence-Base	Other Standards
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Standard 27	Deaths should be reported to the coroner if:		
	<ul style="list-style-type: none"> • you cannot readily certify that the death was due to natural causes • the cause of death is unknown • the deceased was not seen by the certifying doctor either after death or within the 14 days before death • the death was violent or unnatural or suspicious • the death was due to self neglect or neglect by others • the death may be due to an industrial disease or related to the deceased's employment • the death may be due to an abortion • the death occurred during an operation or before recovery from the effects of an anaesthetic • the death may be a suicide • the death occurred during or shortly after detention in police or prison custody 		
Notes	There is no statutory obligation for doctors to inform the coroner: this duty rests with the registrar of births and deaths. However, the processes involved can be accelerated and be made less uncomfortable for the relatives if the coroner is informed directly.		
Evidence Base	None identified		
Other standards	GMP for Physicians (supplement for acute physicians): All deaths within 24 hours of admission and other unexpected deaths should be promptly reviewed in a multidisciplinary forum. Records of these reviews should inform the clinical governance process.		

Standard 28	If a post-mortem is undertaken, then a copy of the post-mortem report must be filed in the record.		
Notes	None		
Evidence Base	None identified		
Other standards	<p>RCS guideline 7A: When a post mortem is performed a provisional 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.</p> <p>RCS guideline 7B: A review of the clinical diagnosis and the findings of post-mortem examinations are an important part of the clinical process and should be contained within the notes.</p>		

RCP Standard	Notes	Evidence-Base	Other Standards
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Medical records management

Standard 29	Doctors should ensure that processes are in place to ensure that their patients' health (and other sensitive) information is safeguarded against loss, damage or unauthorised access and kept confidential in accordance with the latest legislation, and guidance.
Notes	Current (January 2003) documents of importance: <ul style="list-style-type: none"> • Data Protection Act 1998 • Information Commissioner's guidance on health information • ISO 17799 / BS7799 – Security of confidential patient information • Computer misuse act 1990
Evidence Base	None identified
Other standards	<p>CNST Clinical Risk Management Standard 4.1.2: Medical records are bound and stored so that loss of documents and traces are minimised for in-patients and out-patients.</p> <p>CNST Clinical Risk Management Standard 4.1.5: CTG and other machine produced recordings are securely stored and mounted.</p> <p>RCS guideline 8A: ...policies should be established locally with regard to the following:</p> <ol style="list-style-type: none"> 1. Safeguarding information in the records against loss, damage, or use by unauthorized persons. 2. Confidentiality and release of information which takes into account of the Data Protection Act and Access to Medical Records Act 1988.
Standard 30	Doctors should participate in auditing medical records against evidence-based standards.
Notes	None
Evidence Base	One study looked at the relationship between quality of A&E records on doctors' performance and subjective quality of health. ¹⁰³ They found no benefits from more complete records in emergency care, but this result is not necessarily transferable into secondary care since a detailed knowledge of past medical history becomes more important, especially with elderly patients.
Other standards	<p>SIGN 2.5: Regular audit should be performed to ensure that the quality of the IDD is maintained.</p> <p>GMP for Physicians: Physicians should retain minutes of meeting where clinical records have been audited against agreed standards.</p>

RCP Standard	Notes	Evidence-Base	Other Standards
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CNST Clinical Risk Management Standard 4: A comprehensive system for the completion, use, storage and retrieval of health records is in place. Record keeping standards are monitored through the clinical audit process.

CNST Clinical Risk Management Standard 4.1.7: There is clear evidence of clinical audit of record keeping standards for all professional groups in at least 25% of specialties, including any high risk specialties, within the 12 months prior to the assessment.

CNST Clinical Risk Management Standard 4.2.6: There is clear evidence of clinical audit of record keeping standards for all professional groups in at least 50% of specialties, within the 12 months prior to the assessment.

CNST Clinical Risk Management Standard 4.3.2: There is clear evidence of clinical audit of record keeping standards for all professional groups in all specialties, within the 12 months prior to the assessment.

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