

Setting the Records Straight

A Review of Progress in Health Records Services

Proper management of health records and accurate, comprehensive record-keeping are essential to effective patient care. In 1995 the Commission published *Setting the Records Straight*, a study of hospital health records, and reported major problems...

- low status of records departments, with poor facilities for staff and storage of records
- difficulties in retrieving records for consultations
- lack of order and inadequacies of record-keeping within the casenote folder

...and made several recommendations for records managers and trusts.

- setting trust-wide health records policies in conjunction with a health records committee and monitoring performance against them
- setting and implementing an archiving policy, in order to maintain (ideally) only one main library with restricted access
- aiming to have one casenote folder per patient



- agreeing a casenote structure, providing guidelines to staff on maintaining standards for their contents; and monitoring performance against these standards

The report concluded that trusts still had much to do to create a quality records service before the benefits of investing in technology would be felt. This update examines the main changes since the audits in 1994/95.

Health records departments have generally seen significant improvements in the last four years...

- retrieval rates of casenotes at outpatient clinics have greatly improved; nearly half of trusts retrieve at least 99 per cent by the start of clinics

- in 1995 few trusts had electronic systems for tracking casenotes; this has risen to 62 per cent of trusts
- the number of trusts operating a restricted-access library for casenotes has risen from 41 to 62 per cent
- the number of trusts employing technology to solve storage problems and investing in document image processing has increased
- there are fewer records libraries and secondary stores per trust
- basic standards of record-keeping have improved; many trusts have changed the structure of casenote folders
- the status of records departments in trusts is higher; 85 per cent of records managers report to a general manager or director

...however, there is scope for further progress...

- some trusts still perform below the benchmark of 95 per cent availability of casenotes at clinics
- standards of record-keeping vary, and many trusts could improve the contents of their casenotes

...and trusts should consult their auditors to compare their performance with other trusts and identify those areas most in need of improvement.

Value-for-money indicators

This update is part of a series that tracks progress on a number of selected national value-for-money studies, using indicators based on the original study recommendations.



**AUDIT
COMMISSION**

Promoting the best use of public money

Introduction

...the national average availability of patient records had increased...

1. Information about the clinical care of hospital patients is recorded in their health records or casenotes. Accurate and comprehensive recording of information and accessibility to this information are essential for effective patient care and continuity of care between different health professionals.

Casenotes are also important for teaching, research and clinical audit, as well as being a source of managerial, financial and statistical data for the NHS. It is expected that they will play a key part in demonstrating clinical governance.

2. In 1995, the Audit Commission's report, *Setting the Records Straight*, examined a wide range of issues relating to the management of health records services and to the contents of casenote folders. This update reports the results of a follow-up survey of trusts (225 respondents), which was carried out by the Audit Commission early in 1999. It examines the changes that have taken place in the organisation and effectiveness of health records services, the storage of records and their structure and content. Variations in performance in all these areas were similar in both English and Welsh trusts, so results are presented for all trusts together throughout this update.

Retrieving records for consultations

3. An indication of good management and operational efficiency of health records services is the ability to provide 100 per cent of patients' records for outpatient appointments by the time clinics start. In 1994/95 the Audit Commission suggested a benchmark of 95 per cent for casenote availability at clinics, below which performance was considered to be poor. At that time, one-quarter of trusts in the sample fell below the benchmark.

But by 1998/99, this proportion had improved considerably, although 38 trusts were still below the benchmark. During this period, the national average availability of patient records had increased from 96 per cent to 97.3 per cent – a positive, although not statistically significant, result.

4. An important improvement was the proportion of trusts achieving 99 per cent or better

availability of records at the start of clinics, up from 18 per cent in 1994/95 to almost 50 per cent in the follow-up survey [EXHIBIT 1]. Even where health records departments had to supply notes to a number of hospital sites and satellite clinics, these trusts were equally as likely to maintain 99 or 100 per cent availability. At least 20 per cent of the trusts that were surveyed regularly monitored this performance measure themselves.

5. Casenotes that are missing may not just be down to the operation of the records department but also to directorates if responsibility for 'pulling' (retrieving casenotes from library shelves), finding or preparing notes for clinics has been transferred to directorate staff. Often policies and procedures for locating casenotes are not followed by other trust staff, making casenotes difficult to trace.

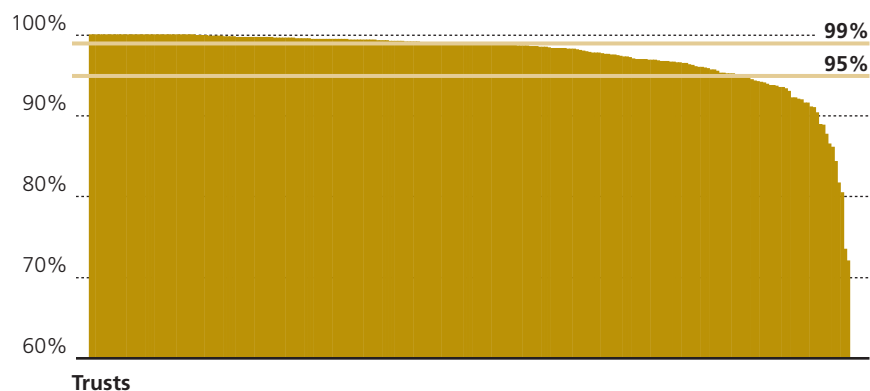
6. For those trusts that do not manage to obtain all records in time for clinics, the outstanding sets are often found during the clinic [EXHIBIT 2]. Although better than not having them at all, obtaining these outstanding casenotes can be time-consuming, and have a knock-on effect on other clinics if staff are taken away from their work to trace missing records. Some 17 per cent of trusts were unable to find any of the outstanding casenotes or did not have the staff time available to continue searching for missing notes. The impact upon patients in these trusts may be quite considerable if their notes are not available for their consultations. Patients may be kept waiting and, without a full set of notes, the consultation may take longer or be less effective. In some cases doctors may even refuse to see patients. These trusts need to examine the adequacy of their retrieval procedures and any consequent adverse effects on patients and workload.

EXHIBIT 1

Casenotes available at the start of outpatient clinics

Nearly 50 per cent of trusts retrieve at least 99 per cent of casenotes by the start of clinics, but a small number of trusts still fall below the benchmark of 95 per cent availability.

Percentage of casenotes available at the start of clinics



Source: Audit Commission

EXHIBIT 2

Casenotes found during outpatient clinics

The majority of trusts find some of the outstanding casenotes during clinics.

Percentage of casenotes



Source: Audit Commission

Sixty-two per cent of trusts now use electronic casenote-tracking

7. The original study reported that, when notes are pulled for clinics, only 60 to 70 per cent are available on the library shelf. The remaining notes are in circulation within the trust. The efficient retrieval of these notes relies on having a proper system for tracing their whereabouts. This may be a manual tracing system, where the destination of a set of notes is recorded on a card that is inserted on the library shelf when the notes are removed, or it may be an electronic system where casenotes are logged out on the tracking module of the patient administration system. This enables anybody looking for a set of casenotes to identify their location by interrogating a terminal, or for anyone to record the transfer of notes at any terminal in the trust.

8. At the time of the original study, few trusts had implemented electronic casenote-tracking. However, those that had invested in electronic systems reported savings through more efficient search processes. Sixty-two per cent of trusts now use electronic casenote-tracking. Of those trusts that do not, many are planning to introduce it in the next 12 months, which will bring the proportion to 80 per cent. There is no significant relationship between casenote availability at clinics and electronic casenote-tracking, suggesting that manual tracing systems can work equally well. But there may be additional benefits from using an electronic tracking system in that it releases resources for improving other aspects of the service; for example, to support a 24-hour service for retrieving records.

Storage of records

9. The original study reported some of the disadvantages of 'open' libraries. When anyone in the trust can remove casenotes without recording their destination properly, notes are more likely to be difficult to trace or track and to go missing, as well as compromising the security and confidentiality of notes. Implementing a 'closed' library with, for example, a keypad security lock and a staffed front desk for issuing and receiving casenotes, usually means physical adjustments to the library as well as requiring extra staff time. However, the benefits of improved reliability, service to clinical staff and security should justify making libraries closed. At the time of the audits in 1994/95, 41 per cent of trusts had a closed library. This has now increased to 62 per cent and is concomitant with a national reduction in the average number of libraries per trust from 2.6 to 1.9, and secondary stores from 1.9 to 1.7.

10. *Setting the Records Straight* reported that many records libraries were overcrowded and that the subsequent introduction of 'overspill' stores sometimes generated further problems. For example, such buildings were often in poor repair, had unsuitable shelving or were not easily accessible. A number of steps can be taken to reduce the amount of material that needs to be held in a library. These should be set out in a clear archiving

policy for the retention and destruction of records. Even where trusts had such a policy, it had often not been implemented because of the staff time required or other financial reasons.

11. Two-thirds of trusts still keep hard copy casenotes and destroy them after the statutory retention period (or longer). However, there is more likelihood of records being stored outside the trust, with one-third of trusts reporting that they use off-site archives. These may be trust-controlled or contracted out. While 48 per cent of trusts are using long-established microfilm technology, there was a significant investment by 42 trusts in document image processing to archive casenotes.

12. The size of casenotes is addressed in two ways by trusts. Only 10 per cent are culling (regularly reducing the size of) notes, reporting that they remove transitory documents after a patient has been discharged. An additional 18 per cent of trusts split casenotes into core and non-core documents, usually to address the problems associated with bulky notes. This total of 28 per cent of trusts compares with just 17 per cent in 1994/95 that reported splitting casenotes to reduce their bulkiness.

...there was a significant investment by 42 trusts in document image processing

Structure and contents of casenotes

13. To ensure quality and continuity of care for patients, the contents of records should be maintained in an ordered way, and be complete. The responsibility for the contents of notes lies with all trust staff who handle, write and maintain them, not just health records staff. Some 63 per cent of trusts reported that they have carried out clinical audits of record keeping in high-risk specialties during the last 12 months, indicating greater concern about the quality of casenote contents.

14. The way that information is grouped within the casenote folder varies between trusts despite the 1965 Tunbridge Report (Ref. 1), which called for a common approach. In addition, a number of organisations – including professional bodies for doctors, nurses and others, the Institute of Health Record Information and Management (IHRIM) and the Department of Health – have issued guidance on how to maintain good records. As part of its original study, the Commission invited a group of professionals to summarise the guidance into a set of good practice principles [EXHIBIT 3].

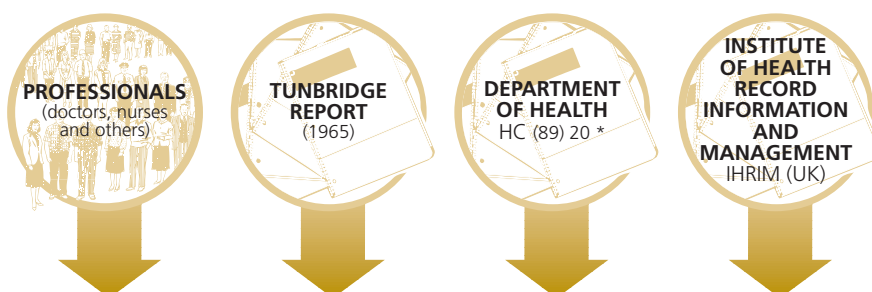
15. In the follow-up survey, trusts checked a sample of casenotes for 17 standards that are based upon the good practice principles covering legibility, patient identification, diagnosis, treatment, nursing records, diagnostic tests, structure, housekeeping of notes, and confidentiality. National results for the individual standards, as well as a composite indicator

incorporating all 17, show a general improvement in casenotes [EXHIBIT 4]. Overall compliance with the standards had risen from 78 per cent in 1994/95 to 86 per cent in 1998/99. Statistically significant improvements have been made to the casenote structure – use of a contents index or filing order printed in the notes was up from 38 per cent to 63 per cent; use of section dividers was up from

EXHIBIT 3

The principles of good practice for casenotes

A group from various professions has distilled a set of good practice principles for casenotes.



- The patient should be clearly identified and the casenotes should set out diagnosis, history, treatment, results and care plans.
- Casenotes should be kept neat and tidy with legible entries signed and dated, preferably in black ink.
- They should be kept up to date and filed in chronological order with the most recent on top.
- Casenotes should have a clear structure, which is agreed with users, and should be organised into sections.
- There should be a policy determining which documents should remain in the casenotes after discharge (culling).
- There should be one set of casenotes for each patient.

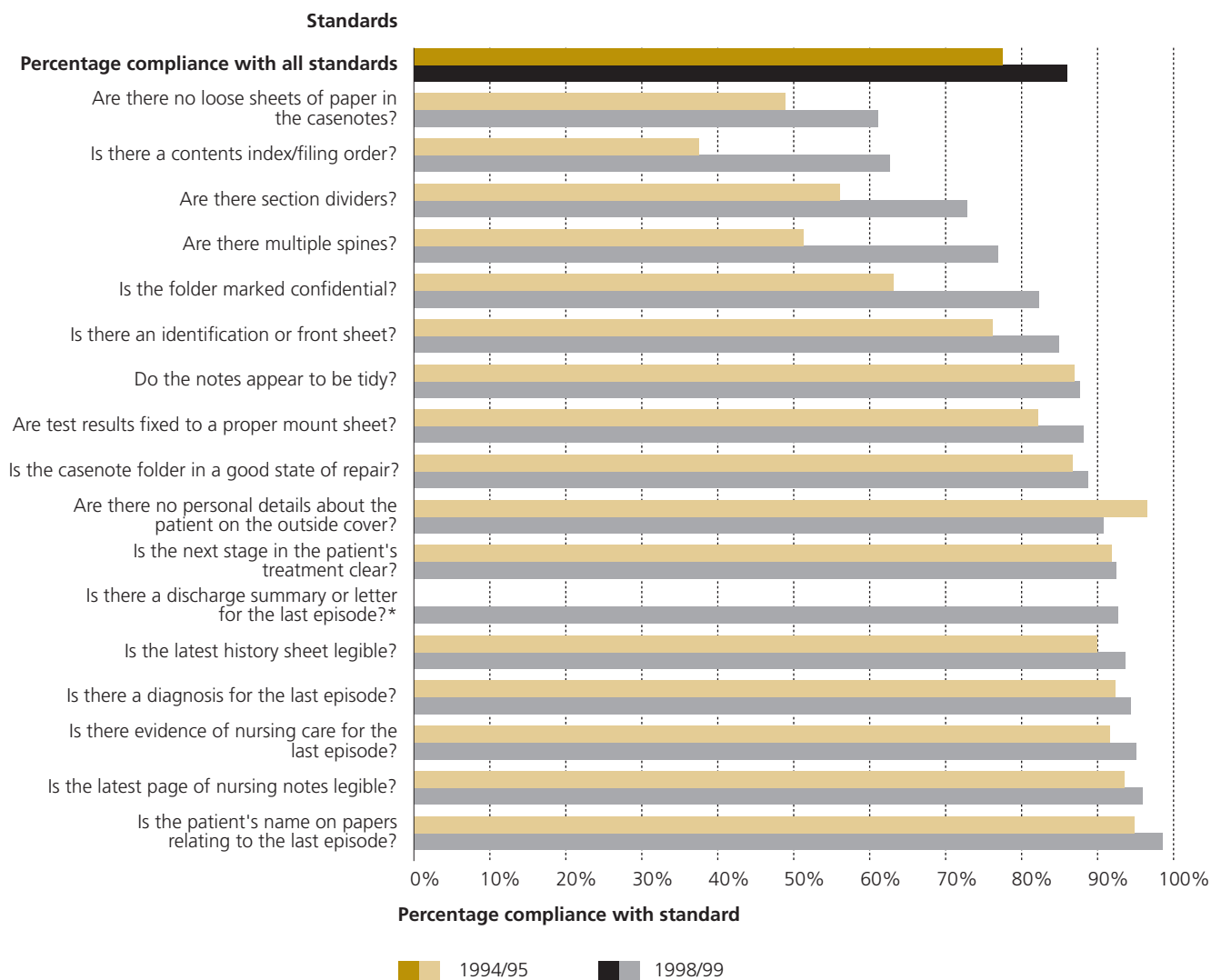
* Now superseded by HSC 1999/053

Source: Audit Commission

EXHIBIT 4

Quality of record-keeping

Nationally, improvements were seen in the standards for casenotes.



* 1994/95 data not available

Source: Audit Commission

56 per cent to 73 per cent; and use of multiple spines – another way of dividing casenotes into sections – was up from 51 per cent to 77 per cent. Clearly, well-organised and indexed notes have encouraged all users to file additional entries tidily, as demonstrated by the increase in casenotes without loose paper – up from 49 per cent to

61 per cent. Yet, despite considerable progress against these four standards, they are also the areas with the largest potential for further improvement. There was also a significant improvement in identifying the patient on all papers related to the latest episode of care, from 95 per cent to 99 per cent.

...the likelihood of casenotes being lost has decreased enormously...

16. The only standard to show a decrease was the one relating to personal details (for example, allergies, blood group, deafness) on the outside cover. In 1994/95, 97 per cent of casenotes in the sample had no personal details on the outside cover. In 1998/99, this had fallen to 91 per cent. As there are no specific guidelines on this issue, trusts themselves determine policy in this respect. They must assess the risk of having no crucial information immediately visible, weigh this against the compromise to patient confidentiality, set out a policy for recording such details and ensure that it is followed. A sensible compromise between confidentiality and risk is to use

‘alert’ stickers on the front cover, and provide details of the condition prominently on the inside.

17. Despite a national improvement in most standards, there is still considerable variation between trusts in their improvements to the structure and contents of patients’ records [EXHIBIT 5]. In a number of trusts, standards have got worse, not better, since 1994/95.

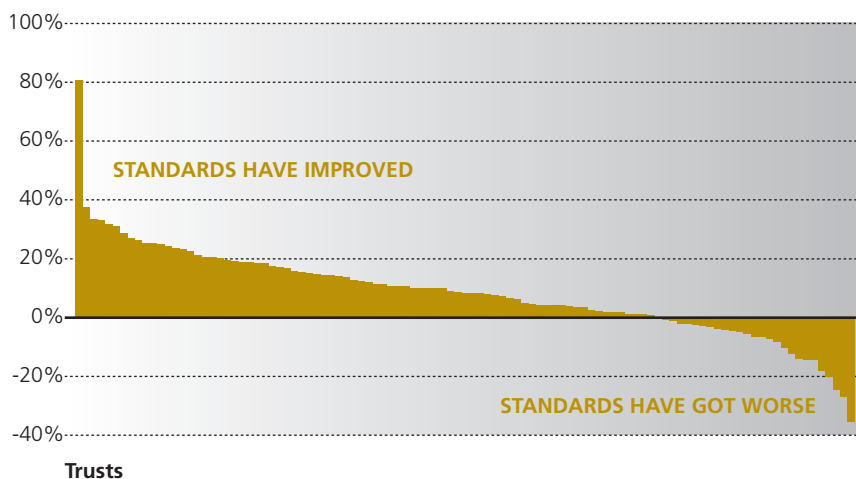
18. There has been no change in the percentage of trusts adopting one folder per patient, which remains at 61 per cent. Some consultants prefer to keep separate specialty notes, for fear of the main casenotes going missing. The evidence suggests that the likelihood of casenotes being lost has decreased enormously during the last four years. However, the lack of change may be due more to the practical difficulties and costs of amalgamating one or more sets of notes, rather than to any resistance to the principle of a single set of casenotes. Trusts that have merged recently have to face this major task in any case, in order to have one hospital number and one set of notes per patient. If more than one set of notes per patient does exist, each should be suitably cross-referenced so that users are aware of the existence of other notes.

EXHIBIT 5

Change in quality of record-keeping since 1994/95

Trusts vary in the extent to which they have improved the standards for casenotes.

Change in compliance with standards



Source: Audit Commission

Organisation and management of health records services

19. This review has revealed some changes that have taken place over the last four years in the organisation and management of health records. Traditionally, health records managers have been managers of people. The national report said that they had to become managers of systems and procedures as well, setting trust-wide policies for health records and monitoring performance, and that they needed to involve senior managers to give them the authority to carry out their new role. This review shows that the status of health records departments and managers is high in trusts, with some 85 per cent of health records managers reporting directly to a general manager or director, while most of the others report to other types of senior managers. Half of health records managers belong to their professional body, the Institute of Health Record Information and Management (IHRIM), and have access to training, networks and the latest thinking on health records management. Active health records committees involving clinicians and directorate staff are an important vehicle for health records managers to consult on policy and procedures concerning health records before decisions are made. In 1994/95, only 50 per cent of trusts had an active health records committee. This has risen to 79 per cent.

20. In 1994/95 it was noted that, in many trusts, staff such as ward clerks and medical secretaries had moved from health records departments to clinical directorates or service groups. This trend has continued over the last four years, although central filing and library facilities remain under the control of the health records manager. Data on the number of tasks carried out by departments reveal the current diversity of health records organisation. Many of the tasks traditionally carried out by health records departments are now devolved to clinical directorates or other staff groups. In 42 trusts, responsibility for clinic preparation of notes had been devolved to directorates. Some health records departments have responsibility only for the 'first pull' for clinics, with directorate staff taking on the search process for the outstanding sets. In 10 trusts the health records departments do not pull notes for outpatients at all – traditionally a large chunk of the work. Of these, three reported not having responsibility for pulling notes for emergencies, inpatients or outpatients, representing a major change in the organisation of records services in these trusts.

This review shows that the status of health records departments and managers is high...

21. Trust mergers have meant that the percentage of health records departments that supply notes to only one hospital site has dropped from 69 to 26 per cent, and over the last four years the percentage that supply three or more hospital sites has risen from 1 to 54 per cent. More trusts are in the process of using technology to support their records services in these larger organisations. Fifty-one per cent of trusts have an electronic results system for

laboratory reports (most include ordering of tests, too), yet most (93 per cent) still put a paper copy in the casenotes as well. The number of trusts using front identification sheets in casenotes has decreased (from 83 per cent to 75 per cent), probably because of the improved accessibility to information systems throughout trusts.

22. We have already mentioned the widespread use of electronic casenote-tracking and the growing number of trusts using document image processing. Few, if any, were using the latter in 1994/95 and usually only in an experimental capacity. Although used primarily for archiving notes, some see this as a key stage towards the electronic patient record. Almost two-thirds of trusts have proposals in their business plans for electronic patient records.

Almost two-thirds of trusts have proposals in their business plans for electronic patient records



Next steps

23. Health records services have generally seen significant improvements in the last four years. The increasing use of technology, and the higher status of health records departments and managers, have assisted the implementation and monitoring of trust-wide policies and procedures.

However, there is variation in performance among trusts and also scope for further improvements in some cases. This follow-up survey will help trusts to identify areas for further progress. The Commission's auditors will assist each trust to do this, using specially developed software to

provide a more detailed analysis of local performance. Chief executives and health records managers should discuss their results with their auditors if they have not already done so.

References

1. Standing Medical Advisory Committee, *Report on the Standardisation of Medical Records* (the Tunbridge Report), Ministry of Health, 1965.

Following up value-for-money studies and audits

Each year the Audit Commission follows up selected national studies and associated local audits that it has carried out to see what changes have taken place. It does this by identifying key indicators – value-for-money indicators (VFMI)s. These are based on the recommendations made by the study and compare new data for these indicators against the data collected at the time of the original audit. The choice of studies depends on the continued relevance of the topic and recommendations, and the scope for change. The results provide not only a valuable national picture of change, but they also allow individual trusts to gauge their own progress against that of other, similar trusts. Separate results are produced by auditors for each individual trust, using computer software that allows them to select indicators and tailor comparative groups to particular local needs. The information for hospital health records, based on a total of 225 returns from trusts, has recently been given to auditors, and chief executives should discuss the mechanisms for local feedback with their auditor if they have not already done so.

© Audit Commission 1999

£5.00

5 copies for £20.00



Printed in the UK for the Audit Commission by Kent Litho, Kent.

Typeset by Eighteen04 Design, Woodbridge, Suffolk

ISBN 1 86240 188 8

Photographs: Hilary Shedel (cover, p4, p11).

.....
*Further copies and copies of the national report on which this update is based, **Setting the Records Straight: A Study of Hospital Medical Records** (ISBN 0118864122, 1995, £10), are available from:*

Audit Commission Publications
 Bookpoint Ltd
 39 Milton Park
 Abingdon
 OX14 4TD

Freephone 0800 502030
