RACGP

Royal Australian College *of* General Practitioners

Improving health record quality in general practice

How to create and maintain health records that are fit for purpose

Improving health record quality in general practice: How to create and maintain health records that are fit for purpose

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

Contents

Introduction

The quality of patient health records kept by general practices is an important factor in safe and effective healthcare.

The primary purpose of a clinical health record is to hold the information about a patient that is required for effective care: good patient information supports appropriate clinical decisions. With changes to the way primary care is delivered, including increasing use of shared care models and the introduction of a national eHealth record (My Health Record), the quality of this information is more important than ever. No longer serving only individual general practitioners (GPs) or practices, information in a patient's health record is likely to be shared between and relied upon by primary, secondary and tertiary healthcare services.

Aside from contributing to effective, safe and personalised patient care, general practice health records may also serve a number of other purposes, including providing data for research and policy, contributing to education, and providing healthcare evidence for medico-legal purposes. All these uses depend on records containing high-quality information that is accessible to appropriate users.

Yet maintaining high-quality health records is not always regarded as a priority by general practices or GPs. Competing demands on busy clinicians and practice staff mean the importance of health record quality is often overlooked, and some may not be aware of what is expected of health records.

To assist with this, The Royal Australian College of General Practitioners (RACGP) has produced this guide, outlining what constitutes a high-quality health record and how practices can put systems in place to ensure they produce health records that are fit for purpose.

Benefits of high-quality health records

Maintaining high-quality health records has benefits for patients, GPs, the practice and the wider community.

For patients, the quality of their health information kept by a practice can affect their healthcare outcomes, as it informs decisions about their treatment and facilitates continuity of care (both within the practice and between other services). High-quality records also make it easier for patients to access and understand their healthcare information.

For individual GPs, high-quality health records allow them to effectively communicate with their colleagues and other health professionals. They allow GPs to take full advantage of clinical information systems to more efficiently manage patient follow-up – through reminders or recalls – for particular patient populations. GPs may also rely on health records in defending against medico-legal claims.

For general practices, high-quality patient health data is becoming more and more essential for quality improvement activities – whether this be carried out by a practice itself or in collaboration with an external agency (eg participation in NPS MedicineWise's MedicineInsight program). It also allows a practice to better understand and identify its own patient cohort. This supports more effective healthcare delivery at both an individual and local population level.

About this resource

Improving health record quality in general practice is designed to help general practices produce and maintain high-quality health records that are fit for purpose. The guide presents six attributes of high-quality health records, and provides guidance about how practices can achieve these, including how to set up a health record system that facilitates the production of high-quality health records.

Tips and case studies are included throughout to give practical information about how to apply the principles discussed.

The attributes of health records presented in this guide align with the Medical Board of Australia's code of conduct for Australian doctors regarding medical records (section 8.4). It should be noted that this guide does not impose new obligations over the current RACGP *Standards for general practices*. Where a recommendation relates directly to a standard or 'Indicator', this is highlighted in the text.

The guide is general in nature and should be applied in the context of existing legislation, charters, codes of conduct, professional standards, clinical guidelines, or policies and position statements relevant to particular disciplines and organisations within the Australian primary healthcare sector.

For example:

- the RACGP *Standards for general practices* (5th edition)[1]
- the Australian Charter of Healthcare Rights[2]
- the Australian Safety and Quality Framework for Health Care[3]
- privacy legislation and associated privacy principles
- legislation that regulates the health disciplines overseen by national boards working in partnership with the Australian Health Practitioner Regulation Agency (AHPRA)
- legislation governing the My Health Record system.

Relevant indicator

Where there is a 'must have' in the *Standards for general practices* (5th edition), we direct you to the relevant Indicator for each section.

Recommendations are provided to assist general practices to meet the required accreditation standards.

Sharing health information

Although issues of privacy and confidentiality lie outside the immediate scope of this guide, they are nevertheless fundamental to what GPs need to consider before sharing health information with others, including other health professionals, patients and specified third parties.

In all instances where the guide refers to the 'sharing' of health information, this is intended to cover:

- the appropriate use and disclosure of information by a GP, including circumstances where use or disclosure is required or authorised by law (eg where a GP may need to use or disclose information to lessen or prevent serious threats to life, health or safety)
- a patient's consent – whether express or implied – to the collection, use and disclosure of health information
- a patient's right to access their own health information, including circumstances where denying access is required or authorised by or under law (eg where access to the information would pose a serious threat to the life or health of any individual).

Why quality matters

High-quality health records support good patient care

General practice patient health records have a number of primary and secondary purposes (Box 1), but above all, their purpose is to support safe, effective and appropriate care for individual patients and practice populations. The quality of health records kept by general practices – including how complete they are, their accuracy and legibility – is therefore critical. This is even more the case as patient health records are increasingly shared with other health practitioners and services (refer to 'Expect to share', below).

High-quality health records facilitate:

- safe clinical decision making
- effective communication between health professionals
- trusting partnerships with patients
- coordination and continuity of care.

In addition to facilitating care, high-quality health records also provide **evidence** of care. Doctors who face medico-legal claims will have a better case if their records are complete and demonstrate comprehensive care of their patient.

Expect to share

The way general practice health records are created and used is changing (Figure 1). Many practices are multidisciplinary, patients may be on shared care plans, and from late 2018, all Australians known to Medicare and the Department of Veterans' Affairs will automatically have a My Health Record created for them, unless they choose to opt out.

GPs are therefore no longer producing health records only for the benefit of themselves or their immediate colleagues, and the assumption of all GPs in a practice should be that at some point, the information they enter into a patient's health record will be shared. A patient's health record might be used by a range of health professionals and services to provide healthcare; it might be accessed by patients themselves, or required by third parties (eg for medico-legal purposes).

To be fit for sharing, patient health records therefore need to be of the highest possible quality.

Box 1. Primary and secondary purposes of health records

Health records may serve multiple primary and secondary purposes.

Primary purposes include:

- helping GPs make decisions about patient care, by providing a structure for thoughts and a record of previous consultations
- recording consultations provided by a range of health professionals to facilitate safe and effective care for patients and practice populations
- providing a source of information to be shared appropriately with other health professionals to facilitate safe and effective care
- providing a source of information to be shared with patients to facilitate a partnership in healthcare based on trust and respect.

Secondary purposes include:

- a tool for education, training and professional development
- a source of health information for clinical audits and quality improvement initiatives
- a source of health information to support the planning, commissioning, coordination and governance of primary healthcare services
- a potential source of data for approved research
- evidence for medico-legal purposes.

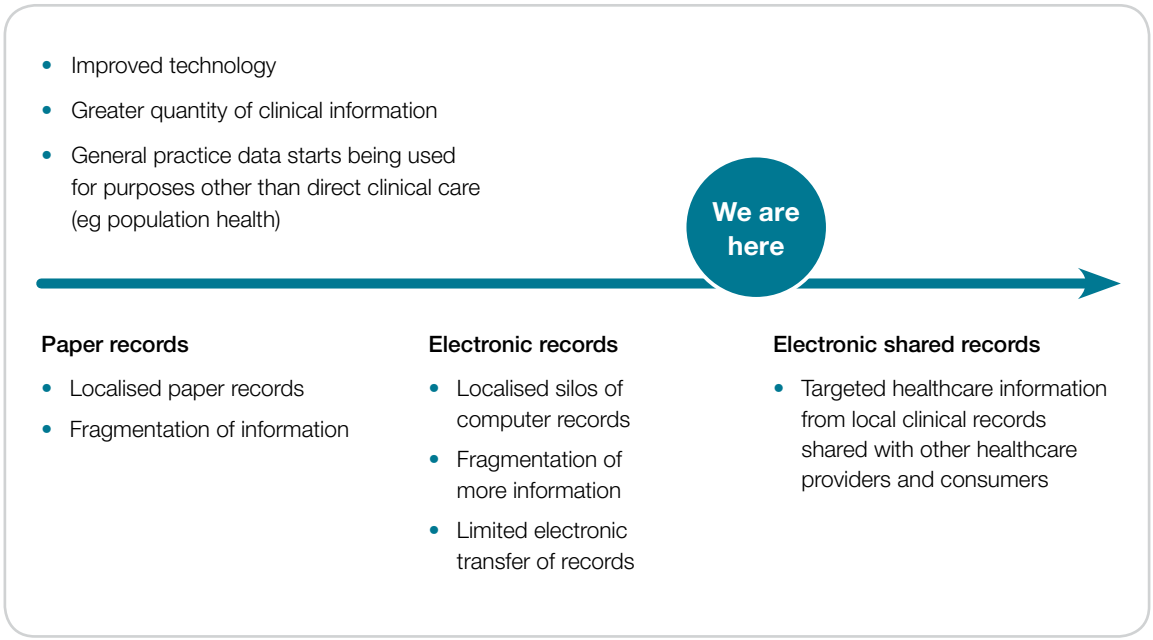

Figure 1. How use of general practice health records is changing

Currently, Australian general practice records are transitioning from locally held electronic health records, where some information is shared within a practice, to shared electronic health records, where local clinical information might be used by a range of healthcare providers.

What is ‘quality’?

Attributes of high-quality health records

Health records are only as good as the quality of the information they contain. The RACGP suggests a number of attributes of high-quality health records – that is, records that contain high-quality information that is suitable for the purposes it serves.

It should be noted these attributes are not discrete and they often overlap. For example, ensuring clinical notes are completed in a timely manner not only keeps health records up to date, it also improves their accuracy and completeness.

The RACGP suggests general practices regularly review their health records and record-keeping practices with reference to the following attributes. This can also form part of a practice’s quality improvement activities.

High-quality health records are:

Accurate

Health records should accurately and comprehensively record information captured about patients.

Accurate health information is critical to patient care. However, clinical information is by nature variable, uncertain and at times incomplete – a result of language use, the way practitioners reach a diagnosis and the variability of clinical terms used by different disciplines.

Practices and GPs therefore need to take care that records correctly reflect:

- patient details, including demographic information
- information captured during consultations
- information collected from other sources.

Relevant Indicators

C6.3D Only authorised team members can access our patient health records, prescription pads and other official documents.

You could:

- maintain a policy addressing the management of patient health information.

QI3.1A Our practice monitors, identifies and reports near misses and adverse events in clinical care.

You must:

- implement and maintain an incident or event register.

QI3.1B Our practice team makes improvements to our clinical risk management systems in order to prevent near misses and adverse events in clinical care.

You must:

- record the actions taken in response to events recorded on the incident or event register.

Tips for maintaining accurate records

- Regularly check that patient contact details are up to date. For example, make it routine to confirm patient details each time they attend the practice.
- Ensure only authorised and properly trained team members can access and alter patient clinical records.
- Whether a consultation is in person, by telephone or conducted by other means, make sure the patient is asked to confirm their identity, and that this is matched to the correct health record before the consultation begins.
- As part of your usual clinical risk management system, you may wish to record and review 'near misses' regarding incorrect or inaccurate incorporation of patient information into records.

> *Since the start of the funding program for shingles vaccine, we've been able to recall and vaccinate over 70% of our eligible patients. It only required a simple search using the practice software, but having accurate data made it so much easier.*
>
> – RACGP member

Complete

Health records should contain sufficient information to reliably serve a range of purposes.

Health records can have a range of purposes (Box 1), and health records should contain adequate information to serve those purposes. This includes information collected by the practice and information from other sources (Box 2).

GPs should consider the many different purposes of health records when recording information during a consultation, keeping in mind the 'expect to share' principle (refer to page 5).

At a minimum, the RACGP's *Standards for general practices* (5th edition) require patient health records to contain:

- (for active patients) identification details, contact details, demographic information, next of kin, emergency contact information
- records of consultations and clinical-related communications
- evidence that matters raised in previous consultations are followed up
- Aboriginal and Torres Strait Islander status
- cultural backgrounds of patient (if relevant)
- lifestyle risk factors
- date of consultation
- who conducted the consultation
- method of communication (eg physical, teleconference)
- patient's reason for the consultation
- relevant clinical findings
- any allergies
- diagnosis, if appropriate
- a recommended management plan and, where appropriate, the expected review process
- any medicines prescribed (including name, strength, directions for use, dose, frequency, number of repeats and date the patient started/ceased/changed the medication)

- patient consent for presence of a third party, if applicable (eg a medical student)
- record of any patient emails received
- documentation of referrals.

Other information health records might contain includes paper notes, application-based measurements (eg blood pressure, weight, glucose readings), complementary or over-the-counter medicines a patient is taking, advanced care plans, immunisations and occasional medication administration (eg monthly depot injections, vitamin B12, implants).

More about the required content of patient health records can be found in Core Standard 7 of the RACGP *Standards for general practices* (5th edition).

Relevant Indicators

C7.1A Our practice has an individual patient health record for each patient, which contains all health information held by our practice about that patient.

You must:

- maintain individual health records for each patient that include all required information.

C7.1B Our active patient health records contain, for each active patient, their identification details, contact details, demographic, next of kin, and emergency contact information.

You must:

- include, for each active patient, all of the required information listed in the Indicator.

C7.1C Our patient health records include records of consultations and clinical-related communications.

You must:

- ensure consultation notes include all mandatory elements
- include a record of all clinical-related communications (including emails) in the patient's health record.

C7.1D Our patient health records show that matters raised in previous consultations are followed up.

You must:

- document matters that have been followed up in the patient health record.

C7.1E Our practice routinely records the Aboriginal or Torres Strait Islander status of our patients in their patient health record.

You must:

- document the patient's Aboriginal or Torres Strait Islander status in patient health records.

C7.1F Our practice routinely records the cultural backgrounds of our patients in their patient health record.

C7.1G Our patient health records contain, for each active patient, lifestyle risk factors.

You must:

- document information relating to lifestyle risk factors such as height, weight and blood pressure in the patient health record.

C2.1C Our practice acknowledges a patient's right to seek other clinical options.

You must:

- keep documentation of a patient's decision to seek another clinical opinion in the patient's health record
- keep appropriate documentation of referrals in the patient's health record.

Box 2. Managing information from other sources

General practices receive a large volume of patient health information from external sources, often in a range of formats (eg pathology results, correspondence from specialists or allied health providers, hospital discharge summaries, significant telephone communications, photos, video recordings).

To ensure information is reviewed and correctly incorporated into health records, practices should implement a system for managing information from other sources. This system should support patient confidentiality, continuity of care and safe clinical handover. It might include:

- making particular team members responsible for receiving and managing information from other sources
- having clear procedures for incorporating information into health records (eg when and how to scan information into records)
- allowing clinicians time in their schedules for reviewing and incorporating incoming clinical information into records
- using secure messaging to receive health information electronically
- reviewing the process regularly to ensure information is being incorporated correctly.

Tips for maintaining complete records

- Use patient registration forms (electronic or paper), so that required information is routinely captured.
- Develop policies and checklists for the procedures involved in managing health information, both from within the practice and from other sources. For example, it could be practice policy that if new patient registration forms are returned incomplete, or not entered into the clinical information system, it is the role of practice staff to follow up with either the patient or their GP to complete the form and enter the information in the system.
- Record information that you would find helpful. Think of a locum GP using your health records: could they use the records to manage unfamiliar patients safely, effectively and efficiently?

Consistent

The practice's health record system should use a recognised medical vocabulary and standardised terms and abbreviations.

Using a recognised medical vocabulary and standard terms and abbreviations creates consistency when recording diagnoses, observations and procedures. This means records are usable by all health professionals who need to refer to a patient's health record. It also allows the practice's records to be searched for patient populations that may need additional treatment or follow-up.

Most clinical information systems will contain a nationally recognised medical vocabulary, coding system or classification system (eg SNOMED CT-AU, the World Health Organization's International Classification of Primary Care [ICPC]) to record patient information. These allow clinicians to use structured data entry (eg drop-down menus and pick-lists) to enter diagnoses, prescriptions, pathology and other diagnostic results. This information is automatically coded and classified by the software so that all patient records contain standardised information.

Free-text information is important for providing a narrative or context for a patient's health information, but it is more prone to ambiguity and is difficult to search. Where possible, free text should be used as a complement to the coding system. Clinicians should be mindful of the terms they use in free text fields and whether their meaning will be clear to others who might read the record, including patients (Box 3).

To help standardise free-text fields, the health professionals within a practice might agree on standard terms – for example, where different disciplines use different terms for the same diagnosis or procedure, or where there are common spelling variations for a disorder (eg 'type 1 diabetes' versus 'type I diabetes' or 'diabetes type 1'). Practices could provide a list of common usage and standard terms to all practitioners.

Using a recognised medical vocabulary and standardised terms in health records will mean:

- key details of a consultation can be recorded in a standardised way
- patient records can be understood more easily by health professionals who have not seen the patient before
- data can be easily and accurately retrieved for auditing, quality improvement, reviewing particular patient populations (eg eligibility for flu vaccinations)
- analysis of practice data is more reliable and accurate.

> *Our practice started participating in NPS's MedicineInsight program, and because part of the feedback is dependent on the quality of the data, we really saw the importance of using correct data entry fields.*
>
> – Member, RACGP Expert Committee – eHealth and Practice Systems

Relevant Indicator

QI1.3A Our practice team uses a nationally recognised medical vocabulary for coding.

You could:

- use patient management software to code patient health information.

Tips for consistent records

- Educate practice staff about the importance of entering information in a standardised way, and provide training in how to take full advantage of the clinical software's structured data entry.
- Maintain an agreed-upon list of standard terms, acronyms and abbreviations that are generally used by healthcare professionals in the practice and by the broader health community. Ensure that everyone in the practice can easily access it.
- Clinicians may set up shortcut keys or autocorrect to spell out common abbreviations in full.
- Use clinical tools to help collect consistent information from particular populations – for example, a template of questions for baby checks that is linked to fields in the record.

Easily read and understood

Health records should be legible and written in a way that is meaningful to other users.

Information in health records should be legible and presented in a way that is meaningful to other people who will access the record – including patients themselves. Documenting health records in a meaningful way can facilitate continuity of care and improve patient outcomes.

The legibility and readability of health records will be influenced by:

- keyboard and typing skills
- familiarity with software and shortcuts
- the quality of scanned documents
- how forms are designed or laid out
- use of suitable typefaces
- language use (Box 3).

Box 3. Language use in high-quality health records

The kind of language used in free-text information can affect how well that information is understood. Language in high-quality health records is clear, unambiguous and meaningful to others.

Remembering that patients can access their own records, and should be able to understand them, GPs should avoid using jargon, shorthand and abbreviations. It is also important that language is respectful.

Tips for legible records

- Avoid idiosyncratic abbreviations, shorthand and jargon (refer to 'Consistent' above).
- Clinicians who aren't strong typists may consider using voice-recognition software to record computer notes.
- Conduct regular 'peer reviews' of health records to see whether they can be easily understood by other GPs.

Accessible

Health information should be recorded in ways that make it readily retrievable.

A practice's health record system should make it easy to retrieve information for a range of purposes. This includes having clear information and procedures for patients to access their records.

A fully electronic system is preferable, as information is most easily retrievable from these systems.

Relevant Indicators

C6.2A Our practice has a system to manage our patient health information.

You must:

- have a system to manage patient health information
- have all patient health information available and accessible when needed.

C6.2B If our practice is using a hybrid patient health record system, a note of each consultation/interaction is made in each system, and that record includes where the clinical notes are recorded.

You must:

- keep a record of consultations in both the paper and electronic health record
- have all patient health information available and accessible when needed.

C6.3B Our patients are informed of how they can gain access to their health information we hold.

You must

- maintain a privacy policy.

We have the case discussions in our practice with the registrars seated around a computer. Another doctor looks at the record and we discuss as a team if the record is clear to the other doctor. My typos are legendary in this gentle and supportive exposé!

– Member, RACGP Expert Committee – eHealth and Practice Systems

Up to date

Information should be recorded in patient health records in a timely manner.

Ensuring information is recorded in a patient's record as soon as possible after it is collected helps with accuracy and completeness of records. Information collected during a consultation should be recorded at the time, or as soon as possible afterwards. Information received from other sources should be entered into a patient's record within a reasonable time frame.

Tips for ensuring records are up to date

- Set aside time for GPs to maintain patient records, including time to review information that needs be entered from external sources. For example, incorporate gaps into daily appointment schedules, or make appointment times long enough for completing notes.
- Set up practice systems, such as software prompts, to remind the practice team to regularly review smoking and drinking status, rather than just 'setting and forgetting'.

Case study

At a major metropolitan after-hours deputising service, GPs beginning their shift would often be assigned 10 or more patients to triage, prioritise and then visit. The service found that doctors were having trouble completing patient records at the end of each shift, as many hours might have passed since seeing a patient before a doctor sat down to complete their consultation notes.

Because of concerns about the completeness of information recorded this way, the service changed its procedures so that each doctor received no more than three patients at a time to assess and visit. They were then given time to complete their consultation notes, before being assigned additional patients, until the end of the shift.

By making a fairly small systematic change, along with introducing a monthly internal audit of patient records, the service made a significant improvement in the quality of its patient health records.

Case study

An RACGP-accredited general practice in Queensland has established an 'accreditation taskforce', which includes a representative from each 'team' within the practice (GPs, administrative staff, clinical nurses, specialist nurses and reception staff).

One of the ongoing tasks for the GPs on the committee is to audit doctors' notes and mentor doctors whose notes are not of the appropriate standard. This process to ensure the quality of health records has led to:

- one GP completing a touch-typing course to improve their keyboard skills
- setting up practice-wide templates and autotext for common terms in the clinical information system to help GPs produce clinical records of an appropriate quality.

This practice also has a 'quality improvement team' to drive quality improvement within the practice, including improvements in health records. One of the achievements of this team has been the consistent coding of consultations across the practice.

Putting quality into practice

Systems and management

A health record 'system' refers to the way health information is collected, recorded and stored in a practice. The system encompasses the clinical information software and how it is used.

High-quality health records depend on a health record system with the right capabilities and capacity for the practice. The use of this system needs to be supported by practice policies and procedures, and by appropriate education and training. It is recommended that practices ensure they have adequate support to implement and oversee operation of electronic health record systems.

Practices may wish to designate a team member to manage the practice's strategy for health records. This role might include maintaining policies and procedures, and coordinating staff education and training; however, it is up to practice management to promote a practice culture that values high-quality health records (Box 4).

Box 4. The importance of leadership and culture

A key part of a practice's record-keeping system are the people who use it. For effective health record keeping to be prioritised, it must become part of routine practice; to become routine, it must be valued by the whole practice team.

The importance of a team culture that promotes high-quality health records cannot be underestimated. This may take time to develop, and it requires strong leadership that supports the practice team. Ongoing education and workplace policies and systems should facilitate high-quality health record keeping.

Policies and procedures

Practices could develop policies and procedures for the following aspects of high-quality health record management:

- using the health record system
- managing risk in the health record system (eg ensuring information is entered into correct records)
- system security – refer to the RACGP's *Information security in general practice* for more information regarding the accepted standards for information security.
- handling health record information (eg for entering information from outside sources and exporting patient information).

All policies and procedures should be documented, and reviewed regularly to make sure the health record system is being used as effectively as possible. Practices could also consider reviewing the team's compliance with practice policies; for example, having the practice team search and report on inconsistent use of diagnosis codes across health records at regular team meetings.

Quick quality checks: Using software features to review health records

Most clinical information systems have features that can help you audit the quality of health records; for example, the ability to track follow-up requests, such as recalls and reminders, that have not been actioned. It may also be possible to run a report of records that contain uncoded diagnoses, which can then be updated with the proper code or term.

Education and training

Education for practice team members to promote high-quality health records should begin during the induction of new members and should be ongoing from that point. This should be aimed at both clinical and administrative staff. Key areas to cover are:

- why high-quality health records are important
- attributes of high-quality health records
- effective use of the practice's health record system.

Training for GPs in the practice might include how to take advantage of clinical software features, such as decision support tools (eg asthma status for beta-blocker prescriptions, suicide risk assessment for patients with a mental health diagnosis) or automated prompts (eg for 'reason for visit' before a record can be closed, or regarding prescriptions that are contraindicated for a particular diagnosis).

Case study

As a quality improvement activity, a New South Wales general practice began auditing the quality of its patient records. Rather than conducting a one-off audit, the practice manager set up a quarterly audit, reviewing 10 records at random from each GP. She decided that reviewing specific qualities each time, such as clarity, timeliness and consistency, would let them easily compare the results of each review and assess improvement.

After three reviews, the practice manager noticed a decrease in the consistency of health information across records, with many diagnoses not being properly coded.

The practice arranged a group discussion at the next practice meeting about the importance of consistency in recording health information, and asked if there were any particular issues people were having. They realised that a quite few new GPs and locums had recently started at the practice, and these doctors were unaware that the practice had a list of standard terms. They also had not read the practice's policy on high-quality health records.

To make sure all new GPs coming into the practice were aware of resources and policies regarding health records, it was decided to run short sessions on high-quality health records at the regular practice meetings. In addition, the list of standard terms and a health record checklist were included in the practice's induction pack.

> *"Our practice has a comprehensive induction of all new team members, including doctors. Part of this process for clinical team members is training in the clinical software, to ensure they can use it competently, and practice protocols for health records.*
>
> – Practice manager

Practice tips for improving health record quality

Improving or maintaining the quality of health records does take effort, and it requires a continuous, practice-wide approach. Although there are no 'quick fixes', focusing on everyday areas of practice such as the following will help improve the quality of health records.

Practice culture

- Educate the practice team about the importance of high-quality health records and how to produce and maintain them.
- Designate a practice champion for high-quality health records who leads by example. Allow them dedicated time to fulfil this role.
- Promote an 'expect to share' mindset among staff.

Increasing skills and knowledge

- Educate, train and support all team members responsible for managing patient information.
- Provide access to education and training about how to use the clinical information system and get the most out of it for maintaining health records.
- Make sure everyone in the practice knows where to obtain support for the clinical information system and software.
- Provide tip sheets and trouble-shooting guides for common problems with the practice's clinical information system.

> *It can be hard to maintain high-quality records, and it requires effort. I think the whole process must be iterative, a continuing cycle of improvement.*
>
> – Member, RACGP Expert Committee – eHealth and Practice Systems

Supporting the practice team

- Make the quality of health records a regular focus of practice team meetings. For example:
  - acknowledge or reward GPs who keep high-quality health records
  - in multidisciplinary practices, organise a meeting to agree on standardised terminology across disciplines
  - make the quality of the patient's health record one of the standard areas to focus on when the practice team conducts case reviews.
- Allow time for the practice team to update their patients' records. For example, if required, provide brief gaps in daily appointment schedules for GPs to complete consultation notes.
- Consider what tools would help staff keep high-quality health records: checklists, standardised forms, proper equipment, software add-ons such as clinical audit tools or data analysis software.
- Conduct regular audits of the quality of health records, measuring them against the attributes described above.

Improving systems

- Implement a feedback process regarding health records to address problems raised by other healthcare professionals, other services or patients.
- Keep track of near misses and mistakes in the incorporation of information from other sources to identify ways to prevent these happening again.

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