RETRIEVAL OF CASENOTES FOLLOWING ADMISSION
How the delay affects patient management

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The Trust has recently released a policy document concerning the medical risks of treating patients without access to medical records. This states: '*The Trust will support a consultant who proceeds if he is comfortable that he is performing the correct procedure on the correct patient. Similarly, we will support any consultant who does not proceed in the absence of casenotes because he or she is uncomfortable about the clinical risk.*'

This audit was undertaken around the time that this policy was released and examines the very real problems and dangers associated with out-of-hours clinical practice. Its authors are a consultant surgeon and her trainee at Furness General Hospital (FGH).

Audit standard for casenotes

'An indication of good management and operational efficiency of health records services is the ability to provide 100% of patients' records for outpatients appointments by the time clinics start.'

In 1994/95 the Audit Commission suggested a benchmark of 95% 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. By 1998/99, this proportion had improved considerably.

We have attempted an audit of the medical records retrieval system at FGH. We are mindful that the audit standard referred to above is that for outpatient clinics. We have attempted to examine the retrieval rate for records pertaining to surgical admissions.

METHODS

A proforma was prepared containing the patient's basic details, date of admission, provisional diagnosis, time of arrival to A&E and to the ward, and the time when the casenotes were requested. These proformas were distributed among the pre-registration house officers and to the ward clerks.

This was a ten-week prospective audit involving 52 patients conducted in the department of general surgery at FGH. Data regarding the request and arrival of casenotes have been taken from ward registers.

RESULTS

Thirty-eight percent of patients did not have details of previous medical history available with a general practitioner's (GP) letter of referral on admission.

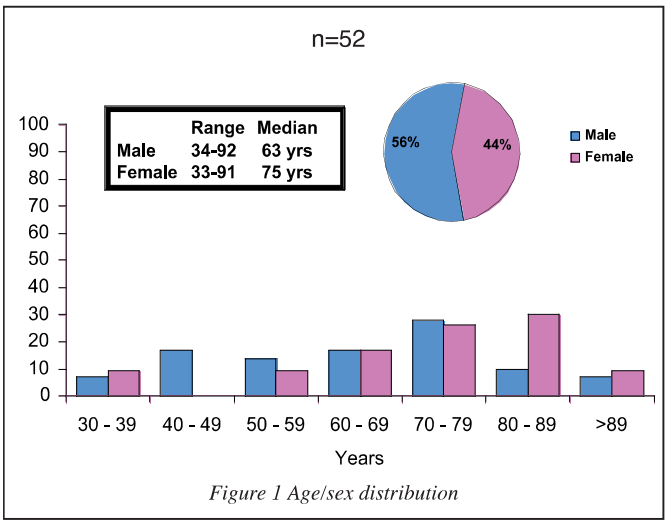

Figure 1 Age/sex distribution

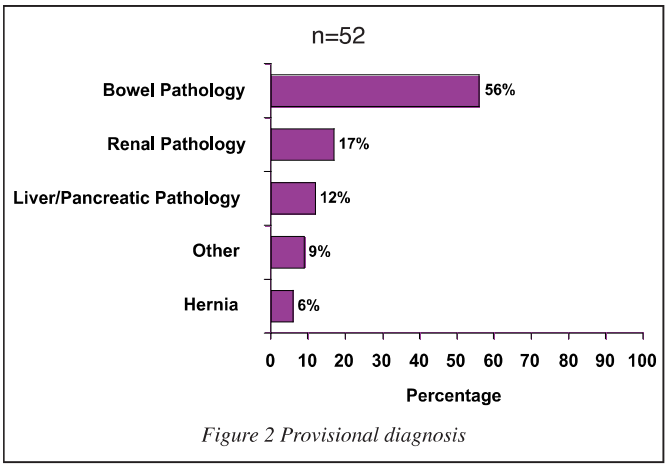

Figure 2 Provisional diagnosis

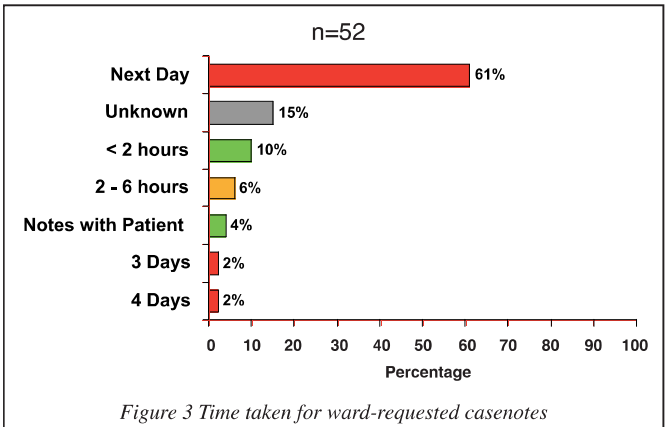

Figure 3 Time taken for ward-requested casenotes
(After admission, 61% of patients' casenotes were requested the next day. Casenotes were requested 3rd and 4th day for 4% of patients)

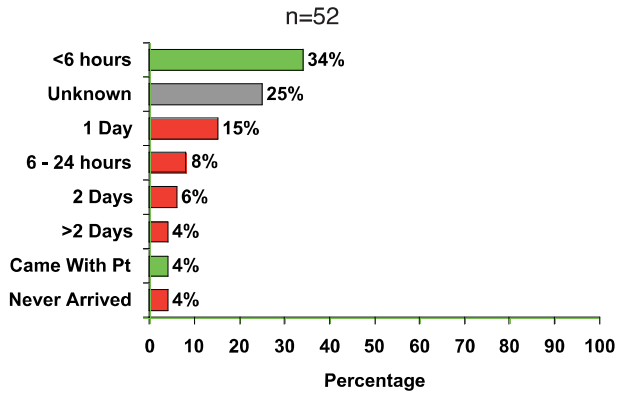

Figure 4 Time from request to casenotes' arrival
(One third of casenotes arrived within six hours to the ward. We did not know the time of the arrival of notes for a quarter of patients. Delays were worse at weekends or if the ward clerks were on leave. Two sets of notes never arrived on the ward during the admission period and it took more than two days for 10% of notes to arrive)

n=8

Casenotes delayed	n=2
Casenotes delayed/No PMH/No PMH in GP letter	n=4
Casenotes arrived/No PMH/No PMH in GP letter	n=2

Figure 5 Surgery carried out
(Surgical management of 8 out of 52 patients was delayed because of problems with access to casenotes) (PMH: past medical history)

DISCUSSION

It is difficult to justify the situation of having to treat a surgical patient without any written records of relevant medical problems. If the hospital trust has records of such details in its possession errors occurring under these circumstances might be difficult to defend. While some patients can be relied upon to give an account of previous medical history, these details may be unable to substitute for the proper casenotes. These include problems with communication, dementia or learning difficulties and the fact that some patients are actually not aware of medical problems.

SUMMARY OF FINDINGS

- only 14% of patients had their casenotes requested immediately after admission
- there was no delay in treatment in 27% of patients whilst waiting for casenotes to arrive
- there was a delay in initiating treatment for 15% of patients
- only 62% of those admitted had a GP letter to know about their past medical history
- only 60% of patients were able to give account of their past medical history

IMPLICATIONS OF FAILURE TO RETRIEVE CASENOTES

- many patients have had their investigations repeated unnecessarily due to casenotes delay
- patients were made to stay in hospital a few days more than they needed to due to decisions about surgical management waiting on casenotes
- unnecessary expenses for NHS to repeat the investigations, to bear the cost of those patients during their stay
- delay in getting a bed for patients who are on waiting list posted for elective surgery

RECOMMENDATIONS FROM THIS AUDIT

- the hospital network should be linked to GP surgeries around this area to allow access to patients' past medical history
- casenotes should be requested immediately after a patient is admitted to a surgical ward in order to prevent possible delays in treatment
- a proper system such as either a manual or electronic tracing system must be in place to track the patient's old records

FURTHER READING

Dr John Wright and Dr Michael Smith. Creating catalysts for change. Patient safety 2004 (National Patient Safety Agency). RCA recommendations 3 and 10: pages 9, 16

Setting the records straight. A review of progress in health records services. Audit Commission update November 1999

Making information technology work for junior doctors. Br Med J May 2003. Section 2. Availability of patient information