1. Introduction

1.1. It is a requirement of appraisal and revalidation for doctors and nurses to demonstrate that they keep good medical records.

1.2. It is also one of the domains of GMC Good Medical Practice- "Record your work clearly, accurately and legibly"

1.3. One of the most common reasons that clinicians are successfully sued is poor record keeping.

1.4. Performance panels repeatedly highlight poor record keeping as a marker of poor clinician performance.

2. Audit- the best way to demonstrate and improve good practice

2.1. The LMC recommends that practice regularly carry out an audit of their clinicians' record keeping.

2.2. This audit can be used as evidence of good record keeping.

2.3. The audit can also be used to highlight less good record keeping, and act as a tool to improve this.

2.4. The LMC recommends that the audit should be completed on a practice-wide and individual level, so that the practice can identify general patterns as well as identifying individual learning needs.

3. Suggested audit criteria

3.1. All clinical encounters should identify who carried out the consultation, where and at what time. (Who/where/when?)

3.2. All consultations which have been recorded with a delay, this should be noted in the record, and a reason for delay also noted (e.g. entered in retrospect due to seeing patient on my way home). (Post-dated reason why?)

3.3. All consultations should identify the reason why the patient had attended. (History?)

3.4. All consultations should identify what examination took place. (Examination?)

3.5. All consultations in which an intimate examination occurred should have a record of a chaperone being offered. (Chaperone offered?)

3.6. All consultations in which a chaperone is present should have the name and role of the chaperone recorded. (Chaperone named?)

3.7. All consultations in which suitable clinical data is recorded, this data should be Read coded rather than entered as free text (e.g. smoking status, height, weight, BMI, BP etc). (Data coded?)

3.8. All consultations should have a diagnosis recorded, either as a link to an existing diagnosis/problem, or as a new diagnosis. (Diagnosis?)

3.9. All consultations should include a management plan, so that the thought process of the consulter is easily defined at a later date. (Plan?)

3.10. All consultations should contain only abbreviations and acronyms which are in common usage. (Abbreviations?)

4. Audit standards

4.1. The practice should select standards for each criterion, though we would expect standards to be high as this is essential to good clinical care.

5. Audit method

5.1. A set number of medical records for each clinician should be evaluated against each criterion; this could be randomly selected, or could be taken as consecutive consultations.

5.2. The number should be chosen by the practice, but at least 10 consultations should be evaluated to give a good sample.

5.3. The evaluator will need some clinical knowledge, but does not need to be a clinician.

5.4. The evaluator should record the results, suggested results proforma is attached.

5.5. The results should be collated for the whole practice, and for each individual clinician.

6. Audit results

6.1. Audit results should be fed back to the practice and individually.

6.2. The practice should reflect as a whole upon the results and identify areas for improvement and an action plan developed.

6.3. Individuals should reflect on the practice and their own individual results, and develop a personal action plan.

7. Completing the cycle

7.1. To continually monitor and improve the quality of note keeping, the audit cycle needs to be repeated regularly, probably annually.

SUGGESTED RESULTS PROFORMA

Consultation	1	2	3	4	5	6	7	8	9	10		
Audit criteria											**Total**	**%**
1. Who/where/when?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N		
2. Post-dated reason why?	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A		
3. History?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N		
4. Examination?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N		
5. Chaperone offered?	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A		
6. Chaperone named?	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A		
7. Data coded?	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A		
8. Diagnosis?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N		
9. Plan?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N		
10. Abbreviations?	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A		

Consultation	11	12	13	14	15	16	17	18	19	20		
Audit criteria											**Total**	**%**
1. Who/where/when?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N		
2. Post-dated reason why?	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A		
3. History?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N		
4. Examination?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N		
5. Chaperone offered?	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A		
6. Chaperone named?	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A		
7. Data coded?	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A		
8. Diagnosis?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N		
9. Plan?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N		
10. Abbreviations?	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A	Y/N N/A		