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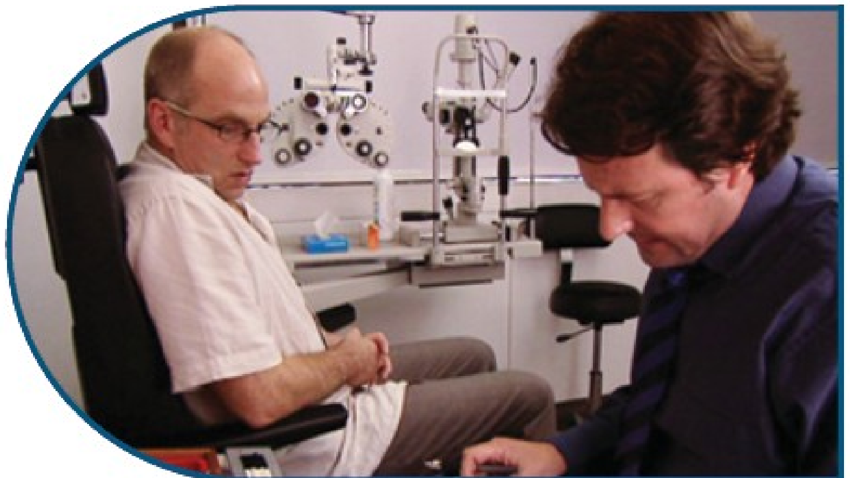

On the Record

Good practice in record keeping

Imagine this

A patient makes an appointment to see you as he is concerned about his vision. He is slotted into a recent cancellation on the following day.

- You see him late on a Friday afternoon; he has some minor complaints about the vision in the left eye
- When questioned he mentions his floaters (which you have noted on previous visits)
- You get a reasonable view of the fundus so don't dilate the pupil but with your indirect lens carefully check the vitreous and the fundus, including the "periphery"
- You can find nothing abnormal and reassure the patient
- You advise him to come back and see you if his symptoms get any worse
- You find a minor change in the patient's prescription and advise him that this can be filled at any time – he indicates he will probably come back with his wife
- Your completed record card (Figure 1) is filed away after he leaves the practice

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The following Monday morning you get a phone call from the patient's wife who informs you the patient has suffered a retinal detachment which required extensive surgery over the weekend and he has lost the sight in that eye; she is very angry.

You are in short succession confused, surprised, affronted and angry. You look up the patient's record card and still can't quite believe what has happened. You do not believe you saw any signs of a detachment developing but wish you had dilated them anyway.

R 6/6 ADD
L 6/9 +
FROM In 19
DIST NR BIF VARI
F L F L F&L REP
OMB DIST NEAR
MOT NPC CONF
HISTORY
Thinks vision worse esp. LE
Occ watery + "fuzzy"
GH – fine
FH – As before
PA MEDIA FUNDI DISCS MACS
— Few vit op's R+L
Otherwise OK
A/V 2:3 R+L
R 0.5 L 0.4
Periph – Normal
RET. R L
AM PM
18 19
SUBJ. +1.25/–0.25x75 = 6/6
+1.00/–1.00x105 = 6/6-2
GIVE: R L As Subj
ADD +
REM 3 6 1 2

Figure 1

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One month later you get a letter from the General Optical Council asking you for your record card and other relevant documentation about the patient.

You respond vigorously denying the allegations.

Six months later the GOC write to inform you that the Case Examiners have referred the complaint to the Fitness to Practice Committee: you are charged with impaired fitness to practice and there will be a formal hearing.

Six weeks later you are asked to provide a larger sample of record cards.

Four and a half months after that you are informed that the GOC are adding “failure to keep satisfactory records” to the charges against you.

Many months later the hearing takes place.

You give evidence:

- You confidently describe what took place in the consulting room that day over 1 year previously
- The GOC's Counsel responds, “Well you would say that, wouldn't you?” and “Do you have any evidence to support this?”
- The evidence you call upon to support your version of events is your record cards!

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The patient gives evidence

The patient describes the events leading to the diagnosis of a retinal detachment one day after seeing you. When questioned about the eye examination conducted by you he states:

- You didn't take his main presenting symptom of severe and recent onset floaters coming down like a curtain across his vision seriously, despite his repeatedly telling you about it
- You gave him a very quick eye test because you were in a hurry to get away
- He remembers you having a very quick look into his eyes with the bright light, but that you didn't put drops into his eyes
- He says you told him there was nothing to worry about and he only needed new glasses

There is a stalemate

You have described one version of events, and the patient has described another.

- Who will be believed? Probably the patient!
- Can you defend the charge of poor record keeping? Probably not!
- Would the outcome have been significantly different if the notes on the record card had supported your position without question?
  Almost certainly yes!

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Introduction

Recording clinical information is a constant feature of day-to-day life for healthcare professionals, including optometrists. It is such an integral part of professional life that we rarely consider either why we keep records or what we should record.

Until recent years it would probably have been considered unthinkable to devote time and resources to training professional people in the art of good record keeping. Today, however, concern is being expressed in many quarters within and without our profession about our attitudes, habits and abilities in this area.

The College of Optometrists considers it an essential part of practice that practitioners keep good clinical records, and as we see the General Optical Council (GOC) considers that failure to keep acceptable and adequate clinical records constitutes impaired fitness to practice. This is outlined in the 'Standards of Practice for Optometrists and Dispensing Opticians section 8'. There is an implication that poor quality records may indicate a lack of patient care and clinical ability on the part of the practitioner'.

In addition, if the patient is seen under the General Ophthalmic Services, regulations require that a full, accurate and contemporaneous record is kept. Failure to do this may be considered a breach of contract.

An increased interest and awareness about good record keeping in general has also been generated by patients seeking legal or disciplinary redress for perceived, or real, shortcomings on the part of their healthcare practitioners.

Many optometrists, particularly those that advise professional and statutory bodies, have to deal increasingly with practitioners whose clinical records they consider inadequate and lacking in detail. The aim of this programme is to guide all optometric practitioners in the art of good record keeping to the ultimate benefit of all concerned.

Why do we keep records?

There are perhaps four separate but interlinked reasons for keeping patient records:

- To retain clinical information
- To identify trends
- To protect our patients
- To protect ourselves

Retain clinical information

The recording of clinical information is for most people a self-evident fact and something that we are taught to do from the very beginning of our professional training. It is also self-evident that for an average optometrist, seeing perhaps 2,000-2,500 patients every year, it would be impossible to remember even one single piece of information about each of these. Every practitioner would recognise the need to record, at the very least, a patient's spectacle prescription in order that breakage and damage to spectacles could be dealt with. The only alternative would be re-examination of the patient's vision every single time.

Identify trends

Most practitioners – perhaps all practitioners who do not work full-time as a locum – would expect patients to return to their practice on a regular and continuing basis. An important feature of all eye examinations is an assessment by the optometrist of whether the patient's ocular condition has altered during the interval since the last examination. This type of comparison is impossible without the guidance of notes taken on each of the previous of visits. Records can be enhanced if such notes are qualified as much as possible by the use of grading scales and images. The value of this information is highlighted by patients who are new to a practice and where a problem or abnormality, perhaps a fundus lesion, is found. In such a situation practitioners are often required to make a judgement that the finding is benign and long-standing, or that it is of recent onset and relates to an ongoing disease process. Sometimes it is necessary to go to great lengths, identifying and contacting the previous

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practitioner, or contacting the patient's GP, in order to make a confident management decision.

Over a period of time all patients' vision and prescriptions will change, but retaining clinical information on a regular basis will enable a much more confident decision to be made about whether longitudinal changes are innocent or sinister.

Protect our patients

All of these factors taken together will help us as primary care optometrists to protect our patients and ensure that not only are our clinical skills exercised on a one-off or occasional basis, but that we are considering the long-term welfare of the patient as well.

Many ophthalmic conditions are chronic and often asymptomatic in the early stages, and therefore will manifest themselves slowly over a period of time. Patients rely on their optometrist to detect changes that may indicate early disease manifestations, and this is one of the key reasons why we recommend regular eye examinations. Without adequate records we are not doing the best for our patients and the benefits of regular eye examinations are lost.

Protect ourselves

It is a feature of modern life that patients are increasingly looking to the law and statutory bodies in order to seek redress for grievances against professional people. Any practitioner finding themselves in this situation will have very little to rely on when they have to defend themselves and their actions. As we see from the scenario earlier, the only piece of the evidence that will support the practitioner's version of events is his clinical record.

The quality of these records therefore becomes of paramount importance. The quantity and quality of clinical information recorded on the practitioner's clinical records will have a direct relationship to his or her ability to defend against charges.

In addition the current attitude to clinical records taken by the GOC and NHS primary care organisations, should they examine them, means that records can in themselves become the object of serious scrutiny.

Key points

- We live in a world of increasing litigation
- If it's not written down you didn't do it
- You may one day have to defend yourself and your actions
- NHS records can be examined regardless of whether there has been a patient complaint, potentially leading to performance review and possible referral to the GOC

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What should we record?

(Figure 2) Does this record card contain sufficient information to protect either the patient or the practitioner? How many of us have worked in a practice, or with colleagues, where this is a typical record? Whatever their style of record keeping, many practitioners would probably feel that this record was somewhat lacking in detail.

So what should practitioners be recording?

The College of Optometrists' Guidance for Professional Practice clearly identifies the scope and nature of the information the College considers an optometrist should be recording in relation to each patient examination. These guidelines are extremely detailed and exhaustive. They specify what is considered best practice in optometric record keeping and may be easily accessed on the College website:

https://guidance.college-optometrists.org/guidance-contents/knowledge-skills-and-performance-domain/patient-records/

Figure 2

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For many practitioners their record cards will fall somewhere between these two extremes. The more a practitioner's records fall short of the College model the more open to criticism they are likely to be. Unfortunately, the experience of professional advisers is that practitioners often do fail to record sufficient information for their records to be considered adequate when subjected to external scrutiny.

So what should the average practitioner do to ensure that they adequately protect themselves and their patients? A consensus is developing about the minimum standard of record keeping that practitioners should try and maintain. This includes relevant details from the patient interview, the current prescription and acuity or the unaided vision, the results of the refraction, the results of a binocular vision assessment, the results of the ocular examination and the advice given to the patient at the end of the consultation. Some of these are self-evident but some deserve further explanation.

Relevant details from the patient interview

It is important that practitioners make notes in relation to their discussions with the patient. Few of us would initiate a patient examination without some sort of question about the reason for the patient's visit and the state of their vision. This information should be recorded, even if the response is negative or does not indicate a particular problem. A key to successful record keeping is to ensure that information is recorded even if the patient has no problems and is happy with their vision. It is also important to record a certain amount of negative information both to show that the question has been asked, and also to show the patient's response.

Key points

Comment on:

- Reason for visit – record in the patient's own words
- Current state of vision
- Specific visual tasks eg. Driving, VDU user
- Own and family history
- State of general health
- Medication

Record a certain amount of negative information e.g. "No headaches"

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Current prescription and vision

Practitioners may not consider it necessary to record the patient's unaided vision if they habitually wear their distance correction (although this may be necessary for certain vocational reasons). However, it is crucial to record the patient's VA with their current prescription, both for distance and near, particularly if the practitioner wishes to justify a modest change in the prescription.

Results of refraction

This should be quantified wherever possible.

Results of binocular vision assessment

Results of ocular examination

Oph – NAD is not adequate. The ocular examination may be by direct or indirect ophthalmoscopy and a number of different ocular structures will be examined. It is important that a comment is made in the patient's record about each of these different structures. The suggested key structures requiring comment are listed below and should be considered the minimum amount of information to be recorded:

- External eye (lids, lashes, conjunctiva, corneal surface, tear film etc.)
- Ocular media (diagrams of opacities are particularly helpful)
- Blood vessels (crossings, calibre, A/V ratio etc.)
- Disc (C/D Ratio and colour and regularity of the neuroretinal rim)
- Peripheral fundus
- Macula

Record observations routinely even if things are normal. The use of the term NAD is disliked by many practitioners who prefer to use "normal" or similar phrase. Avoid difficult to substantiate comments such as "healthy"; all you can say is that what you have seen looks normal, you cannot say, because you cannot know, that the tissue is healthy. The key to good record keeping is to

comment on each of the individual ocular structures rather than a global comment relating to a whole examination of the eye. It is the presence of a comment which is important. The use of ticks should be avoided as it may be construed as indicating the test was carried out, but not necessarily that the result was normal.

Key points
Comment on:

- External eye
- Ocular media
- Blood vessels
- Disc
- Peripheral fundus
- Macula

Do record things that are normal

Also:

- Record results accurately
    - Consistent with symptoms and history
    - Consistent with action taken

- Use quantifiable assessments where possible
    - Grading scales
    - Actual measures eg:
        - Tear prism height
        - Tear break-up time

If you create and store digital images for record keeping purposes make sure that you have written notes to show that the image has been assessed and found to be normal.

Advice given to patient

This is an area where experience shows practitioners are particularly poor at recording information. This can cause particular complications in litigation or disciplinary situations where a practitioner's defence may rest on their sketchy recall of consulting room conversations a long time before. Your version of

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events is likely to differ significantly from the patient's, and their version may appear the more believable. It is therefore important to regularly make a note about the advice you have given to your patient. Always note your explanation for a patient's presenting symptoms, the prescription you are giving, why and what it is to be used for, and any other action you need to take. This may be particularly important, for instance if a prescription change is likely to be poorly tolerated initially, e.g. a significant axis change likely to cause spatial distortion. If you work with a dispensing optician but suggest a particular form of spectacle correction in your consulting room note this information down on the record card.

Practitioners frequently discuss problems with patients in a less formal and structured situation than that of the eye examination. This may be a conversation on the telephone, or even over the reception desk. Whilst in many cases this conversation will be innocuous, a patient may be asking you for specific advice or there may be some particular dissatisfaction such as non-tolerance. It is important for the protection of you and your patients that any advice given in this situation is noted on the record card. If, for instance, you advise a patient who is having problems with a new pair of spectacles to continue wearing them for two weeks and then to come back and see you if the problems persist, note this advice on your record card. Don't forget to include the date, and perhaps the time. It is also important not to overlook patient confidentiality with these types of conversation. Ensuring that no identifying or personal patient details can be overheard by others in the practice, should a conversation take place outside the privacy of the consulting room, is good practice.

Key points

Itemise specific advice e.g.

- Rx given and why
- Suggested usage
- Dispensing suggestions
- Explanation of symptoms
- Re-examination period
- Itemise action taken e.g. referral decisions, reports to be sent

Record dated and timed notes of telephone or other conversations particularly if you are giving clinical advice or the patient has a complaint

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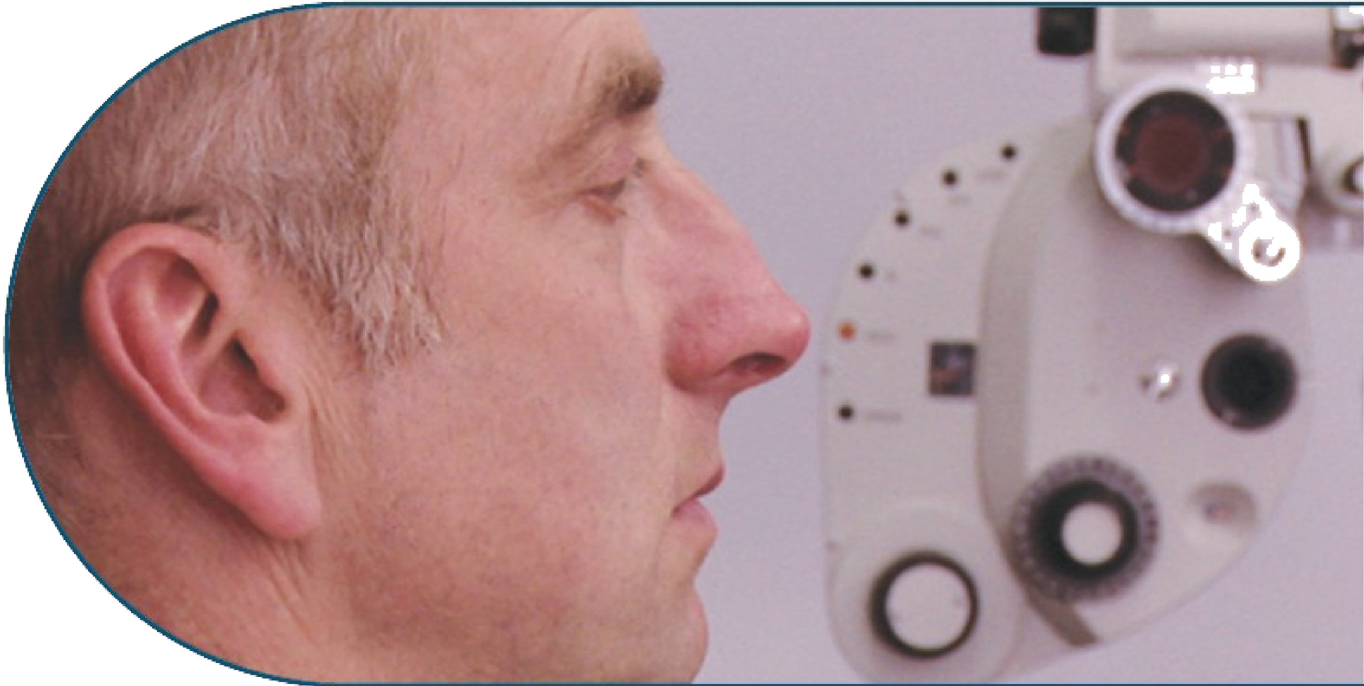

Contact lens patients

All of the key points above apply to all types of patient. Contact lens patients at one level are no different to spectacle patients in their record keeping requirements although different clinical procedures will be recorded and different emphases will be placed in certain areas. In the case of contact lens patients, however, the advice to record all observations and results even if they are normal is especially important. The temptation to record little or no information when the patient is being seen frequently and when the consultation may be relatively short may be great. Non-attendance for any reason should be noted on the record card. The advice to note down less formal conversations and any advice given may be particularly important for contact lens patients.

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Conclusion

Don’t panic!

But be sensible. Good record keeping IS important.
It will benefit both you and your patients. Be self-critical about your record cards and if possible participate in peer review groups where good record keeping hints and tips may be picked up. If you don’t feel your current record cards are adequate, particularly if space is limited, then seriously consider updating your system so that you can record all the information you want.

The use of electronic record cards can encourage good record keeping but it is still vital to ensure the information entered is complete and not just a copy from a previous visit.

If using paper record systems, several “model” record card designs have been suggested, such as that produced by the AOP (visit the DOCET website at www.docet.info to download an image of this card). Many practitioners prefer this pro-forma type of card as it acts as an aide-mémoire, and it may help to develop good record keeping habits as well as always locating particular information (e.g. tonometry results) in the same place for easy reference later. But free-hand notes on plain paper may be acceptable as long as all the appropriate information is recorded in a legible format.

However you record it – Make sure you DO record it!

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Key points

- Keep good records
- Record ocular examination results in full
- Record itemised advice given to a patient
- Make sure you have enough space to record all you want to
- Clearly separate entries of different dates
- Clearly separate Optometric Dispensing and Admin data
- Don't embellish your records by adding extra information after the event
- Abbreviations can be used
- Records must be legible

Further considerations:

- Remember your statutory requirements and the College Guidelines
- Keep up to date with changes in treatment criteria
- Keep up your clinical skills

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DOCET is a special Committee set up by the Department of Health to oversee the management of Government funds with the aim of improving the eye health and eye care of the population through continuing education and training (CET) for optometrists.

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