MEDICAL PRACTICE

Contemporary Themes

Case note chaos: prevention is better than cure

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Abstract

The long term storage of hospital clinical records is becoming a big problem. A great reduction in the bulk of case notes can be achieved by compartmentalising unstructured case notes. Such a system has many advantages for medical staff, and its widespread use would do much to alleviate storage problems in future years.

Introduction

Hospital medical records officers are facing an enormous problem of case note storage.¹⁻³ For historical, epidemiological, and research purposes clinical records often survive longer than the minimum period recommended by the Department of Health and Social Security.^{1,4} Congestion of storage facilities may be reduced by microfilming or by retaining only selected case notes or samples from notes,¹ but whatever policy is adopted all hospitals will still have many case records in the original format.

Previous reports on the standardisation of hospital medical records were concerned principally with the form and content of basic documents rather than with the structure of the case record,^{6,8} but various filing systems were accepted, and there was a consensus of opinion that documents of a similar nature should be filed together.^{7,8} Though some hospitals have introduced compartmentalisation, in which dividers partition the case note into several sections, unstructured case notes in which documents are filed in the order that they are received are in widespread use elsewhere.

Unstructured case notes have several inherent disadvantages. Individual entries, details of a patient's past history, and laboratory results are often difficult to find, and since all reports from one laboratory are not filed together it is difficult to compare results. There is an unfortunate but predictable tendency for a doctor to repeat an investigation rather than to search for a previous result. When a laboratory displays sequential results cumulatively redundant report sheets can be thrown away, but these are not easily found in unstructured notes and often remain in place. Each time a patient attends hospital new report mount sheets and clinical note paper need to be added to the notes. These are often only partially used and commonly not used at all, but blank sheets remain in the notes, getting buried behind new entries. Copies of clinic letters and discharge summaries are occasionally sent to colleagues in other departments but are sometimes returned to the case record so that two or more copies of the same letter are filed in different places.

Thus the use of unstructured case notes increases the demand on laboratory and stationery resources, on storage facilities, and on the time of secretarial and medical personnel. Inevitably, haphazard case notes are treated with little respect by users, and the problem is thus compounded. I therefore compartmentalised the notes of 200 patients who were attending a nephrology outpatient clinic. The notes were representative in age, size, and content to those in use elsewhere in the hospital, and any conclusions drawn from the exercise are thus valid on a wider scale.

Method

Each case record was first dismantled by cutting and removing the elastic treasury tag with which it was bound. The contents were then sorted into nine categories: six for laboratory reports (bacteriology, clinical chemistry, haematology and immunology, radiology, pathology, and electrocardiography), one for nursing notes, one for hand written clinical notes, and one for correspondence. All results were detached from their original mount sheets and were remounted chronologically on new sheets with all

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other results from the same laboratory, each mount sheet being filled before another was used. All redundant mount sheets were discarded.

The nursing section contained nursing notes, routine observation and fluid balance charts, consent forms, and drug prescription cards. Charts that recorded no abnormal conditions and which were of no relevance when the patient was discharged were discarded. Medical notes were filed together and discharge summaries were kept alongside the clinical notes that related to the relevant admission. All handwritten medical notes from the previous six years were retained, but some older ones were discarded if their condition rendered them illegible or if an accompanying typewritten letter or discharge summary contained the same information. Outpatient clinic letters were filed together in the correspondence section, and all supernumerary copies of letters were destroyed. All important information previously contained in the original case note was thus preserved.

Items such as envelopes, old outpatient clinic appointment cards, now irrelevant memos, and even old name cards from the head of the bed were removed, and tattered case note folders were renewed. All discarded material was shredded by the hospital medical records officer, who verified its suitability for destruction. The revised case note with indexed dividers was bound using a plastic Gazebo Mediclip. The whole project occupied a two week period during which clinical commitments were light.

Results

The overall volume of the 200 case records was reduced by 30.5% from 11.8 cubic ft (0.3 m³) to 8.2 cubic ft (0.2 m³) with the removal of 4.7 cubic ft (0.1 m³) of waste (fig 1) and the addition of 1.1 cubic ft (0.03 m³) of case note dividers. Many notes that had previously occupied two volumes are now contained in one, but where two are still necessary one volume is used for results and the other for notes and correspondence. Access to any item of information and comparison of results is quick, with none of the frustration that used to accompany note searching. Redundant cumulative result sheets and supernumerary copies of letters are no longer retained since duplicated material is now obvious at the time of filing. The fullest use of clinical note paper and report mount sheets ensures that a minimum amount of stationery

is used. The revised notes have since been used on two occasions for a research project, and the required data were retrieved with pleasurable ease. All regular users of the notes approve, with none preferring the original system.

Discussion

It would be impractical to suggest that all existing unstructured hospital case records should be refiled like this because of the staff time required. Furthermore, where compartmentalisation is in use there will be local variations in the structure of the notes. But the

FIG 2—Documents can be inserted or removed without dismantling notes.

introduction of compartmentalisation in newly issued case notes would effectively promote the economical use of resources and alleviate storage problems, especially if parts of the notes are to be selected in the future for microfilming or long term storage. In addition, an essential feature of case notes is ease of access to the information they contain,⁸ particularly since patients are often seen by different doctors at each visit to hospital.

The use of a device such as the Gazebo Mediclip is necessary with compartmentalisation since it permits pages to be inserted or removed at any point without the need to dismantle the notes (fig 2). This design satisfies the criteria for the ideal fastener⁸ because it is safe, easy to use, takes up little space in the folder, and holds a bulk of documents securely without damaging them.

Although rigorous file keeping has already been suggested as one solution to storing case notes,² medical records officers will want evidence of the benefits of compartmentalisation before introducing such a system. More and more clinical records are being created: the problem of storage is becoming critical.¹ The quest for a cure is underway but must not eclipse the old maxim that prevention is better.

References

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FIG 1—The author with waste material before it was shredded.