PRACTICE OBSERVED

Practice Research

Newly registered elderly patients: who are they and why such delay in the transfer of their medical records?

HELEN J GRAHAM, BRIAN LIVESLEY

Abstract

The time taken to transfer the records of elderly patients registering with a new general practice was investigated. Thirty five (5%) of a total of 671 patients aged 75 and over were entered as new patients on to the age-sex register of an urban group practice during one year. Twenty nine had moved into the area and six had changed their general practitioner for personal and other reasons. An average of 141 (range 71-296) days elapsed before dispatch of their medical records to the new practice. During this period an average of 3.5 (range 0-15) consultations with a general practitioner were recorded, indicating the need of such patients for medical care. The long delays were caused by the processing of medical records at the central register and the transfer of records between family practitioner committees and general practitioners. Delays were most apparent in the time taken for general practitioners to dispatch the necessary documents to the family practitioner committees, and these should be minimised.

The use of a summary card written and updated by the general practitioner and retained by the patient would facilitate continuing care should patients change to a new practice. Meanwhile, assessment of elderly patients after registration with a new practice by a member of the primary health care team may identify problems before the records have been transferred and may help the resettlement of these high risk elderly patients.

Introduction

Elderly patients who have recently moved house are at greater risk of needing medical care.^{1,2} Long delays in transferring medical record envelopes between general practitioners are particularly serious for the elderly, who are more likely than younger patients to have multiple illnesses and disabilities that present complex problems of management. We thought that it was important to identify the delays affecting new patients aged 75 and over who registered with this practice as we had found a substantial turnover (13%) of such patients due to new registrations, removals from the area, and deaths.³ We set out to define the demographic characteristics of new patients aged 75 and over with particular reference to accepted risk factors,⁴ the patients' reasons for moving (or for changing their doctor if they had not moved), the time taken for their medical record envelope to be transferred, and the number of consultations with the new general practitioner before the records arrived (which we accepted as an indirect index of their need for care).

Patients and methods

During the 12 months from 1 December 1985 a monthly printout of new registrations of patients aged 75 and over, including the date of initial registration with the practice, was obtained from the computerised age-sex register of the 15 030 patients in this urban group practice of seven principals. All new patients were given temporary medical records. The receptionist sent the patients a letter welcoming them to the practice and inviting them or a close relative to complete an enclosed socially oriented questionnaire. This non-clinical approach was designed to minimise any prompting of health oriented contact with the practice. The questionnaire asked patients for the following information: marital state (and if widowed, whether in the past 12 months), if they lived alone or with others, if they had children, their reasons for changing general

Group Practice, 1 Forest Hill Road, London SE22 0SQ

HELEN J GRAHAM, MB, MRCP, general practitioner and research fellow

Clinical Gerontology Research Unit, Dulwich Hospital, London SE22 8DF

BRIAN LIVESLEY, MD, MRCP, director and consultant physician

Correspondence to: Dr Graham.

practitioner, and the date of moving house if they gave this as a reason. In addition, they were asked if they had been admitted to hospital in the preceding 12 months and, as a further indicator of vulnerability, if their mobility was so limited that home visits would always be required.

On receipt of each patient's medical record envelope the dispatch date stamped by the family practitioner committee was noted. The interval between this date and the patient's initial registration with the practice was calculated, and if the patient had moved the interval between moving and registration was calculated. The numbers of recorded consultations with a general practitioner and admissions to hospital during this period were obtained from the patient's temporary record.

Results

On 1 December 1985, 671 patients aged 75 and over were listed on the age-sex register. During the subsequent 12 months 35 new patients (5% of total) were added. They comprised 10 men and 25 women, 12 of whom (34%) were aged 75-79, 15 (43%) aged 80-84, and eight (23%) aged 85 and over; corresponding proportions of patients aged 75 and over already on the register were 47%, 30%, and 23% respectively.

All questionnaires except three were returned within four weeks of being posted. The three non-responders were sent reminders, and two returned their completed questionnaires promptly; the third responder had moved into sheltered housing, and the warden completed and returned the questionnaire on his behalf.

Of the 35 patients, 22 were widowed (two in the previous 12 months), eight were married, three were single, and two were divorced. Twenty patients lived alone (17 of whom had moved into flats in sheltered housing complexes) and 15 lived with others, four in sheltered housing. Nine had no living children. Most patients (29) had limited mobility and, being unable to travel to the surgery, would always require home visits; six were able to travel independently.

The reasons given for registering with a new practice were: moving into the area, 29 patients; personal preference, three; excessive distance from the previous practice, two; and retirement of a local general practitioner, one. Among the 29 patients who had moved the average time between moving and registering with the practice was 24 days; 21 patients had entered sheltered housing complexes, seven had moved to live with relatives, and one had exchanged rented accommodation because of previous substandard housing. In all, 22 patients had moved within the family practitioner committee's area and seven had come from outside London. Thirteen had been admitted to hospital in the 12 months before registration.

The average time between registration and dispatch of the medical record envelopes from the family practitioner committee for 29 patients was 141 (range 71-296) days. Three patients died before their medical record envelopes had been received (death occurred 227, 120, and 94 days after initial registration), and the records of three patients were still awaited 12 months after registration with the practice. An average of 3.5 (range 0-15) consultations with a general practitioner were recorded for all patients, and five patients had to be admitted to hospital during this period.

Discussion

Our study showed that newly registered elderly patients are a vulnerable group; 60% had changed their general practitioner after moving into sheltered housing, 20% after moving to live with relatives, and the remainder for personal reasons. By the criteria of Taylor and Ford most (33) of the 35 patients were at high risk⁴: they had had a recent change of dwelling, were extremely old (80 and over), lived alone, were childless, or had been discharged from hospital in the previous 12 months.

The absence of a record of a patient's medical history hampers

continuity of clinical care, which is particularly important for patients aged 75 and over owing to the high prevalence of accumulated diseases and disability usually associated with multiple treatments in this age group. Under such circumstances the new general practitioner has to piece together fragments of the patient's history and former management. In our study the absence of medical records complicated the management not only of the five patients who had to be admitted to hospital but also of those requesting medical care in the community.

A previous study suggested that an average delay of 123 days occurred between applications by patients of all ages to register with a new practice and the receipt of their medical records.⁵ Two years ago we thought that this problem was worsening and was particularly frustrating in the care of the elderly; our results confirmed this impression.

The present process of transferring medical records is unsatisfactory; we found not only that the new family practitioner committee took an average of 141 days to send the medical record envelope of patients aged 75 and over to the new general practitioner but that the envelope then took another three weeks to arrive. In patients who have moved house this problem is further aggravated by an additional mean delay of 24 days between changing address and registering with the new practice. Thus six months may elapse after registration before the new general practitioner receives the patient's medical record envelope. This period is a substantial proportion of the lifetime remaining to patients aged 75 and over.

Surprisingly, the registration of new patients and the transfer of their medical records to the new practice is a lengthy process with 14 stages,⁶ which for brevity we have reduced to eight as follows: stage 1, the patient is accepted by the new general practitioner; stage 2, the general practitioner forwards the acceptance document to the local family practitioner committee; stage 3, action is taken by the family practitioner committee, which then sends the registration document to the National Health Service central register at Southport; stage 4, action is taken at the central register, which refers back to the patient's previous family practitioner committee; stage 5, the previous family practitioner committee writes to the patient's previous general practitioner requesting return of the medical record envelope; stage 6, the previous general practitioner returns the envelope to the family practitioner committee; stage 7, action is taken by the family practitioner committee, which then forwards the medical record envelope to the new family practitioner committee; stage 8, action is taken by the new family practitioner committee, which then sends the medical record envelope to the new general practitioner. Only stages 3, 4, and 7 are eliminated if the patient remains within the area covered by the original family practitioner committee. Moreover, the waiting period may be doubled if the patient's medical card, FP4, is mislaid and form FP1 has to be used.⁶

The planned computerisation of records held by family practitioner committees should improve the internal functioning of each committee, but the main delays are those incurred during processing at the central register (on average 25 days⁶), in dispatch to general practitioners and family practitioner committees, but, most of all, by general practitioners themselves in forwarding acceptance documents and medical record envelopes to family practitioner committees. What is required is an immediate response from the patient's previous general practitioner, who should be encouraged to return medical record envelopes more promptly. Ideally, this would happen after he or she has written a letter introducing the patient to the new general practitioner, but many patients do not inform their current general practitioner about their intention to move or the date of moving.

We suggest that the widespread introduction of a "summary card" compiled and updated by the patient's current general practitioner would be extremely useful. The card would be an accurate synopsis and should be retained by the patient for the use of any new general practitioner. When a hospital provides the care the summary card would automatically become a shared care summary card, still retained by the patient or the key person providing care. The summary card would list the patient's medical problems with dates, relevant history, next of kin or key person providing care, and

current treatment and might include the minimum social data requirements that have been reported recently.⁷ Such a scheme is compatible with the present trend towards autonomy of patients and could be developed by either local family practitioner committees or district health authorities.

All of our newly registered elderly patients who were unable to travel independently to the surgery (83%) were in well defined at risk groups. These particularly vulnerable patients might be better served by the new practice if their needs were identified and resettlement helped at an early visit after registration. This could be done by the district or practice nurse, the health visitor (if available), or the general practitioner. The process of transfer would be eased, and any serious difficulty arising from missing clinical information could be recognised early and the information obtained by contacting the patient's previous practice or hospital.

Although the transfer of medical records is currently taking even longer because of the computerisation of family practitioner committees' records, both patients and general practitioners may look forward to a more efficient system, which should allow an improved standard of care for the vulnerable elderly patients who move to a

new practice. We believe that the use of summary cards would contribute further to improved standards.

We thank the practice receptionist, Mrs Barbara Phillips, who helped to identify the new patients.

References

- 1 Williamson J. Screening, surveillance and case-finding. In: Arie T, ed. *Health care of the elderly*. London: Croom Helm, 1981:208-9.
- 2 Ferraro K. The health consequences of relocation among the aged in the community. *J Gerontol* 1982;38:90-6.
- 3 Graham H, Livesley B. Changes in the population aged over 75 of an urban general practice: implications for screening. *Br Med J* 1986;292:453-4.
- 4 Taylor R, Ford G, Barber H. *Research perspectives on aging*, 6. Mitcham, Surrey: Age Concern Research Unit, 1983.
- 5 Fraser RC. Patient movements and the accuracy of the age-sex register. *J R Coll Gen Pract* 1982;32:615-22.
- 6 Anonymous. The transfer of medical records [Editorial]. *Family Practitioner Services* 1985;12:48-50.
- 7 Jachuck SJ, Mulcahy JR. Minimum data set necessary to promote the care of the elderly in general practice. *J R Coll Gen Pract* 1987;37:207-9.

(Accepted 25 November 1987)

ONE HUNDRED YEARS AGO

All reasonable people must sympathise with the efforts of the Government of India in the cause of administrative economy. But there is such a thing as false economy, and this kind of economy is often as cruel and unjust as it is false. A striking example of this has caused a good deal of unpleasant comment in India. We notice it to show the authorities there that, although the tragedy occurred in a remote district, it cannot be allowed to pass without grave notice at home.

Backerganj, in the Sunderbunds, is an exceedingly populous but very unhealthy district; the population varies from 700 to 900 per square mile. This being so, it cannot be wondered at that the administrative and judicial work of the collector and magistrate severely taxes the powers of the civil servant charged with the administration of the district. The late Mr. H. I. Fasson had the misfortune to have to discharge, single-handed, the onerous duties of this position. This gentleman contracted a malarious fever in the jungles of Chittagong, which he was unable to shake off. He was frequently prostrated by this fever, and, while labouring under the racking headaches and other depressing symptoms of this depressing malady, went on performing his daily duties, involving great mental exertion.

It will not surprise our readers to hear that he broke down, and in a fit of utter despondency died by his own hand, "sacrificed to the miserly spirit that pervades the present Government in its dealings with its servants." "Will it be believed," says a writer in the *Calcutta Englishman*, that an important district like Backerganj has been without a European surgeon for upwards of a year?" Yet so it was. Had a competent medical officer been within reach, this valuable public servant would, long ere matters reached such a pass as we have described, have been properly cared for, struck off harassing duty, and removed to a better climate.

This is not a solitary example of the consequences of this pitiful economy. Another civil servant, not much more than a year ago, was cut off by an attack of fever, which under rational treatment would, in all human probability, have had a happier issue; but as the Government could not afford to give the needful help in the shape of a European medical officer at the station, this unfortunate gentleman, whose legal acquirements were such as to mark him out for the highest honours of his service, was cut off after a brief illness. Appointments in the Indian Civil Service are much coveted, and able and highly educated men strive for them, often to the permanent injury of their health. It does not appear from the above that the Government they serve sets a high value on their lives. Such a narrative as we have related is calculated to cool the ardour of competitors.

It is not only in the manner we have indicated that false and unjust economy is being carried out in India. The members of the Medical Service are always among the first victims when money is to be saved. Under a new rule recently promulgated doctors are mulcted a hundred rupees per mensem when they go on privilege leave; and this often when they are driven by illhealth and the pressure of work to seek a little relaxation. This rule applies to medical officers only.

We have already called attention to the fact that the Medical Service of India is kept so short-handed that, unless on sick certificate, furlough to Europe is suspended. There are numerous officers whose regulation leave has been due for eighteen months or two years who cannot get it. In time of war no one complains of this; in time of peace it is a flagrant breach of faith. How long is this persistent ill-treatment of an indispensable and most useful and hard-working class of officers to go on? We suppose until the "worm turns," and the Government of India knocks in vain at the doors of the various schools of medicine in the kingdom for candidates for commissions in a service where such treatment awaits them. That day will come soon, and the sooner the better.

(*British Medical Journal* 1888;i:256)

The Margarine Act, for preventing the sale of butterine or any compound of butter under any other name than that of "margarine," comes into force this week, and active steps are being taken by the local authorities to carry out its provisions. The provisions of this Act, on which we have already reported, are very severe, and might in many respects be taken as a model for the improvement of the Adulteration Acts generally. The many loopholes which the Adulteration Acts offer to offenders are carefully stopped in this Act; thus the onus of proof that he was in any way deceived as to the nature of the article which he is selling is thrown upon the vendor. The inspector is not compelled to make a purchase of the article and to divide samples; and it is not sufficient that the article shall be colourably what it pretends to be, or that ignorance of its source or origin shall be pleaded. The whole responsibility is put on the vendor instead of, as heretofore, largely on the purchaser, and the old rule of law, *caveat emptor*, is efficiently abolished. If the Adulteration Acts generally were amended on a similar model, the material well-being of our population, especially of the poorer classes, would be improved. Milk ought certainly to be protected in the same way and to the same extent as butter. It is, however, notorious that skimming and adulteration are habitually practised with impunity to the extent of a least 15 or 20 per cent, and such is the weakness of the Adulteration Acts that analysts and sanitary inspectors are powerless to stop it. So also as to the numerous mixtures sold as coffee. By the use of various additional titles, and the many other little devices which the Adulteration Acts favour, it is well known that a large part of the coffee and tea sold is fraudulently adulterated to an enormous extent; and, indeed, very few articles of food escape deterioration by fraudulent admixture in some form or other. Were the penal clauses of the Adulteration Acts generally brought into accord with those of the Margarine Act, all this would very soon be put an end to.

(*British Medical Journal* 1888;i:30)