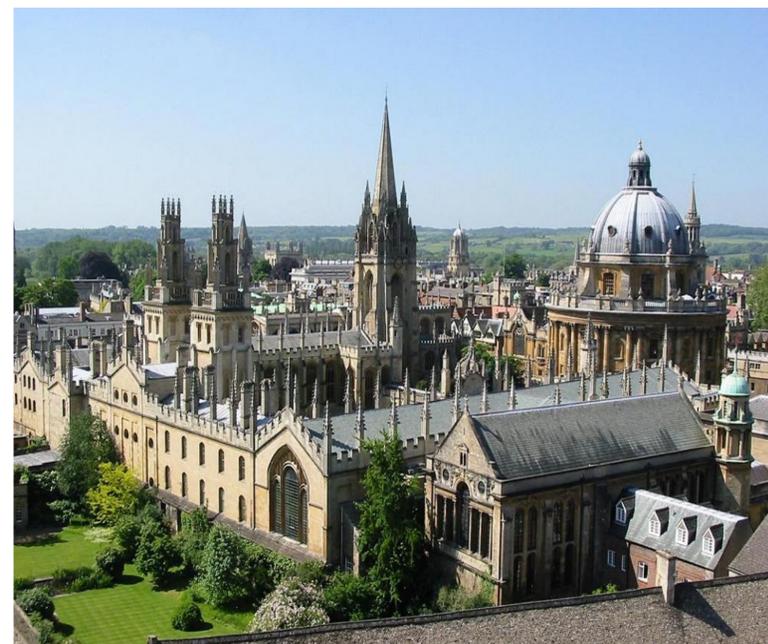


Identifying the minimum requirements for patient record cards in osteopathy

NCOR OXFORD RESEARCH HUB

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Aim

It is now 100 years since the beginning of the modern medical record with the creation of the "unit record" at St Mary's Hospital, London¹. Standards of record keeping among health care professionals are frequently criticised; the Oxford research group has attempted to create a patient record card that meets the minimum requirements for health care professionals and is appropriate for osteopaths.

Methods

A literature search was conducted to identify published studies looking at the creation of patient record cards in the medical, chiropractic, physiotherapy, dental and chiropody professions. A number of electronic databases were searched including PubMed, AMED, CINAHL, PEDro and OSTMED. Hand searching of paper copies of the British Osteopathic Journal and the Journal of Osteopathic Medicine was also carried out. Studies were examined to identify key features which were common to all and demonstrated a minimum standard of information required for good standards of record keeping. Guidance information from the S2K document produced by the General Osteopathic Council² was also examined.

A draft patient record card was created using a consensus process between the members of the Oxford research group³. The patient record card was piloted in practice and an iterative process was undertaken to refine the patient record card and identify the key elements required within it to support good standards of care and patient safety.

The literature was also examined to identify key elements within the consultation process that must be followed to allow the consultation to be satisfactory to both patients and practitioners.

Results

An enormous variation was found in the record keeping requirements between different health care professions.

The temptation is present when examining the literature and examples of medical record cards to try and build a patient record card that covers as many clinical eventualities as possible. This would produce a "box-ticking" approach to the case history process leaving little opportunity for the development of clinical reasoning skills; these very skills are of paramount importance when practitioners are faced with an unusual or challenging clinical situation.

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Literature from the aviation industry was also examined⁴. When making pre-flight checks, it is now recommended that a minimum number of items should be included on information checklists; this is intended to encourage alertness and lateral thinking thereby guarding against complacency which could affect both safety and performance.

The necessity to gain a patient's permission for access to their GP or to hold information on a database was also discussed as part of the design process. The importance to actively obtain a patient's permission was stressed; this can no longer be assumed to occur by default.

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Discussion

Although models emanating from the field of clinical medicine and other health care disciplines need to be carefully considered when applied to osteopathic practice; they do, nonetheless, provide an important framework for the development of a patient record card for the osteopathic profession.

The next development for patient record keeping is the electronic storage of patient data; this is occurring more commonly in osteopathic practice as it is in mainstream health care organisations. This creates many advantages, not least the ability to easily access data for clinical audit purposes in line with the requirements of clinical governance demanded by many health insurers. Increasing legal claims are being experienced by all health professionals both nationally and internationally; osteopaths are also being affected by this trend. This underlines the importance for all health professionals to retain accurate and high quality patient records; the development of this patient record card by a consensus process from within the profession is intended to facilitate this process.

References

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