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Lessons from the TAPS study

Errors relating to medical records

The Threats to Australian Patient Safety (TAPS) Study collected 648 anonymous reports about threats to patient safety from a representative random sample of Australian general practitioners. These contained any events the GPs felt should not have happened and would not want to happen again, regardless of who was at fault or the outcome of the event. This series of articles presents clinical lessons resulting from the TAPS study.

Clinical lesson

A high standard of clinical record keeping is essential in general practice. Practices must be vigilant in ensuring that current contact details are always available on each patient and that the right patient's details are always recorded in the right patient's medical record.

Case study

A man with a background of developmental delay, epilepsy and schizophrenia attended the practice on a regular basis. He did not have a good knowledge of his own medications. He used two different surnames, being the name of each of his divorced parents. The practice mistakenly held two different electronic records for him, one under each of these surnames. Each record contained a different medication list. He was prescribed a new medication that interacted with a medication listed in the second medical record. As a result he became oversedated and was lethargic and depressed. It was some time before the mistake was discovered.

Comment

This case study illustrates the importance of good medical record keeping. In this case, the practice failed to recognise that this man was using two different surnames and had two separate medical records. This can be a challenge whenever patients change their names, which of course can be for a range of social reasons.

Around 20% of all errors reported by general practitioners participating in the TAPS study related to practice and health care systems, and one-quarter of these were due to errors related to patient medical records or practice filing systems.[1,2] These errors resulted in a range of patient safety issues. Some were potentially less serious such as annoyances when pathology requests or referrals had to be rewritten, or when electronic pathology results were unable to be easily filed into the practice system when it used a different way to record patient details. More serious problems included abnormal results such as INRs being unable to be communicated to the patient, due to having no phone number or out of date contact details on the patient record.

Patient record errors included reports of doctors having failed to adequately check for and record medication allergies when prescribing a new medication. Errors related to the knowledge and skills of health professionals in managing medications accounted for 11% of all reported errors.[2]

A large survey of family doctors in the USA looked at information missing from patient records, and found that missing clinical information was common and could adversely affect patients. The problem was less likely to occur when clinicians used full electronic medical records rather than paper records or a combination of paper and electronic records.[3] This recommendation was also made by GPs participating in the TAPS study (*Table 1*).

Examples of types of record and filing system errors reported in the TAPS study included:

- failing to record patient contact details (eg. current landline and mobile telephone numbers) or having outdated patient contact details in the practice records
- having multiple records for the same person with different details listed in each, such as two separate medication and allergy lists
- filing results or correspondence into the file of a different patient with a similar name

- spelling errors (particularly surnames) in patient electronic records causing difficulty in importing electronic investigation results into the patient file
- losing paper based patient records in the practice filing system
- having a colleague move practice and remove the records of their regular patients without leaving a copy at the original practice
- failing to record adequate clinical details in the patient record about each consultation
- failing to update changes on the record made outside of the practice such as during home visits or visits to patients in aged care facilities
- recording details of a consultation in the wrong patient's file, especially in the electronic medical record of the previous patient
- having some parts of a paper based patient record missing (eg. notes falling out of a record in the filing process)
- having parts of a patient's records stored on both a computer and a paper file, leading to some clinical information missing in the history if one or the other is used.

Table 1. Lessons for preventing medical record and filing system errors

- Ensure that practice administrative staff always check and update patient details on arrival
- Ensure the correct patient is listed on the practice appointments system
- Check that the correct patient file is open as you commence each consultation
- Avoid using a combination of paper and computer records simultaneously; it is best to update the computer record and cease using the paper record
- Always update any changes to the patient's electronic medical record after a home visit or other visit outside the surgery
- Always make adequate notes about patient management during each consultation
- If a patient's medical record is sent to another practice, always ensure that you keep a copy

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