Australian Doctor.

E-records know-how

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Complete and accurate electronic clinical records could be just five steps away.

DURING GP training sessions I explain the 20/80 rule: participants can be expected to remember only 20% of what they are told. With quality documentation and follow-up practice, however, this figure can be improved.

Some GPs say if they learn at least one new thing, the training has been worthwhile. But we can raise the bar to ensure GPs not only remember the key messages of a training session but are convinced of the need to make changes to their work practices. Lessons on the particular key presses and which boxes to tick to achieve the "key message" can come later.

There are five main messages in a GP training session:

- You must understand how to accurately record past history items and "reason for contact" in the electronic record.

If you don't do it correctly, you will have inaccurate summary history lists in referrals, care plans and health assessments. These may be filled instead with trivial items or repeated items (eg diabetes appearing many times) — or have no items, because the summary box has not been ticked.

You may also have few or no items showing in the "reason for contact" of previous progress notes and, importantly, other clinicians are likely to find it difficult to read the patient's clinical record.

- Select diagnoses/reason for contact from the coded list for most patient visits.

Free texting does not allow the checking of drug/disease interactions or efficient database searching.

- Keep medication lists up-to-date.

If a patient is no longer on a medication, delete it. If a medication is prescribed or supplied elsewhere, record it. Unless you do this you are handing on inaccurate information to other health providers. If a patient has a specialist appointment, give them a copy of the medication list to take to the specialist; the specialist can update the list and the patient can give you the updated list at the next appointment.

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- Always use existing tools to record measurements.

For example, never free type BP, Ht/Wt directly into progress notes, care plans or health assessments, as they get "buried" and can't be easily found later. It also means you cannot graph the measurements or view the recordings over time.

- You are wasting your time if you retype the same thing.

Learn how to create short cuts so that two or three key presses will expand your text. You will find short cuts in progress notes and in AutoText on your word processor.

If you can get all the GPs in the practice to agree in principle with these five key messages and to learn the correct buttons, menu items, key presses and boxes to tick, the practice is well on the way to having complete and accurate clinical records.

To help, the North East Valley Division of General Practice's web site has some "cheat sheets" (see www.nevdgp.org.au/?content=14#CheatSheets). A 10-page training booklet, Using Medical Director To Record Clinical Information More Accurately, is also available. I can e-mail a PDF copy to you if you send a request and your details to noel@nevdgp.org.au.