The standardisation of hospital medical records / report of the sub-committee.

MINISTRY OF HEALTH

Central Health Services Council

STANDING MEDICAL ADVISORY COMMITTEE

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REPORT OF THE SUB-COMMITTEE

LONDON

HER MAJESTY'S STATIONERY OFFICE

PRICE 4*s.* 6*d.* NET

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1965

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GENERAL INTRODUCTION

1. At their meeting on 14th March, 1961, the Standing Medical Advisory Committee agreed to set up a sub-committee, the terms of reference of which were:

'To consider the problem of standardisation of hospital medical records and to report back to the Standing Medical Advisory Committee having examined a number of the standard forms used in various regions and teaching hospitals.'

2. Mr. W. Turner was appointed Secretary of the sub-committee and served until 9th September, 1963, when Mr. C. G. R. Alderman was appointed Secretary. We are greatly indebted for the initiative, tact and zeal with which Mr. Turner undertook the work on behalf of the committee and for his continued help, after his transfer to other duties, in the editing of the report. We would in addition wish to record our thanks to representatives of a number of branches of the Ministry of Health for their assistance in providing information and also for their help in our deliberations.

3. A number of special surveys were undertaken at the instigation of the committee. We would like to express our thanks to the Hospital Management Committees concerned, and particularly to the Secretaries and Records Officers of these committees for their valuable help.

4. The first meeting of the committee was held on 12th June, 1961, and we have had eighteen meetings of the full committee. In addition there have been fourteen meetings of sub-committees. A list of the bodies and individuals consulted and those submitting written and oral evidence can be found in Appendix B.

I. THE FUNCTION OF MEDICAL RECORDS AND THE NEED FOR STANDARDISATION

5. We began our study by collecting from a number of hospitals sets of medical record forms currently in use. They presented very wide variations: in lay out, in methods of filing, and in size. We also asked Regional Hospital Boards if they had attempted any degree of standardisation and with what success. The answers showed that very little standardisation had been achieved and that frequently there was no standardisation even among hospitals in the same group. We discovered that some limited attempts had been made but had usually failed because of the preference of hospital doctors for their established systems. The experience of Regional Hospital Boards led us first of all to consider if any standardisation of medical records was practicable even if it was desirable. We found that there was considerable awareness of the advantages of standardisation but that this was not sufficient to arouse any pressing demand among hospital doctors for standardisation. This apparently conservative attitude is based on the sound practical approach towards innovation inherent in the practice of medicine: if well tried methods work, any change which is not based on personal experience needs very solid evidence. We therefore agreed at the outset that we would recommend standardisation only if it presented well defined advantages and that we would recommend standardisation only in those parts of the medical record system where these advantages were of real importance.

6. Although our terms of reference referred only to the problem of standardisation we found that our work called for consideration of much wider aspects of medical records. We were forced to give thought to the first principles of medical records: their purpose and function. Perhaps because the first principles seem obvious we found that little had been written, at least in this country, on the philosophy of medical records but coinciding with our term of office we noticed some interesting discussions, particularly Mr. H. A. F. Dudley's paper read to the conference of the Association of Medical Records Officers at their conference in 1962(1), and an article by Mr. Bryan N. Brooke in the Lancet(2). A scientific session at the B.M.A. conference at Oxford in 1963 was devoted to medical records(3). We hope that this represents a growing interest in this relatively underdeveloped field of study and that it will lead to consideration of the purpose of medical records being taken further than we felt able to do within our limited terms.

7. Medical records are as old as medicine itself and some of the ancient records contain most admirably succinct and workmanlike accounts of conditions and their treatment. Their nature emphasises the basic character of medical records at all times: running records which are essential to the management of the patient's treatment. But the records of the past also tell us a great deal about the development of medicine and illustrate most clearly how current practices have developed from past experience. This leads us to ask if medical records should be more than running records; whether they should also be shaped with the future use of current records specifically in mind. We agreed that the answer to this would have a fundamental influence on our approach to standardisation.

8. There is already a good deal of retrospective research into medical records. Individual doctors look back into records of their own making as part of the process of personal development which is an essential feature of the practice of medicine; or they may carry out some line of clinical research in which they are interested; or they may simply pursue an idea which though hardly formal research may nevertheless be valuable. On a wider scale medical records are used by workers following a particular line of clinical research, and by epidemiologists and workers in social medicine. All this work is however fragmentary and limited in scope. At present the only morbidity survey for general hospitals undertaken on a national scale is the Hospital In-Patient Enquiry, but this cannot claim to be comprehensive since the only morbidity data analysed is the discharge diagnosis and the enquiry covers only ten per cent of discharges and deaths. It is tempting to consider the unique opportunity offered by the National Health Service for a national system of data analysis on a far more detailed and comprehensive scale. Clearly our present methods of maintaining medical records are quite inadequate for such a project. Even on the present limited scale, research into medical records is far from easy. Individual doctors are helped by memories of their own past cases and the extraordinary ability of medical records officers to retrieve documents on the flimsiest of

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(1) Dudley, H. A. F., 1962. The Medical Record. London, Association of Medical Records Officers Ltd., p. 580.

(2) Brooke, B. N., 1962, Lancet, i, 738

(3) 1963, Brit. med. J., ii, 309.

evidence, but if the researcher has to look into other people's records his task can be very difficult indeed. Intensive research on the scale envisaged would call for detailed codification of the information in the case papers. This is by no means a far fetched proposition but we had to ask ourselves how far retrospective research could go even with the most sophisticated techniques of recording and data analysis.

9. Of the types of research based on medical records, clinical research is perhaps the most demanding in the range of information needed but it must be admitted that for this purpose records unrelated to a specific research project can never contain all the information which a future researcher will consider essential. Mr. Bryan N. Brooke in the article referred to in paragraph 6 made the point forcibly:

> 'How can the man who recorded the note guess that years later some investigator will require to know whether Pumpernikel's sign was present in cases of knock knee? Still more, how can he guess that for the future investigation to be valid he must state that it was *not* present; that the absence of a statement to that effect cannot fairly be regarded as evidence that the sign was absent?'

Within certain limits however past records do contain valuable information even for clinical research; if nothing more they can indicate broad trends and suggest the lines of forward research.

10. Retrospective research for the purposes of epidemiology and social medicine is less circumscribed by the inevitable incompleteness of clinical data and it is therefore easier to foresee the extensive use of current records in future research in these fields. Recently interest has been shown in broadening the scope of present studies. A correspondence in the British Medical Journal starting with a letter from Professor L. J. Witts, Dr. E. D. Acheson and Dr. S. C. Truelove suggesting the need for a national epidemiology([1]) was followed by a pilot study at Oxford under the directorship of Dr. Acheson. The Oxford Linkage Study as it is known aims to link in one file, for the purposes of epidemiology, health records of individuals at present filed separately in the various parts of the National Health Service. The study is continuing and it is therefore too early to draw firm conclusions from it about the way a national epidemiology might develop. We think however that some development on these lines is inevitable but much will depend upon the sort of records which are kept.

11. Apart from their value in medical research, medical records have further functions which relate not only to the clinical management of the patient's treatment but also to the administrative management of the hospital. The latter is a use of medical records which is still comparatively underdeveloped in this country, but in the United States of America, even without a national hospital service, analysis of medical records for management purposes is now extensively undertaken. We think that in the future a much greater use of hospital medical records will be made in the United Kingdom for these purposes.

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(1) Acheson, E. D., Truelove, S.C., Witts, L. J. 1961. Brit. med. J. i. 668.

12. The functions of medical records described in paragraph 11, though important, do not directly affect doctors and nurses who treat the patient in hospital. We could hardly recommend standardisation if it did not bring positive advantages to them and direct benefit to their patients. The hospital doctor likes his medical records to be in line with his personal practice of medicine, and as we remarked earlier, this has inhibited moves towards standardisation. We do not however accept that the personal nature of a doctor's service necessarily means that the forms he works with must be of his own design. Many hospital doctors do in fact work with record forms not of their own choice, though there is a tendency for a clinician to introduce case history forms to suit himself and for a radiologist or a pathologist to introduce his own system. But medical record systems cannot change with every change of consultant and since junior medical staff have little say in the choice of forms they work with, diversity is not to be defended on the ground that it lets each doctor have the form he wishes, and its disadvantages are marked. Hospital doctors move between hospitals, particularly when in junior posts and even consultants may work in a number of different places. It is wrong that they should have to accustom themselves to different designs of forms in each hospital they work in. At best it is inefficient and awkward and at the worst it can lead to mistakes. It should not be forgotten that nursing and administrative staff may have no part in the design of the forms with which they work every day.

13. Lack of standardisation is also a disadvantage when records have to be referred to other hospitals.

14. Perhaps the most serious argument against diversity of medical records is that it allows them to be underrated as an instrument in the discipline of medicine. The value of keeping good medical records is stressed in the training of medical students, but these good habits are hard to maintain among the confusion of documents which the hospital doctor meets later in his career. A desire for some sort of system may be seen in the way that certain records used in postgraduate medical schools have virtually imposed themselves as standards in some specialties.

15. Our consideration of the functions of medical records leads us to the conclusion that for all the purposes they serve standardisation is right in principle. Any system of standardisation must allow freedom to introduce new forms for special purposes or modifications dictated by changing medical or social needs. In the course of all our studies we learned nothing which caused us to reject standardisation as a practical proposition. In the pages which follow we therefore lay down the broad lines on which it should be started and we suggest the design of some of the basic forms. We also attempt to forecast the shape of future developments and proffer some suggestions about how they might be met.

II. MEDICAL RECORD TERMS

16. Medical record documents and procedures tend to be known by a number of different terms. Generally the alternative terms are well understood and there is no confusion. We felt however that in this report we ought to submit to our own views on standardisation and keep our references uniform to avoid risk of ambiguity. We have drawn up in Appendix A a glossary of medical record

terms to define the terms we have used. Most of these are commonly accepted terms but in a few instances we have introduced names which are at present unfamiliar, for instance "identification sheet" instead of "front sheet" and "discharge diagnosis" instead of "final diagnosis" and we have done this because we found that the usual terms did not fully accord with the function we were attempting to describe. In the hope that the glossary may also have some wider value as a point of reference we have added some common terms not referred to in this report.

17. We are aware that an international study project has been started to draw up an international glossary of terms and definitions(1). This is a very worthwhile project but it still has far to go before it can have an influence on the terms at present in use in this country.

III. THE CONFIDENTIAL NATURE OF MEDICAL RECORDS

18. (a) The confidential nature of medical records cannot be overstressed and must always be borne in mind by those who have to handle such records. The records should never be left in a position where the patient, the patient's relatives, or unauthorised persons can obtain access to them. Certain records, such as those relating to temperature, pulse and respiration rate, to treatment and to other matters of communication may, for convenience, be placed in the proximity of the bed but the other medical records, i.e. those contained within the case folder, must always be kept in a safe container or trolley in the Sister's office or similar accommodation. Patients should never be asked to take their own records to another department unless they have first been placed in a sealed container. Hospital Management Committees should ensure that all staff employed in the hospital who have access to medical records should be informed that they must treat any information gleaned from such contact as highly confidential.

(b) Personal medical information submitted to the General Register Office or to the Ministry of Health is always treated as highly confidential and access to such information is never given to any unauthorised person. If access is required by a bona fide research worker he is only given the name of the hospital concerned whose doctors may have knowledge of the patient's condition. Thus the disclosure of information relating to an individual for research purposes requires the consent of the consultant in charge of the case. Finally, access to any particular individual has to be through the family doctor and the identity of a particular patient should be revealed only after the consent of both the family doctor or, if still an in-patient, of the consultant, and the patient has been obtained.

(c) The Public Records Act directs that public records thirty or more years old which have been selected for preservation shall be placed in the Public Records Office or in some other place of deposit appointed by the Lord Chancellor and that they shall not be available for public inspection until they have been in existence for fifty years or such period as the Lord Chancellor may prescribe. The Lord Chancellor has exercised his power to vary the normal

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(1) International Glossary of Terms and Definitions. 1960. In Proceedings of the Third International Congress on Medical Records. Edinburgh, p. 151.

period of fifty years during which the right of inspection is to be withheld in the case of medical records and has directed that free access shall not be permitted until they are one hundred years old. This ruling indicates the attitude of the Lord Chancellor's Department to the confidential nature of medical records. This advice has been taken into account in the recommendations made later concerning the preservation of medical records. (See paragraph 28).

IV. THE MANAGEMENT OF MEDICAL RECORDS

19. The case record of a patient is compiled from a number of different notes brought together in such a way as to give the doctor in charge of the case quickly accessible information about the patient at any time whilst the patient is in his care. This information reaches the record from his own notes and from a variety of other sources—from the family doctor, from the special diagnostic departments, from nurses, from relatives and from the social services. The relative value of particular records changes with time. Some of the records will remain of the greatest relevance throughout the patient's treatment, whilst others, of the greatest consequence at a particular time, will be of little relevance when superseded by later notes. The change in importance of records is even more marked when the patient has successive spells of treatment in hospital. Anyone who has had to plough through hospital medical records in search of the currently relevant information about a patient will recognise the value of the good management of records which ensures that those needed are in the correct place at the right time, yet will admit how rarely this is achieved in most hospitals today. We felt that even before we studied the detailed standardisation of records themselves we ought to consider if we could evolve some standard system which would help towards the better management of records.

20. We approached this by considering how medical records could be classified according to the likely period of their relevance. There are for instance a number of records completed during a particular spell of treatment in hospital which will be of importance to the patient's care throughout his stay and during any later spells of treatment. We decided to identify these as *primary* documents. Other documents may convey information vital at a particular time which is superseded by later notes so that when the patient is discharged the former documents contain little of continuing relevance. We felt that for the sake of good management the important conclusions from such documents ought to be recorded on the primary documents. From the medical point of view therefore medical records would seem to fall into two classes: primary documents of long-term value, and others whose value does not extend beyond a particular period of in-patient treatment. Some of the non-primary documents however have legal value in that they might be needed in the case of litigation and we felt that these ought to be separately identified. We shall refer to these as *secondary* documents and the remainder which have neither legal nor medical significance after discharge of the patient we shall refer to as *transitory* documents.

21. We felt that classification of medical records in this way offered a key to a standard procedure for record management. It provides the basis for a rational filing system for forms, and it assists in decisions as to which forms should be kept in the case folders after the discharge of the patient, and how

long they should be kept. We felt that the numbering of medical records in accordance with the above principles would be a help to management and should therefore be related to the classification and to the filing system. Our detailed recommendations for putting into effect these principles are discussed below.

(a) CLASSES OF RECORDS, NUMBERING AND FILING ORDER

(*i*) *Primary records*

22. Primary records are those records which will form the permanent constituents of the case folder. They are the major documents to which reference is made during a patient's treatment in hospital. It should be the practice to record the significant findings from all other documents on the primary documents. This, we think, is a necessary discipline in the use of records and will simplify the task of all who will have to refer to them. We carefully considered the range of primary documents and we think that they can be limited at present to the list given below. We recommend that they should be given identification numbers as shown. Even though we have not recommended a standard layout for all of these at this stage we recommend that the filing order should be as listed. In this we introduce no fundamentally new principle since the order is already in use in a large number of hospitals.

HMR 1 — Identification sheet (formerly known as the front sheet)

HMR 2 — Discharge summary

HMR 2A — Standard discharge letter.

HMR 2B — Post-mortem report.

HMR 3 — General practitioner's letter of referral.

HMR 4 — History sheet and continuation sheet.

HMR 5 — Operation sheet and authority for consent.

HMR 6 — Anaesthetic sheet.

HMR 7 — Nursing record.

HMR 8 — Social records.

(*ii*) *Secondary records and transitory records.*

23. These are the records which though providing vital information at particular times are not necessarily of long-term interest for medical purposes. Diagnostic reports are a good example. They all assist in the assessment of the patient's illness but many show no significant variation from the normal and are therefore only negatively of diagnostic value. Whatever their significance, however, the abnormal features of a diagnostic report should always be recorded on the history sheet. There are many other documents adding to the bulk of the case papers which similarly communicate to the hospital doctor information which he should interpret and record in the case history.

24. From the medical standpoint all documents of this class have fulfilled their purpose when the hospital doctor has seen them and recorded his interpretation on the primary documents. Some, which we call the secondary documents have, however, legal importance in the event of litigation. We recommend that the secondary documents should be filed below the primary documents followed by the transitory documents which have neither long-term, legal nor medical value. We list below the more important documents in these groups and we recommend that they should be numbered as shown, whether standard documents or not, and that the filing order should be as follows:—

Secondary documents.

HMR 100 — Mount sheet.

HMR 101 — Pathology report form.

HMR 105 — X-ray report form.

HMR 106 — E.C.G. report form.

HMR 107 — E.E.G. report form.

HMR 111 — Drug sheet (see paragraph 91).

HMR 112 — Pharmacy request form (in-patient).

HMR 113 — Pharmacy request form (out-patient).

HMR 120 — Communications sheet (see paragraph 92).

HMR 130 — Other secondary documents (to be given a suffix locally according to need).

Transitory documents.

HMR 200 — Temperature, pulse, respiration and blood pressure chart.

HMR 210 — Other transitory documents (to be given a suffix locally according to need) such as electrolyte, fluid balance, urine charts, etc.

HMR 250 — Standard envelope.

(b) PRESERVATION OF HOSPITAL MEDICAL RECORDS

(*i*) *Medical Records Proper.*

25. Information relating to previous admission to or attendance at hospital is of great importance to the management of the case when the patient requires further treatment in hospital. All the relevant information ought to be available but if it is filed with a mass of documents containing information no longer relevant the task of every person who looks at the record is made unnecessarily complicated every time he picks up the document. There is also the practical problem that storage space for records is necessarily limited and we were told frequently that the storage of records was a serious and ever growing problem.

26. Circular HM(61)73 which is current guidance on the preservation and destruction of medical records gives for the life of a medical record a minimum period of 6 years after conclusion of treatment (or 3 years after death of a patient). For psychiatric records the minimum period is 7 years after discharge

of the patient or of his attaining the age of 21 whichever is the later (or 3 years after the death of a patient). The circular gives no guidance on maximum periods. We found in practice that the majority of consultants do not agree to the destruction of medical records at all and therefore although the HM circular pointed out that micro-filming was uneconomic a considerable number of hospitals had been forced to micro-film records in order to release space.

27. We felt that the classification of medical records discussed above offered a solution to the problem of storage and opportunity for providing a more efficient system for the recall of records. If the key facts on the secondary and transitory records are properly transferred to primary records then the only records needed for medical purposes in recalled files would be the primary records and we recommend that the aim should be to reduce the case folder to these records alone on the patient's discharge. For legal reasons the information on secondary documents is needed for six years but there is no legal necessity for the secondary documents to be in the case folder. In many hospitals copies of certain types of secondary documents are kept suitably filed for administrative or professional reasons in the diagnostic departments. Provided such records are retained for at least six years, the secondary documents could be discarded from the case folder when the patient is discharged from hospital. When a copy of a secondary document is not available elsewhere the original will have to be kept in the case folder for six years. All transitory documents by definition would normally be discarded on discharge of an in-patient. Certain documents may be of value for immediate follow-up and where this pertains would need to be specially marked for retention. This procedure for discarding secondary and transitory documents either on discharge or after six years from the date of discharge would do much to reduce the bulk of documents and make the records more manageable. The practice we have recommended of dividing documents into primary, secondary and transitory, may seem a counsel of perfection to many Hospital Management Committees since shortage of staff might lead to failure to reproduce the essential components of the secondary documents on the medical case history sheet. This criticism we feel may be valid if the policy proposed were to be introduced immediately. Nevertheless we consider that the recommendations submitted will prove to be sound as a long term policy and will almost certainly apply once computer storage is readily available. In the interim, where a Hospital Management Committee recommends that certain of the secondary documents should be retained for more than six years the system is flexible enough to permit temporary modifications. It will be necessary for arrangements to be made for the appropriate secondary document or documents to be suitably noted and then filed behind the primary documents in the appropriate order.

28. It remains to consider how long it is reasonable to keep the primary records. We think that insistence that medical records should be retained indefinitely frequently arises from a purely negative attitude. With changing techniques, particularly in diagnosis, most records become less valuable with time and the information may even be misleading. Furthermore symptoms and signs considered significant may not have been appreciated in the past and in consequence not recorded, which detracts from the value of the notes for the purpose of retrospective studies. After examination of the many professional and administrative aspects of the problem we recommend that the normal

maximum period of retention of primary records should be 20 years after the date of last attendance. Personal records may have special value for the individual consultant throughout his lifetime; hence every consultant should be informed of the expiry date before further action is taken. Some records likely to be of special value for clinical research e.g. when hereditary factors are involved, or for historical reasons, should be retained as long as necessary but would need to be specially marked at the time of discharge or after 20 years. This will not be such a problem in the not too distant future when computer storage is not merely available but common practice.

29. We were reinforced in our approach to the problem by a small survey which we carried out in a number of hospitals of varying functions and size (see graph at Appendix C). We found in every case that the proportion of records recalled fell very sharply from the first year after the last attendance to a very small proportion after 6 years, and this leads us to recommend that records up to 6 years from the date of the last entry should be readily available for recall but that older records could be separately stored if necessary on account of accommodation difficulties. There are potential administrative difficulties in adopting this policy, but they can be overcome by re-registering as new patients those who re-attend when the case folder is filed in the 7-20 year period.

30. An interesting feature of the reports we received from the hospitals which co-operated in our recall survey was a slump in recall rate which seemed to follow the limitation of recalled records to micro-filmed copies even when copies enlarged to full size were available. This seemed to indicate that micro-filming inhibits the recall of records which might otherwise be useful. We thought that the procedure we recommend would make micro-filming unnecessary.

31. To sum up, we recommend that on the patient's discharge from hospital all transitory documents should be discarded together with all secondary documents, where copies of essential information would be available elsewhere for 6 years; otherwise secondary documents would be retained in the case folder for 6 years before discarding. Primary records except those of special medical importance should be discarded 20 years after the date of the last attendance.

(*ii*) *The preservation of histological material.*

32. The histological examination and interpretation of biopsy material are often of supreme importance in determining the diagnosis and subsequent treatment of a patient. The histological material may therefore be deemed to be part of the recorded evidence relating to a patient's case, and it may be held that there is a legal obligation to retain such material, properly filed, in the pathological department for the minimum period of six years applicable to medical records themselves. It is recommended that where paraffin processing has been used, every paraffin block containing tissue relevant to diagnosis should be preserved. It is the practice of many laboratories to file one or more, stained or unstained, sections on slides; this is convenient for review of the material but the blocks should not be disposed of. It is strongly recommended that after the lapse of six years all paraffin blocks embodying tissue which reveals a pathological process should be preserved so long as records or reports identifying them are retained in the pathology department or as suggested in the case of the medical records (paragraph 28) for an arbitrary maximum period of

20 years. Blocks may be stored in comparatively small space if each is clearly numbered on a properly waxed in label. Though bulkier than slides, paraffin blocks are lighter and less fragile and will provide sections at any time for re-examination by new techniques and in the light of new knowledge. Where only frozen tissue has been sectioned, without subsequent paraffin embedding, every endeavour should be made to retain one or more permanently stained and mounted sections. In the case of post-mortem tissues the preservation, preferably in the form of paraffin blocks, of any of histological or scientific importance, is recommended. It is especially advised that relevant post-mortem material should be retained for at least 3 years, (a) if the patient died in circumstances in which there might be a claim against hospital or doctors, (b) if death might be related to industrial, accidental or criminal activities, or (c) if there is any other reason to believe that the cause of death might be disputed.

(*iii*) *The preservation of X-ray films.*

33. (a) The permanent or long term preservation of all radiographs presents a special problem because of their bulk and because of shortage of space for filing in radiological departments. We therefore considered whether this problem could be solved by reducing radiographs on 35 mm. film, but we came to the conclusion that technical considerations and problems of reference ruled this out as a practical proposition. We then looked at the need for retaining all radiographs indefinitely. It appeared to us that many of them would be of ephemeral interest, e.g. simple fractures, and could therefore be safely disposed of after a period. We therefore recommend that preservation of radiographs should be judged by the same criteria as other medical records, and since they cannot be regarded as primary documents they need not be retained longer than 6 years.

(b) We have been informed that not all X-ray films in every hospital are adequately labelled. From every point of view it is essential that sufficient data should be legible on each film so that it may be accurately related to the patient and to the date of the examination. We realise that there are various methods of marking or labelling films but we think that, where the addressograph is in use for other records, it might with advantage be applied to the photographic method of film labelling.

V. THE MECHANICS OF MANAGEMENT

(a) SIZES OF HOSPITAL MEDICAL RECORDS

34. The diversity of hospital medical records is particularly illustrated by the number of different sizes of case papers in use. Although we had no particular evidence that this was a cause of concern to users in the hospital service we agreed that standardisation would get nowhere without standardisation of size: it was the key to the whole problem of implementation. This was so important that we had little need to look into the further advantages of standardisation but there are some obvious direct advantages, for instance in ease of filing copies of records transferred between hospitals, ease of reproduction and utilisation of standardised equipment.

35. The most direct advantage however would be to general practitioners. Representatives of general practitioners left us in no doubt of the difficulties they faced at present in filing papers from hospitals which bore no relationship to the existing sizes of their medical records. The referral of a patient to hospital by a general practitioner may lead to a considerable amount of correspondence and with the increasing use of 'open' diagnostic facilities by general practitioners the number of records held by a general practitioner which contain reports from hospitals grows annually. We consulted representatives of general practitioner organisations, and although some of the representatives did wish to see the introduction of a new form of record, the majority felt that the present forms EC7 and 8 and the medical record envelopes EC5 and 6, were adequate, provided a more generous allowance of the gussetted envelopes was provided. We therefore decided not to pursue further the question of a new form for the general practitioner since we felt that any new development could be accommodated in the standard sizes A6 or A5, which we have recommended for the several forms of communication within the National Health Service. (See paragraph 37). Nevertheless we hope that general practitioner organisations will continue to give serious study to the purpose and best use of the existing records as well as to their improvement.

36. We started our consideration of the range of sizes to be recommended as standard from first principles, ignoring for the time being any tradition in sizes. The requirements as we saw them were that the size of the basic documents in the case folder should normally be sufficient to allow information on each separate aspect of the record to be contained on a single sheet and that the sheet should be convenient for handling and filing. Copies of documents which were liable to be sent to general practitioners should as far as possible be of a size convenient for the general practitioner's record, either unfolded or with the minimum of folds.

37. In applying these requirements to the standard sizes obtainable in the United Kingdom we found that the range of sizes approved by the British Standards Institution (1) and commonly known as the International Paper Sizes were suitable. The advantages generally of these sizes are amply brought out in the publications of the British Standards Institution and of the British Federation of Master Printers (2) and we have noted the particular advantages to the hospital service. After full consideration we recommend the use of the following sizes for the reasons stated:

(a) The size A4 of the range ($8\frac{1}{4}$" x $11\frac{3}{4}$"/210 mm x 297 mm) is a suitable size for most of the case papers.

(b) The smaller sizes of the range A5 ($5\frac{7}{8}$" x $8\frac{1}{4}$"/148 mm x 210 mm) and A6 ($4\frac{1}{8}$" x $5\frac{7}{8}$"/105 mm x 148 mm) are also convenient for correspondence, referral forms and reports.

(c) The constant ratio of the sides of different sizes of the range is an advantage in photocopying and offset litho printing.

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(1) Brit. Stand. Instn. 1959. Printed Matter and Stationery (B.S. 3176: 1959) London, British Standards Institution.

(2) Brit. Fed. Mast. Print., 1960. International Paper Sizes. London, British Federation of Master Printers.

We were also happy to find that the size A6 which is convenient for short communications and most diagnostic reports fitted in the general practitioner's record envelope without difficulty. Larger papers when folded (once in the case of A5 and twice in the case of A4) present the same size as the A6, and thus the use of the A6 to A4 range for correspondence to general practitioners would allow them to file hospital papers conveniently and in the minimum space. The thickness and quality of paper are also relevant and these are dealt with in paragraph 50.

38. Theoretically therefore the International Standard Paper Sizes are right for hospital standards but we had to accept that these standards would be quite new to the hospital service. Although the diversity of sizes in use was considerable, quite a large number of hospitals used the size 10″ x 8″ for the main case history papers and few used a size as long as the A4 size. This in itself was not serious because we were confident that if hospitals were convinced that the new standard sizes were most suitable for good management they would readily accept unfamiliar sizes, and in fact in our consultations we found that people in hospitals who had to work with the records would find the sizes acceptable. It was strongly represented to us however that a change to the new sizes would be expensive because new filing equipment would be required. Hospitals using shelving would have little difficulty in adapting but many hospitals also use metal filing cabinets of quarto size which it is said are too small for a case folder containing the A4 case papers.

39. We felt therefore that the problem of cost would be a decisive factor and we made an attempt to assess it. We selected a representative sample of 10 per cent of the non-psychiatric hospitals in England and Wales and asked for information on the sizes of their storage equipment, the sizes of case folders, and on the number of files opened annually. From the results of this census we made an estimate of the cost of replacing quarto filing cabinets by foolscap filing cabinets obtained through central supply. We came to the conclusion that the limits of the extra expenditure if all filing cabinets were replaced would have been in 1962 between £100,000 and £200,000 for England and Wales. This was less than we had at first thought and moreover, it must be realised that this would be a once for all expenditure, spread over a number of years as the new sizes were gradually introduced. Standardisation of size would also allow standardisation of the whole range of filing equipment with consequent economies which would go far, ultimately, to repay much of the initial cost of standardisation. For those hospitals which might feel unable to consider the introduction of the newly recommended standards for financial reasons, it would be possible to proceed through the expedient of a slight modification of the folder size. The ideal length of the new case folder will be $12\frac{1}{2}$″, to take A4 sheets $11\frac{3}{4}$″ long. The inside measurement of a quarto drawer is $12\frac{5}{16}$″. If the new folder is cut $12\frac{1}{8}$″ long, it will fit the quarto drawer, but the margin for filing accurately is very small. By pre-punching all printed sheets accurately, and this should be routine, the risk of inaccurate filing would be minimised. When larger cabinets were purchased, the folders cut to $12\frac{1}{8}$″ could be filed together with the $12\frac{1}{2}$″ folders without difficulty.

40. Our enquiry showed that there was great variation in the use made of filing cabinets: some hospitals used only shelving while others filed a considerable proportion of their records in cabinets. The increase of expenditure consequent on the introduction of the recommended standardisation of record size will therefore fall unevenly. It must be expected that those hospital groups faced with heavy replacement expenditure may be reluctant to make or even consider immediate change for financial reasons. Some of these hospitals might however reconsider the use of the more economical and more convenient system of shelf filing which we commend for the following reasons:

(1) The working space needed for a filing cabinet is approximately twice the floor area occupied by the cabinet because room must be left for the drawers to be fully extended. Therefore each cabinet needs an allocation of six square feet of floor space. Further a cabinet utilises space only up to a height of four feet from the ground and the space above is often wasted. Shelving on the other hand need only be 14″ deep and requires only a two foot six inch gangway. Shelving can provide storage space accessible without ladders up to a height of six feet from the floor. The space above six feet up to ceiling height can be used for secondary storage. In an area of 100 square feet 10,000 case note folders can be stored in filing cabinets. In the same area about 15,000 can be stored on shelves six feet high accessible from the floor

(2) Cabinets are prone to mechanical defects (e.g. drawers "sticking", runners getting out of adjustment) but there are no moving parts in shelves to cause trouble.

(3) Less effort is required by the staff to take files from shelves than to open drawers, remove the files and close the drawers again.

(4) Shelves are easier of access; with filing cabinets a clerk searching through an upper drawer blocks access to files in the drawers below.

(5) Filing trolleys can be freely used with shelving unimpeded by open drawers of filing cabinets.

(6) Cabinets are more costly. To store 20,000 files would need cabinets to the value of £375/400. Steel shelving, (erected locally), could be provided for as little as £110 to accommodate the same number of files.

There is general agreement as to the value of shelving for long term storage but a case can be made for the use of filing cabinets for the initial years on the grounds of security since filing cabinets can be locked. The greatest disadvantage of shelving when they are open to the atmosphere is the increased risk of contamination of the documents with dust and soot. The fitting of blinds can reduce this risk.

41. Our final conclusion was that whichever system is chosen cost was not a factor which should deter us from recommending sizes which would otherwise be right for the hospital service. We therefore recommend that hospital medical records should be standardised in the A range of the British Standard paper sizes.

42. Although the use of medical records outside the hospital service was not strictly within our terms of reference we felt that our recommendations would have an impact on the forms used in other branches of the National Health Service, and in the welfare services outside it. There is an increasing flow of forms between the branches of the Health Service and between the health services and other government departments. Many of these forms seem to come to rest inside the general practitioner's record envelope. We hope that all authorities and government departments in communication with the National Health Service will have regard to the advantages of standardisation of sizes of forms which have to be kept by another authority. In particular the forms which might have to be kept by a general practitioner would be more convenient for him if they were of the same size as the hospital papers which make up the majority of the papers he is called upon to retain.

(b) THE UNIT SYSTEM

43. The unit system of hospital medical record keeping by which is meant the keeping in one folder of the records relevant to a patient's care in hospital is normally so convenient that it needs no new argument in support. It is already in use in the majority of hospitals and in most of those in which it is not in use tradition or the sectional interest of individual doctors rather than clear advantage to the service seem to be the reasons. We recommend that the unit system should be the standard in the hospital service. Records being confidential documents, we are legally advised that it is no longer necessary to exclude from the unit system any records even, for example, those relating to psychiatric illness, cancer or venereal disease. Records in accident and emergency units often have a temporary value only and we have suggested in Section VIII ways of linking them with the unit records.

(c) TRANSFER OF RECORDS

44. With the introduction of standard sizes, photocopying should be much simpler, particularly if sheets are written on one side only. Furthermore, ready photocopying would obviate the necessity of records leaving the record office when requests were made by other departments or other hospitals. This system would also minimise the loss of medical records and would assist the policy of their not being removed from the hospital.

(d) METHOD OF FILING

45. There are two main methods of filing. One is that in which the papers are filed loose in a pocket; in the other, papers are fixed to the case folder by a clip or tag. The pocket system has the advantage that the case folder is slimmer since it needs no bulky fastener and it is easier to withdraw individual papers and to file and make entries on them. It has however the disadvantage that no matter how disciplined the user the papers become disarranged, and more liable to become dog-eared, and are in constant danger of being lost. The large number of different types of clips and fasteners we saw in use with the alternative system, suggested that the ideal fastener has not yet been discovered. All add to the bulk of the case folder, some make the record stiff and unwieldy in use, and some tear the papers at the filing holes. After full consideration we think

however that the disadvantages of the pocket system are greater than the advantages and we recommend the fastened record. Of all the systems of fastening that we were shown we favoured most the type consisting of a simple flexible metal strip such as annealed brass which passes through four holes in the gusset of the inside of the case folder, through filing holes of the case papers, and then is simply turned over at the protruding ends. No further binding clip is necessary and the strip can be bent any reasonable number of times without breaking. This was the slimmest fastening we saw and held the papers most effectively. We recommend this type of fastening. In making this recommendation we accept that filing is more difficult, and that sheets suffer from wear and tear at the punch holes. We think (a) that papers should be filed behind the *rear* of the gusset which would become the medium against which the sheets are turned (b) we think the filing sequence we have recommended provides for the minimum number of sheets to be removed during filing (c) that the quality of paper we shall recommend will be able to withstand reasonable wear and tear and (d) that the specification for mount sheet paper should take account of strength rather than appearance.

(e) USE OF COLOUR AND OTHER IDENTIFICATION SYMBOLS

46. The use of colour on medical records is a most useful way of readily distinguishing between documents which need quick identification. It has its dangers however. Too much colour is confusing. Certain colours make ordinary typing or writing difficult to read, and of particular importance to our terms of reference, diversity in the use of colour is confusing when staff and records are mobile.

47. Colour may be used in several ways. Papers may be tinted, colour printed on a white or coloured background, colour flashed, or strips on a white or coloured background may be used. The range of coloured paper which provides a distinctive background to black printing and to black or blue writing is very limited, yellow being the only colour which provides a background comparable to white. We decided therefore that we could recommend the use of tinted paper for only one document in the case papers. The discharge summary is the document most frequently sought and hence should be readily identifiable at short notice. We therefore recommend that the use of tinted paper should be limited to the discharge summary and the colour used should be lemon yellow (see HMR 2).

48. The range of colour symbols must also be strictly limited if the objective of distinction is to be achieved. We came to the conclusion that only three primary colours could be safely used and this of course puts a serious limitation on the use of colour symbols. Colour symbols are more common than tinted paper and we found a great diversity in their uses. Some hospitals use them for distinguishing between consultants and departments as well as for report forms. We felt that in a number of cases colour was not achieving any purpose other than providing a gaily coloured case history, and in some instances merely added confusion.

49. In surveying the need for colour symbols we came to the conclusion that pathology report forms had the greatest claim. An individual case history can contain a large number of pathology report forms covering a wide range of different tests. Without a distinguishing symbol they present difficulties in reference and filing. Other types of report forms also need to be readily identifiable but we agreed that these could be distinguished by large letter symbols on the bottom right hand corner of the form, for instance XR for radiology forms and E.C.G. for E.C.G. reports.

We recommend that colours should be limited to pathology report forms and the discharge summary but that all report forms should be distinguished by black letters. In addition there should be an agreed symbol for each laboratory department to cover those hospitals using photostatic reproduction of reports. The colour coding and symbols for pathology report forms should be standardised as follows:

Bacteriology:	Blue	Bact.
Chemical pathology:	Green	Ch.P.
Haematology:	Red	Haem.
Histology:	Black	Hist.

(f) PAPER QUALITY

50. We found that one of the most frequently expressed doubts about standardisation arose from the fear that hospitals might be compelled to obtain supplies centrally and therefore would be expected to use a cheap quality paper. The source of supply of either paper or forms is not within our terms of reference but if Her Majesty's Stationery Office is asked, paper to fit any specification can be supplied.

51. Different qualities of paper are required to allow for the various ways in which forms are to be used and we drew up, in general terms, the following specifications to serve as a guide:

Writing Surface

Suitable for ink, ballpoint pen, pencil and typewriter.
Suitable also for printing with metal, plastic or paper plates.

Erasing Quality

Not important, but it is convenient if typewriting can be erased.

Opacity

In some instances it will be necessary to write on both sides of a form and in these cases the opacity must be such that there is a minimum of 'show-through.'

Thickness, Bulk, Weight and Toughness

Capable of frequent handling without becoming 'dog-eared'. Should withstand wear at punch holes. Not too bulky.
Varying thickness will be required for different forms, e.g. X-ray and pathology reports need not be quite so heavy.

Permanence

Suitable for retention for 20 years.

Translucency to Ultra-Violet Light

Should be suitable if required for this method of photocopying.

Printing

Should be suitable both for typeset and offset, and will be required with the 'grain' the correct way for offset.
Thus the following forms should be of a strong bond or cartridge of good white shade preferably of an all chemical wood finish, gelatine, or starch-surface-sized high finish, substance approximately 72 g. s. m.:
History Sheets, Identification Sheets, Communications Sheets, Nursing Records (all on A 4) (but not including the Standard Mount Sheet).

Carbonised Forms

N.C.R. paper may be required and carbon backed paper may also be used. Papers should be suitable for whichever process of carbonising or spotting is selected. They should be of good white shade, substance 47 g. s. m.

Standard Mount Sheet

To withstand wear at punch holes, this will need either to be of heavier and stronger paper, or to be reinforced at the punch holes.

VI. STANDARDISATION OF DOCUMENTS

(a) DOCUMENTS IN GENERAL

52. When we come to the question of standardisation of layout we are of course touching the problem at its most sensitive. Anyone who has designed a form is usually ready to defend it most passionately—and usually with good reason—because it represents his needs most effectively and embodies the whole weight of his experience. We therefore approached standardisation with great care. We were clear that we would only recommend standardisation of layout where good management demanded it. But even though we have limited our recommendations in this way we recognise that some of the layouts we recommend will call for compromise by those who believe that their existing systems are adequate or preferable for their own use.

(*i*) *Standard headings*

53. Whatever the layout of a form, whether it is a standard one which we recommend or one of a hospital's own design we think that the layout of the heading of a form should be standardised. By this we mean the title of the form and the identification details of the patient and the hospital. It is obviously to everybody's advantage if any member of the staff in any hospital wherever he is working knows where to look for these basic details. We found in fact that a common system was beginning to emerge already and we do not therefore think that there should be any difficulty in introducing standard headings.

54. In considering the actual standard layout of the headings we had to take into account the fact that both manual and mechanical systems of reproducing patient identification details were in use and that there was quite a wide range of mechanical systems. (We refer in more detail to mechanical systems below). We decided that the minimum patient identification details for any form were full name and unit number. These take up little space and for manual recording the box for them need only be small. Mechanical recording plates however commonly contain other details which it is not economic to mask out and therefore we decided that the box should be large enough to take the normal size of mechanically recorded impression or label. For manual recording the words 'name' and 'unit number' need to be printed in the box and these could not fit the details printed on the form by a mechanical system. We found however that the printing could be faint enough and small enough not to conflict with any mechanically recorded overprinting. Our examination of records in use showed that the most common place for the patient identification box was at the top right hand corner of the form and we think that this is the right place. The unit number should be at the top right hand corner of this box. The title of the form should be at the top of the form and the form number should be at the top left hand corner. The space to the left of the patient identification box we suggest should be used for hospital identification particulars. We noted that in a number of hospitals it was the practice to print the consultant's name in very large letters, dominating all other identification particulars. We can see no practical value in this and we deprecate it. The standard layout we recommend is illustrated in figure 1.

(*ii*) *Mechanical systems for registration and documentation*

55. Although the use of mechanical registration systems presupposes some degree of standardisation, if only of sizes of spaces, we have indicated above that the adoption of any particular system of registration, manual or mechanical may require the acceptance of a standardised design for headings. We however went into the use of mechanical systems in some detail to determine if a specific recommendation on their use was called for. (See paragraph 58).

56. The process of writing the identification particulars of a patient on the various documents used during the period of a patient's treatment in hospital either as an in-patient or as an out-patient is a tiresome business. It involves clerks and nurses in repetitive tasks and can irritate the patient if he is asked for the same information time and time again. There is a risk of error, particularly in recording the patient's unit number, on every occasion that the details are written down. Inevitably in a busy department some of the writing is hurried and far from clear, and there is a temptation to miss out details.

57. All these disadvantages can be removed by a system in which the identification details are reproduced from a master prepared on the initial registration of the patient. There are at present in use three main types of equipment. One uses a metal or plastic plate embossed with the identification details as the master. Another uses a silk stencil on which the details are typed, and the third uses a paper master which can be used with a spirit duplicator. In each of these systems part of the information on the master can be masked out to produce a limited range of information needed on some documents. Each of the systems

has relative advantages and disadvantages. The metal plate system for example provides a very clear print which can be reproduced any number of times. The capital equipment however is more expensive than in the other systems and the embossing process is noisy. The spirit duplicator system is much cheaper but there is a limit to the number of copies it can produce and the print tends to fade after prolonged exposure to light. All the systems have the disadvantage that mechanical breakdowns disrupt the service and they need great care at the initial registration stage to avoid errors which would be repeated on all the documents printed.

58. In deciding whether or not to introduce a mechanical registration system a hospital authority will be strongly influenced by the economic factors which include the capital and running costs, costs of training staff, additional stationery, and so on, to be set against saving in clerical, nursing and medical staff time and the fact that the machines can be used for other purposes. Some of the advantages we have mentioned however are imponderable and therefore to some extent there will be a subjective factor affecting the choice. Comparison of the decisions made by a number of hospitals showed that in fact the subjective factor was dominant and we were glad to note that there was a healthy scepticism towards sales pressure which is especially strong in this field. We have concluded that the comparative weight of the factors affecting a decision on this choice of mechanical registration systems varies so much that we cannot give any firm recommendation. We hope that Regional Boards or the Ministry of Health through their advisory services will be prepared to give advice about the considerations affecting the choice of systems to hospital authorities who are contemplating them.

(b) PRIMARY DOCUMENTS

(*i*) *The Case Folder*

59. We have already recommended a type of case folder in paragraph 45 above. After consultation with the Medical Records Officers Association, we agree that printing on the outside of the folder should be limited to the patient's number and a permanent place should be found for the words *Confidential* and *Not to be taken out of the hospital*. We consider that printing on the cover of any information other than that stated above is undesirable. There is a case for writing the name of the patient on the cover for ease of reference in clinics and hence a space should be allotted for this purpose. Some hospitals may wish to have their name recorded on the outside. This could be done by using a rubber stamp and not necessarily by printing. Many hospitals utilise the inside of the folder for recording important data. Whilst the way in which the folder is used must be left to the discretion of each Management Committee, we feel that any important medical or administrative details of permanent value, that is to say required for 20 years or more, should not be printed on the folder since changes of folder may well be necessary. The folder is referred to as HMR.F. (see fig. 17).

(*ii*) *The Identification Sheet*

60. This form, commonly known as the front sheet, contains identification particulars of the patient and information of administrative value. We think

that it is possible to confuse the name front sheet with the case history sheet which on occasions is also known as the front sheet and we recommend that the name '*identification sheet*' should be used in future. (See Appendix A).

61. In considering the need for standardisation of the identification sheet we became aware that this is a key form for the extraction of statistical information essential for management and for epidemiological research. We realised that much has still to be done in applying hospital records for these purposes but we felt that processing of this sort of data is an inevitable and necessary evolution in the Health Service and we came firmly to the conclusion that we must look ahead to the time when extraction of data from hospital records is an essential function of the hospital administration. Workers who are the forerunners in this field impressed us with the difficulties they now face in extracting even simple administrative details from hospital records because of their diversity. We were in no doubt therefore that we must recommend a standard layout for the identification sheet and one which as well as meeting the administrative needs of the hospital must be suitable for modern methods of collecting and processing statistics. We did not think that there should be any conflict in these aims because we could not see that there need be any statistics collected which would not be of value in the administration of the hospital itself as well as for use in planning national needs.

62. Whilst we are convinced of the need for more effective collection of statistical data from hospital records we appreciate the difficulties for hospital staff who have the job of extracting the information and we realise that it is difficult to maintain any enthusiasm in producing statistical information which is not of obvious value to the patients and to the hospital administration. Since much of the data requested is likely to be utilised on a regional or national basis, it may be difficult to convince hospital staffs of the importance of such data. The introduction of mechanisation will undoubtedly lead to the feeding back of regional and national data which should help hospital staffs to realise the importance of the accuracy of standardisation of the information they are called upon to collect (see paragraph 108). The comparatively limited co-operation with the Hospital In-Patient Enquiry when it was entirely voluntary illustrated the difficulty and we know that some hospital groups are still reluctant to send in the returns. We regard this as an entirely understandable attitude in the busy hospital service where the immediate needs of the patients dominate. We therefore decided that if possible the production of data for processing away from the hospital should be a by-product of the recording of information which was essential for the hospital's own administration.

63. The solution we decided could be found in a procedure by which the Identification Sheet (HMR 1) would be the basic source document from which statistical information could be derived. After it is created and the 'arrival' part of the strip is completed, it should be photo-copied. The copy could first be held and used as an indicator of patients in hospital and might also be used to capture information at various stages of the patient's progress. After discharge of the patient it would become a control document for the case folder, remaining outstanding on the file, until diagnosis, disposal and all statistical functions were completed. At this point, the copy of HMR 1 would become the form for using or sending forward for data processing. It could be used by the General Register

Office, and/or for linkage studies and/or local processing as necessary. The first stage in producing statistics must be to feed back activity information rapidly to the hospital itself. The next stage is to provide regional and national tabulations as at present produced by the Hospital In-patient Enquiry of the General Register Office. HMR 1, being a summary with a content that it is hoped will be common to all hospitals, will serve these statistical purposes and as the system evolves, possibly others in the future.

64. The upper half of the identification sheet (see fig. 2) contains standard registration particulars, with some additions, which are commented upon in paragraph 67. The form will be completed manually, but could also be used with a labelling system. For this reason we recommend a sheet and not the printing of identification details on the inside of the case folder because (a) of the difficulty of copying either by carbon or photo-reproduction, and (b) because covers are frequently damaged and liable to be replaced.

65. In the lower part of the sheet there are three positions for admission or new attendances. HMR 1 is intended to be used for either in-patient or out-patient registration but this arrangement will not invalidate its use for data processing of either in-patient or out-patient statistics. It may be necessary to reserve one of the spaces for special purposes. Psychiatric records require special administrative details in addition to those already available on HMR 1 and it is conceivable that special requirements may be necessary for the accident service. There is a further value in keeping one of the spaces free in that it will encourage hospitals to experiment with developments.

66. We have consulted the General Register Office about the details which they would need on the form and they are satisfied that these fulfil their requirements as far as can be foreseen. The subject of hospital statistics is however still in a stage of early development but we feel that the unification of the Identification Sheet and the statistics is a desirable step and we hope that it will be introduced in all hospitals at a very early date. However we also realise that the details we have included in our design may require considerable further consultation.

67. Few of the entries on the form call for any explanation since they are already included on the majority of identification sheets at present in use. Some however are not so obvious. The space for maiden name as well as married names is included for two reasons. It ensures association with previous medical records and it is of great advantage to *ad hoc* research calling for record linkage with other branches of the Health Service, and with birth records when family linkage is involved.

68. The spaces for particulars of diagnosis may appear inadequate to those who use the International Statistical Classification of Diseases, Injuries and Causes of Death. We are advised however that in many hospitals, often through inadequate staffing, it is difficult to get completion of even the basic diagnoses. We have therefore been compelled to modify our ideals by accepting the minimal requirements and for the present those hospitals who use a better classification may need to provide a special sheet in the folder for this purpose.

69. We have included a space for recording the National Health Service number although we realise that this is not normally recorded nor has any value to the hospital. The National Health Service number is however the only safe means of identifying the patient when hospital records are being linked either with previous hospital records or with other Health Service records. As it is allocated when a birth is registered it forms an identification which is available throughout life. In the case of immigrants, a number is allotted by the Executive Council after registration with a general practitioner. Although the number is at present not normally used we are convinced that it will be needed for the more comprehensive data extraction of the not too distant future and we think that it would be valuable to establish the procedure of recording it now.

(iii) Discharge Letter and/or Summary

70. We were asked by the Minister to recommend a form of notification to a general practitioner of his patient's discharge from hospital for inclusion in a hospital memorandum on discharge procedure. The design we recommended is contained in the appendix to the memorandum enclosed with H.M. (63)24 (see fig. 4). We think that in most cases the discharge letter must be followed as soon as possible by the full discharge summary but for some treatments, the discharge letter itself which should be sent at the time discharge is decided upon will be sufficient. We think in this case a copy of the discharge letter should be kept in the case folder, unless a discharge summary is also written.

71. There are a number of items of information which should be known by the general practitioner which might not occur to the hospital doctor completing the form. An example is information given to the patient's relatives. We were also told that difficulties occurred when hospital doctors included dietary supplements with the drugs recommended on the patient's discharge. It was suggested that we should design the form to remind the hospital doctor about these but we decided that for flexibility in use the form should be kept as simple as possible and we think that other methods should be found of reminding the hospital doctor about the things he ought to bear in mind when completing the form. We suggest that notes of guidance be included in any handbook issued to housemen and, if forms are padded, printed on the cover of the pad. It has been suggested the form could be readily adapted for use in the Accident and Emergency department.

72. Since the memorandum on discharge procedure was issued there have been a small number of complaints from general practitioners that the size A5 which we recommended is unnecessarily large for the majority of discharge letters and that A6 would be adequate. We think that this can only be tested by experience and we recommend that the size of the form should be reviewed when it has been in use long enough.

73. We recommend that a copy of the post mortem record, in the few instances when it is necessary to include it in the hospital documents, should be sent to the general practitioner.

(iv) General practitioner's letter of referral

74. Letter forms used by general practitioners for making out-patient appointments for patients are already being employed successfully in many parts of the

country. Some of the arguments in favour of standardisation which we have put forward before do not apply strongly to this form. It was represented to us that general practitioners who might use any one of several hospitals under a number of different hospital authorities had to carry a stock of forms for each of the groups which had its own design. This problem was particularly annoying in Greater London and some of the other conurbations. It was suggested to us that a standard form which could be used for any hospital would solve this difficulty.

75. There are two main types of forms at present in use. One type consists of a simple request for an appointment and a list of questions to be completed by the patient to help the hospital to complete identification particulars in the case papers before the patient attends. In the other type, space for the general practitioner to write a clinical note for the consultant is added. The main advantage to the hospital in either type lies in the greater convenience of a written request over a telephone request by spreading the appointments work over the day and in the opportunity it offers of linking previous papers and in completing documents before the appointment day. There is also a reduction in the pressure on the telephone switchboard. For general practitioners or patients, there is advantage in avoiding a telephone call to the hospital the making of which at certain times of day can be difficult and, with STD, expensive. To the patients there is the added advantage of spending less time at the appointments desk on first attendance.

76. When we came to consult general practitioners about the design of the form we found that there was a certain amount of opposition to it. It was argued that the use of the form detracted from the personal nature of the relationship between the general practitioner and the hospital consultant, and that it was always preferable for the general practitioner to write a personal letter to the consultant. We had sympathy with this view but we had to accept the position that the use of a form was spreading simply because it was found to be so convenient for everyone concerned. Hospital authorities who had established the use of a form were asked specifically to report any comments from general practitioners. No criticisms were received; on the other hand several authorities reported favourable comments. We therefore decided that we would recommend a standard form to remove the present disadvantages to general practitioners arising from the lack of standardisation but emphasise that they should remain free to choose whichever means of communication with the hospital consultant they prefer.

77. The design we recommend is illustrated in figure 5. It will be seen that we have recommended a design containing space for the general practitioner to write a clinical note which will remain sealed for the consultant to open himself after the records staff have opened the part of the form containing the patient's identification details. We think however that the general practitioner should feel free to write a separate personal letter instead if he wishes. It had been suggested that the part opened in the records office should contain a note on degree of urgency. The reason for this was said to be that in some hospitals where similar forms were already in use, the note to the consultant remained sealed until the date of the appointment with the result that urgent cases were not identified unless the registration clerk was warned by an appropriate entry.

We deprecate this system most strongly. We are firmly of the view that the general practitioner's note should be read by the consultant or a member of his firm on the earliest possible occasion after the receipt of the form. We have therefore not included a space for recording urgency as we did not consider it necessary.

78. Some hospital authorities prepay the postage on the appointment forms because, we were told, this ensures the maximum use of the form. We think that the advantages to the hospital are so distinct that the forms should be prepaid, the cost being met by the hospital authority. But there are difficulties. Usually the business reply system is used and this ensures that the cost of the postage falls directly on the hospital authority which receives the form. To use this system however the full address must be printed and this of course removes the advantage of universality of the standard form. The simplest answer would have been to use the official paid frank but we are told that this is not admissible for the hospital service. The solution we suggest is for standard pre-stamped forms to be issued by Regional Hospital Boards through Executive Councils to general practitioners. The cost of the forms should be shared by hospital authorities, including the teaching hospital groups in the region, according to an estimate of the forms returned to each hospital authority.

(*v*) *The History Sheet*

79. There is a great variety of case history sheets in use, varying from plain sheets to most complicated printed forms. The designers of the many types of printed form had obviously developed them with great care and we were not prepared to criticise them. All that we would say is that the more complex forms can be inhibiting to those who have not been concerned in their design. The simple unprinted form is used in many hospitals and we think that for hospital doctors as a whole, particularly for junior doctors who cannot have forms of their own design, it has advantager. We have therefore included the plain history sheet in our list of standard forms (figure 6). The same form is of course suitable for the case history continuation sheet in all cases.

80. In the example (figure 6) the maximum space has been allowed for mechanical registration for the benefit of those hospitals which use a large plate. In many instances hospitals use a much smaller plate merely recording the patient's name and number. We hope that in using the smaller size, clarity will not be sacrificed.

81. Figure 6 is printed on one side only as this is an advantage in photo-copying but if paper of a suitable quality is used, the sheet may be written on both sides.

(*vi*) *The Operation and Anaesthetic Documents*

82. It is customary, in hospitals in this country, to obtain the patient's or, in the case of a minor, the parent's or guardian's consent before undertaking any operative procedure or treatment. A variety of consent forms are at present in use in hospitals but we were given to understand that an increasing number used the form suggested by one of the medical defence societies. We can see the advantages of such a procedure and recommend its general adoption. In a number of hospitals the consent form is included on the operation record either

as a special paragraph or footnote, or printed on the back of the operation record. We hope that one form will be developed to meet the varied requirements of the consent forms at present in use. We would however endorse an extension of the practice of printing the details on the back of the operation form since the inclusion of the information on a major document will make for ease both of filing and of reference and will lessen the chance of loss.

83. Operation and anaesthetic forms are being increasingly used to record much detailed information about the pre-operative and post-operative treatment, as well as details of the operation itself and of the anaesthetic or anaesthetics used. It was customary in the past to record all the essential facts on the medical history sheet but there are advantages for ready reference to, and analysis of, the findings, to have the data on a special form. We consider that such information will require in the future to be processed for use with some form of mechanical sorting if full advantage is to be obtained from the data: hence the urgent need for standardisation in the lay-out of such forms. The latter view coincides with that of a number of leading surgeons and anaesthetists. A recent article in the journal Anaesthesia ([1]) indicates that the anaesthetists have the problem under review. In view of the need in the first instance to get the specialist bodies concerned to agree as to the basic data that must be recorded we consider the time is not yet opportune for us to submit pro formas for these purposes.

84. In drawing up the operation form we consider it important to find a place to record the name of the surgeon actually performing the operation and of the theatre sister or nurse in charge of the case in the operating theatre. We recommend that the size of the forms, HMR 5 and 6, should preferably be A 4.

(vii) The Nursing Record

85. This is sometimes known as the day and night nursing report. Its purpose is to provide a running record of the nursing care given to the patient during his stay in hospital together with observations on his progress and response to treatment. It contains essential information for medical and other staff concerned and it may provide valuable material for medical and nursing research. The nursing record will also include additional information which may not be recorded elsewhere for example the notification of relatives of a sudden change in a patient's condition and whether they have been seen by the doctor. In some hospitals the nursing report is written in a ward book but the practice is growing of keeping an individual record for each patient. The employment of part-time nursing staff, shift systems and recovery and intensive care wards all point to the need for carefully compiled written nursing records and the system of a separate form for each patient. For convenience the forms should be filed in a good quality loose leaf folder holding all the nursing record sheets of patients being nursed in the ward. In wards where team nursing is practised it will generally be necessary to have a folder for each team. The record should be filed with the patient's case papers on his discharge. It should be of size A4 or A5 which are a convenient size for the record and accord with the sizes of the other case papers. Figure 7 shows the design. As in the case of other forms the lay-out

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(1) Odham, K.W., Anaesthetic and operation records: a description of a new type of combined form. Anaesthesia, London, 1963, April, vol. 18, no. 2, pp. 213–216.

allows for the name, unit number and other particulars to be inserted at the top of the form either by manual or mechanical means. Each entry made on the form should be dated and signed with the initials and full surname of the nurse writing the report.

(viii) Social records

86. Increasing importance is attached to the reports of almoners, social workers, health visitors, and psychiatric social workers regarding the medico-social aspects of the patient's illness. In the past these records have tended to be filed away in the department and not readily available. To indicate their importance in the medical record we propose that they should be considered as primary documents and have accorded them the number HMR 8. Occasionally the special confidential nature of such records may necessitate their being enclosed in a sealed envelope. In such circumstances we suggest that they be enclosed in a sealed envelope, HMR 250, and re-marked 'HMR 8, highly confidential' 'confidential', or with other suitable instructions.

(c) SECONDARY DOCUMENTS

(i) Standard Mount Sheet

87. We think that there should be one sheet, of suitably heavy and good quality paper, for mounting in particular X-ray forms, pathology reports (either mixed or classified) and similar reports. The reports affixed to the sheet will readily identify it, and therefore no printed heading is necessary, vide figure 8.

(ii) Pathology report forms

88. The general principles of standardisation should apply to these forms. A blank report form is shown in figure 9. This is of a size suitable for correct mounting across an A4 mount sheet and provides space for an identification label. Smaller report forms of A6 size might alternatively be used and are recommended for the general practitioner service. The use of size A6 is likely to be more acceptable to those hospitals using the smaller registration plate (see paragraph 80). The increasing use of automation and teleprinting for recording the results may mean that the whole pattern of reporting pathological information may need to be reviewed and the introduction of special strips considered.

(iii) X-Ray report forms

89. Practice in specialist departments varies and it is difficult to develop a standard form. Figure 10 shows one type of form, without clinical details, which can be used with the mount sheet. It is in the style of a combined request and report duplicate form, and is suitable for either manual or mechanical recording. One copy may be filed alphabetically in binders in the X-ray department, where the accumulated copies will form an index reference in which all reports from one patient will be gathered together. Since this form must be mounted correctly across the A4 mount sheet it is not identical with the general practitioners' A6 size of form.

(*iv*) *The Communications Sheet and The Drug Sheet*

90. The practice in some hospitals is to use the treatment sheet, often a card, which is normally kept on the bed board in the ward during the patient's stay and is used by the doctor to note treatment to be given to the patient, diagnostic examinations to be arranged and often as a drug prescription sheet. It is a very useful form but the use of it for many purposes has some serious disadvantages, as it tends to be confusing and great care has to be taken to cancel instructions and to note when the doctor's instructions have been carried out. If it is used as a prescription sheet it has in some hospitals to be sent to the pharmacy and is often missing from the ward when it is needed there. This latter problem is the most serious and for this reason we think that there should be a separate drug sheet used exclusively for recording drug prescriptions and their administration.

91. This separation of the functions of the treatment sheet only half solves the problem, for the drug sheet might well be needed in the ward whilst it was being used in the pharmacy. We therefore decided that, where prescriptions are to be dispensed in the pharmacy, they should be written on a pharmacy request form in duplicate, with carbon transmission provided. The first copy would be sent to the pharmacy and, being retained there, would cover the legal requirements. The second copy would be mounted on the drug sheet and so provide a record similar to the direct entry which is made on the sheet when a prescription is dispensed from the ward sister's cupboard. A record will thus always be available in the ward, showing in chronological order the drugs ordered, with a clear indication of action taken, and of prescriptions that are current. The drug sheet (HMR 111) can, if so desired, be enclosed in a folder and attached to the patient's bed. Our recommended designs with pharmacy request form (HMR 112 and 113) are illustrated in figure 11 (drug sheet) and figures 12 and 13 (pharmacy request form).

92. As drugs have now been given a proper place in the case folder, the treatment sheet can be abandoned as such. All relevant medical observations and notes will be recorded on the History Sheet. Instructions to staff and requests for other departmental services are, we think, matters of communication and matters that should clearly be seen to have been dealt with. We propose then a 'Communications Sheet' designed to be used on the same principles as the drug sheet—figure 14 shows the design. This sheet would not obviate the use of X-ray and pathology request forms—figure 14 shows the form in figure 11 altered for use as a standard form with suitable headings for any purpose, e.g. Diets, indicated on the sheet.

(*v*) *E.C.G. and E.E.G. reports*

93. There is considerable difference in the practice of recording these tests and we therefore think the time is not opportune to consider a standard form but they could be recorded on a mount sheet, size A4 or A5 and numbered appropriately HMR 106 and HMR 107.

(d) TRANSITORY DOCUMENTS

(*i*) *Temperature, Pulse, Respiration and Blood Pressure Chart*

94. A wide variety of charts are used in British hospitals today for the recording of temperature, pulse, respiration and blood pressure and they are often

employed to record much detailed information relating to other functions and to treatment. A prototype has been devised and used in a number of hospitals. It has the advantage of adaptability and can be used as either a 24-hour or a minute chart. The range of the respiratory and pulse rates and of the temperatures have been selected to cover the usual range. The rare occasions when exceptional temperatures, pulse or respiration rates need to be recorded can be written as figures. Spaces are provided for the recording of bowel action, etc. This transitory document has been given the reference HMR 200 (see fig. 15).

(*ii*) *Standard Envelope*

95. For some time to come numerous reports and correspondence will be received which are not easily filed in the standard case folder. It is suggested, for the sake not merely of tidiness but to prevent loss of such documents, that a standard envelope, suitably punched for filing should be provided. Such an envelope could easily become extremely bulky and the depository of useless documents which should have been destroyed. The envelope could also be used to file more important documents particularly those of non standard size, and thus create new disposal problems. Records departments, before introducing such an envelope should realise the dangers of its use.

The envelope is put in the category of transitory documents, and given the reference HMR 250.

(e) FORMS NOT IN THE CASE FOLDER

(*i*) *Notification to a general practitioner of his patient's admission to hospital*

96. For the sake of good communications within the health service we commend the practice, already established by a number of hospitals, of sending a notification to a general practitioner that one of his patients has been admitted to hospital. We think that this should be done automatically on the patients admission and we therefore recommend that the notice should be as simple as possible and should be signed by the admissions clerk on behalf of the group secretary. The size of the form should be the British Standard A6 (see fig. 16), (HMR 300).

(*ii*) *Post mortem request and authorisation forms*

97. These forms are used in connection with requests for and authorisation of post mortem examinations, the performance of which is governed by the Human Tissue Act, 1961. A convenient size for the forms is A4.

VII. RECORD BOOKS

98. Apart from the case papers a number of records relating to patients are kept in record books. The use of some of these books has not kept pace with the modern practice of keeping the records about a patient as a unit. Some of the record books are essential for control and for summarising information which cannot at present be done so conveniently from the case papers (although we can look forward to the time when some of this information will be produced by data processing from individual records) but some of the books are only kept because of tradition dating back to earlier methods of record keeping. We have summarised our views on the more common types of record books as follows:

(i) *Hospital Admission/Discharge Register*
This is an essential administrative record.

(ii) *Ward Register of Patients*
This is normally kept by the ward sister for her personal convenience. We do not think that it is an essential document.

(iii) *Post Mortem Book*
This is not essential as a clinical record since the information recorded in it should be available in the case folder on form HMR 2B. It may, however, continue to have a value in the internal working of the Pathology Department.

(iv) *Operation Book*
This book is useful for a number of administrative reasons, for example in registering the theatre load and for costing. It also tends to be used for the recording of clinical information such as premedication, anaesthetic used, and name of surgeon. We recommend that the latter information and particularly the name of the surgeon performing the operation and the name of the theatre sister or nurse in charge of the case in the operating theatre, should be contained on the operation and/or anaesthetic form, HMR 5 or 6, and filed with the case papers. We recommend that the use of the operation book should be retained for administrative reasons.

(v) *Accident and Emergency Register*
This is an essential register in the primary treatment department of the accident and emergency unit. The minimum particulars are: (a) date, (b) name of patient, (c) date of birth, (d) address, (e) how brought in, (f) external cause of injury or nature of emergency, (g) time, (h) name of doctor who saw the patient, (i) primary diagnosis, and (j) disposal.

(vi) *Nursing Report Book*
In paragraph 85 we have recommended that the nursing report should be kept on a form for each patient. We therefore regard this book as redundant.

(vii) *Record books relating to Dangerous Drugs*
Certain records must be kept in accordance with the regulations under the Dangerous Drugs Act, 1951.

(viii) *Four-hourly Temperature Book*
This is a traditional record outmoded by modern practice and should not be kept.

(ix) *Wound Book*
The main function of this book has been to record staphylococcal infection in hospital. It is now common practice to use forms for reporting infections. This is more convenient for central analysis and follow up.

(x) *Pathology Day Book and Radiology Day Book*
These are used in the administration of these special departments, but some consultants have evolved procedures which avoid their use. We do not therefore consider them essential.

VIII. CLINICAL RECORDS IN ACCIDENT AND EMERGENCY UNITS

99. The management of records in accident and emergency units in relation to the rest of the hospital has its own peculiar problems. The majority of patients who attend an accident and emergency unit have no contact with other departments of the hospital and for them the full hospital records procedure is hardly appropriate, but a significant number will have to be registered either as in-patients or as out-patients and for these there must be a link between the records of the accident and emergency unit and the main body of hospital records.

100. In describing the functions of medical records in accident and emergency units we had some difficulty with terminology in view of the recommendation ([1]) of the Central Health Services Council sub-committee on Accident and Emergency Services that the word 'casualty' should be abandoned as a description of any type of hospital service. The new concept of an accident and emergency unit breaks down the barriers between the old styled casualty department and the rest of the hospital yet we had to accept that for record purposes the part of the accident and emergency unit where patients are seen initially and given primary treatment and investigation is distinct. We have decided to use the new terminology in relation to records of the work of this part of the unit.

101. Because the majority of patients will be seen only in the Accident and Emergency Department for incidents having little or no significence in the patient's future medical care we agreed that this department should have separate records with a series of numbers separate from the unit system of numbering for the rest of the hospital records. The normal practice is to maintain two major records within the accident and emergency department: the register ('the accident and emergency register') and the record card for clinical notes which we recommend should be known as the primary accident and emergency record. The primary accident and emergency record, being the clinical record, is the one with which we are mainly concerned. This record ought to contain in addition to a comprehensive account of the treatment in the unit details of the circumstances which led to the patient's arrival. It ought to provide the initial information for other departments of the hospital, or another hospital, if the patient continues his treatment there. These objectives create the main difficulty in the management of accident and emergency department records. In some hospitals the original primary record goes with the patient to the other department, in other hospitals the accident and emergency department retains the primary record and passes information to the other department by some form of internal referral slip. With this system the complete initial clinical record is not available to the other department.

102. Conditions in hospitals vary so much that we cannot be dogmatic about the solution to this communication problem. We think that if facilities allow, the best way would be for the primary record to be kept in the accident and emergency department and a full copy, preferably a photo-copy, to be sent to the

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(1) Ministry of Health, Central Health Services Council, Standing Medical Advisory Committee, Report of Sub-Committee on Accident and Emergency Services, 1962, London, H.M.S.O.

other department. We would hope that a copy of the discharge summary would be sent to the accident and emergency department and the case notes suitably marked to ensure that this was done.

103. The sub-committee on Accident and Emergency Services recommended the development of a standard primary record to help accident and emergency units in their duty to produce comprehensive analyses of cases treated (paragraph 66 of the sub-committee report).

104. We gave considerable thought to the recommendation but in attempting to devise a form as a national standard we were confronted with the difficulty that the accidents to be analysed varied so widely in different parts of the country that details required in one area would not be relevant in another. We therefore decided that the design of the primary record should, for the present, be left to local initiative. We hope that the proposed development of the Accident and Emergency Service will lead to the establishment of a working party from amongst those responsible for such a service to devise a record in which all essential information can be recorded on a standardised lay out. Our immediate recommendation concerns size only. We suggest that the primary accident and emergency record should be size A5 and preferably on thin card.

IX. PSYCHIATRIC RECORDS

105. It is appreciated that there are special administrative differences, as well as problems of confidence, relating to psychiatric records. On the other hand there is increasing realisation that ill-health is due to a combination of physical, mental and social factors and therefore the medical record must relate to the whole individual. The medical record is not complete if it does not contain the psychiatric as well as other reports. The administrative problems peculiar to the psychiatric hospitals arise from the special legal responsibilities of such hospitals regarding mental ill-health but these difficulties could easily be met by having a special administrative section on the lower part of the identification sheet. The problems of confidence and the confidential character of some psychiatric records are perhaps more complex than those of patients admitted to an acute general hospital. In government departments there are recognised degrees of confidentiality. In medicine there is a legal definition of confidentiality and over and above this there is always the problem of professional secrecy. A consultant cannot withhold evidence if subpoenaed by the court without rendering himself liable to contempt of court. Notwithstanding these legal aspects there is much information arising from patient's statements or those of relatives or social workers which could have serious consequences regarding a patient's acceptance in society if they were to be generally known. Moreover a good doctor/patient relationship can only be developed and maintained if the patient and others giving information can be assured of its confidential nature, yet it is essential that such information should be passed from one doctor to another when the responsibility for the care of the patient is transferred but that such information should not be freely available in the normal hospital record. Some consultants have in the past kept dual records, the official hospital record and private record. There may be justification for such a practice but provided the highest ethical standards of the medical profession are maintained such a practice is neither necessary nor desirable. In the handling of medical records within the hospital, however, many persons have access to the records and in consequence it may be desirable to consider that some parts of the documents are more confidential

than others. To meet this particular problem which is most important in psychiatric hospitals, it is suggested that any documents of a highly confidential nature, should be kept in a specially marked and sealed envelope, HMR 250, and be retained as a primary document, instructions being given to this effect.

106. The system of registration suggested for the identification sheet should prove very valuable to psychiatric hospitals since it will assist in the relating of previous incidents where the individual has been admitted to any hospital in the United Kingdom after the date of the general adoption of the identification sheet.

107. There are many systems of filing but the suggestions proposed could readily be adopted to meet the requirements of a psychiatric hospital. The importance of the discharge summary and the preparation of periodic summaries of the out-patient record should enable the essential data to be easily filed and obviate the necessity for combing through haphazardly arranged records. The essential history could be up-dated to be included with the records of the latest incident and only new facts recorded, thus avoiding unnecessary wastage of time and duplication of records.

X. MECHANICAL SYSTEMS AND DATA PROCESSING

108. The medical records of the hospital service, together with those of the other branches of the National Health Service, provide a unique mass of information of inestimable value for the management of the service and for epidemiological and clinical research. Efforts to utilise this information come up against the barriers of inaccessibility and lack of standardisation. The standardisation of medical records is an essential preliminary to the efficient utilisation of mechanisation. We hope that this report will encourage the adoption of standardised methods for the recording of essential data on hospital and other clinical records. But even after standardisation has been achieved, manual methods of extraction are expensive in both medical and clerical time. Many problems remain unsolved because few people have the energy and patience to undertake the laborious task of sorting and extracting records manually.

109. In the business world almost every organisation the size of the Health Service now employs some or all of the many methods of mechanisation available for the recording, transport and storage of records and essential data. This applies even when the businesses have a diversity of units of very differing sizes so that the particular problems of the Health Service are not such as to make it impossible to utilise efficiently some of the newer methods of mechanisation. Mechanisation should not be considered as a new fangled idea or the latest craze, but merely as an extension of the typewriter, the slide rule and the adding machine. The great advantage of electronic systems is their capacity for storage and speed of working which can remove so much of the tedium of routine recording as well as providing built-in methods for checking accuracy.

110. There are two broad classes of electronic computing equipment available for the processing of medical and hospital data, the digital computers and the analogue computers. The latter, whilst very efficient in making analyses, are more limited in their range of usage but they have the advantage that they can

simulate biological and physiological mechanisms and in consequence have a very important role to play in the control of laboratory procedures. There are considerable potential uses for the analogue computer in the hospital laboratory services and in some of the specialised investigation departments. The digital computer is capable of storage and of analysing at varying degrees of rapidity vast quantities of data. The latter, however, must first be processed and this is time-consuming in skilled manpower. It would not be appropriate to enter into any discussion in this report on the various techniques for processing hospital data. But since the digital computer provides a rapid and accurate method of storing and retrieving data, it could readily be used to yield both local and national analyses of items, such as patient movement, hospital costing, the factors concerned in the beneficial effects or otherwise of early convalescence, the use of wards for special purposes, the planning of multiple shift schedules, etc. In the clinical field the information could be readily used to undertake epidemiological and statistical studies, such as those relating not only to the incidence of disease but to particular conditions such as congenital abnormalities, factors concerned in perinatal mortality, the comparative value of different methods of maternal care and the toxic effect of drugs. In the United States, following the introduction of computers for the study of certain diseases, it was found that initially more than half the proformas were inadequately completed. Within a short space of time this inadequacy had been reduced to less than 5 per cent because the rapid feed back of information to the medical staff convinced them of the value of standardisation in the recording of data and also because it extended their range of experience by making available to them figures relating to many consultants and hospitals. Many experiments are taking place in the use of computers for the storage of medical records. There remain many technical difficulties still to be overcome but the equipment or, in the jargon of the technique, the hardware, exists which would allow medical histories to be stored either regionally or nationally and to be capable of recall either as a printed document or on a screen in different parts of the hospital.

111. This superficial reference to data processing and the use of electronic forms of mechanisation is as far as we feel able to go within our terms of reference. We have, however, felt it necessary to draw attention to the potentialities of the new methods because of the extended scope they would give to the use of hospital medical records and also because they underline the value that may be obtained from standardisation of lay out and in the selection of essential material. Familiarity with procedures that have been rationally evolved is likely to increase the efficiency of all staff, clerical and medical, concerned in the use of hospital records. We would not wish to press for the adoption of mechanisation merely on the grounds that it is something new or on the grounds of immediate economy. Initially the introduction of mechanisation would be costly but evidence from the business world and the limited experimentation in the medical and hospital field in the United States, together with a few pioneer efforts in this country, clearly demonstrate the value of such methods in extending the use that can be made of hospital records and of the enormous potentialities for the discovery of new facts for increasing the efficiency of the service that can be given to the public. In the long term we do feel that economies may be effected through the enhanced ability to store records in a small space and to transmit with a minimum involvement of manpower. Possibly the

greatest advantage of mechanisation is that it will facilitate operational research into many aspects of the Health Service and that the benefits would not be confined merely to the management of hospital records.

XI. THE IMPLEMENTATION OF STANDARDISATION

112. The implementation of our recommendations cannot be other than voluntary by hospital authorities. For quite a long time therefore standardisation will remain an objective rather than a fact. Some of our recommendations can be implemented without difficulty. For instance the policy on preservation of medical records which we suggest in Section IV could be adopted at once. Our recommendations on the use of colour could take effect quite soon. But our recommendation on the sizes of hospital medical records which is, from the practical point of view, the most far reaching may be less quickly implemented depending upon the resources available to each hospital and the initiative to make the change. This will inhibit the introduction of some of the other changes we recommend, the important one on the use of the identification sheet in particular. We hope therefore that hospital authorities will carefully consider the advantages of standardisation and will keep the awkward interim before effective standardisation as short as possible.

113. In view of the rapid development in the use of modern methods of mechanisation the early introduction of standardisation of records is of increasing importance if advantage is to be taken of the new methods of sorting and storing the information they contain.

XII. THE FUTURE

114. In this report we have been able to do no more than discuss the need for standardisation of hospital medical records, to indicate the lines along which the hospital service should be moving, and to recommend the standard design of a limited number of the basic forms. In the section on mechanical systems and data processing we have attempted to look forward to the major advances we should expect in the use of medical records. These will have a profound influence on record keeping but even before they begin to take effect there will inevitably be limited advances. We hope that it will be possible to extend gradually the range of standardised forms and of course the standardised methods we have recommended must be changed with developing ideas; it is an essential of a standardised system that it should be flexible and sensitive to change. We are therefore convinced that there should be established a permanent body to act as the point of reference for changes in medical record keeping. Such a body would for instance deal with the implementation of standardisation of particular forms which we expect will be recommended by professional bodies from time to time, but its most important function would be to provide a stimulus to new ideas and to ensure that the hospital service remains forward looking in the use of medical records.

115. The composition of such a body needs careful consideration. An official body however competent would have the disadvantage that it could not so easily carry the professions with it as a body with which working members of the profession were associated. There are a few members of the professions who are leading the development of medical records and we think that they ought to be

brought in. At the same time other professional members less committed to this line would add authority. At this point we might add the usual apology for suggesting an addition to the proliferation of committees but we would not expect the full committee to meet very frequently; much of the development work can be done by officials and by outside committees of the professions which are already in existence. Our final recommendation is therefore that the work which we have begun should be carried on by a body specifically constituted to keep under review all forms of medical records so as to meet the rapidly changing needs of the modern hospital service.

SUMMARY OF PRINCIPAL RECOMMENDATIONS

1. Medical records should be classified according to the likely period of their relevance. The terms primary, secondary and transitory are suggested (paragraph 20).

2. Forms should be given standardised reference numbers to indicate the order of filing (paragraphs 22-24).

3. Primary documents only should be retained in the case folder after the patient's discharge. Secondary documents may be discarded if copies are filed elsewhere for 6 years. Transitory documents should be discarded on the patient's discharge (paragraph 27).

4. The normal maximum period of retention of primary records should be 20 years after the date of last attendance (paragraph 28).

5. Records up to 6 years from the date of last entry should be readily available for recall but if necessary on account of accommodation difficulties older records could be separately stored (paragraph 29).

6. Paraffin blocks embodying tissue should be preserved so long as relevant records are retained in the pathology department. Where only frozen tissue has been sectioned, permanently stained and mounted sections should be retained. In certain circumstances post-mortem material should be retained for at least 3 years (paragraph 32).

7. Preservation of radiographs should be judged by the same criteria as for other medical records (paragraph 33).

8. International Standard paper sizes should be used (paragraphs 37 and 40).

9. Shelf filing system is commended (paragraph 40).

10. Unit system of record keeping should be standard in the hospital service (paragraph 43).

11. Papers should be fastened in a gussetted folder (paragraph 45).

12. The use of tinted paper should be limited to the discharge summary which should be yellow (paragraph 47).

13. Colour symbols should be limited to pathology report forms but all report forms should be distinguished by black letter symbols (paragraph 49).

14. Guidance on paper qualities is offered (paragraph 51).

15. Lay-out of headings should be standard (paragraph 54).

16. Printing on the outside of the case folder should be limited to the patient's number and the words *Confidential* and *Not to be taken out of the hospital* (paragraph 59).

17. The front sheet should henceforth be known as the identification sheet (paragraph 60).

18. The lay-out of the identification sheet should be standardised (paragraph 61).

19. The production of data for processing away from the hospital should be a by-product of the recording of information essential for hospital administration (paragraph 62).

20. The recording of the National Health Service number should become a routine practice (paragraph 69).

21. A standard form of referral for use by general practitioners should be introduced (paragraph 76) and it should be pre-stamped and issued by Regional Hospital Boards through Executive Councils (paragraph 78).

22. Nursing record should be on a separate form (paragraph 85).

23. There should be a separate drug sheet for recording prescriptions and their administration (paragraph 90).

24. Where prescriptions are to be dispensed in the pharmacy they should be written on a pharmacy request form (paragraph 91).

25. Instructions to staff and requests for other departmental services should be entered on a new form, the communications sheet. The treatment sheet should be abandoned (paragraph 92).

26. Comment is made on the future use of various record books (paragraph 98).

27. Attention is drawn to the potentialities of the new methods of mechanical systems and data processing (paragraph 111).

28. The interim before effective standardisation should be kept as short as possible (paragraph 112).

29. A permanent body to act as a point of reference for changes in medical record keeping should be established (paragraph 115).

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Numbers refer to paragraphs except where otherwise stated.

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APPENDIX A

GLOSSARY OF MEDICAL RECORD TERMS COMMONLY USED

I. General

(i) *A Medical Record*	Any document on which information about a person in a professional relationship with a doctor is recorded.
(ii) *Case Papers* (Sometimes known as *The* Medical Record)	A dossier comprising medical record documents of an individual patient.
(iii) *Case folder*	A folder enclosing the patient's case papers.

II. Primary Documents[1]

(i) *Identification Sheet* (Formerly known as the Front Sheet)	A form containing the personal and administrative details relating to an individual patient, and to the discharge diagnosis.
(ii) (a) *Discharge Summary*	A statement completed by the consultant or his assistant on the discharge or death of the patient containing a summary of the significant findings, results of investigations, treatment, progress, and disposal of the patient.
(ii) (b) *Post-mortem record*	The pathologist's report of the post-mortem examination including, where appropriate, a record of the histological or other laboratory examination of post mortem material.
(iii) *Discharge Letter*	A letter sent by a hospital doctor informing a patient's general practitioner of the patient's discharge from hospital. It also contains details of diagnosis, treatment and drugs recommended, and information given to the patient and/or relative. In minor cases the letter can take the place of the discharge summary.
(iv) *General Practitioner's Letter of referral*	A letter from a general practitioner to a hospital requesting a consultation appointment for his patient. It may contain the general practitioner's clinical note for the consultant.
(v) *History Sheet* (and *Continuation Sheet*)	The part of the patient's case papers containing the doctor's clinical notes and details recorded by the doctor of the patient's treatment and progress.
(vi) (a) *Operation and/or Anaesthetic Record*	A record of a surgical operation and of the associated anaesthetic procedure
(vi) (b) *Consent Form*	A form signed by the patient (or the patient's representative) consenting to the performance of an operation and the administration of an anaesthetic.

(1) See paragraph 22.

(vii) *Nursing Record*	A report sheet for each patient on which the nurses responsible for his care record notes on nursing treatment and significant events during the patient's stay in hospital.
III. Secondary Documents(1)	
(i) *Standard Mount Sheet* (Often called Backing Sheet)	A sheet included in the case papers for the purpose of affixing reports returned from special departments.
(ii) (a) *Request Form*	A form completed by the doctor requesting investigation of the patient, or of specimens collected from the patient in special hospital departments, e.g. departments of radiology, pathology, electro-cardiography, electroencephalography, medical photography.
(ii) (b) *Report Forms*	Forms completed by the department concerned recording the results of an investigation requested by the doctor in charge of the patient.
(ii) (c) *Combined Request/Report Form*	A form providing for both the request for and the report of an investigation.
(iii) *Drug Sheet*	A form for recording by the doctor of all prescriptions for drugs.
(iv) *Pharmacy Request Form*	A slip on which the doctor writes the prescription for a drug to be obtained from the pharmacy.
(v) *Treatment Request Form*	A form completed by the doctor requesting treatment of the patient in a special department, e.g. physiotherapy, orthoptics or occupational therapy, where a separate letter accompanying the referral of the patient is not appropriate.
(vi) *Communications Sheet*	A form or card on which the doctor records all instructions for the management of the patient including investigations and treatment other than prescriptions for drugs.
IV. Transitory Documents(2)	
(i) *Temperature, Pulse, Respiration, and Blood Pressure Chart* (commonly known as the TPR chart)	A chart showing graphically recordings of a patient's temperature, pulse, respiration and blood pressure.
(ii) *Electrolyte Chart*	A chart for recording details of the content of such substances as sodium, potassium and chloride in fluid intake, blood levels and excretions.
(iii) *Fluid Balance Chart*	A chart for recording details of a patient's intake and excretion of fluids.
(iv) *Urine Chart*	A chart for recording details of a patient's intake and excretion of fluids and results of urine tests.

(1) See paragraph 24.

(2) See paragraph 24.

V. Documents not Contained in the Case Folder

(i) *Notification to General Practitioner of a Patient's Admission to Hospital*	A letter sent by the hospital to the patient's general practitioner informing him of the patient's admission to hospital.
(ii) *Post-mortem request and authorisation forms*	Forms addressed to the hospital pathologist containing (a) a request from a doctor for the performance of a post-mortem examination, and (b) an authorisation by the person lawfully in possession of the body for the conduct of the post-mortem examination expressed in terms which fulfil the requirements of Sections 2(2) and 1(2) of the Human Tissue Act, 1961. The forms are often conveniently combined on a single sheet of paper which may also provide for a signed statement authorising the removal of the eyes for therapeutic purposes. These forms are necessary for all post-mortem examinations, except those authorised by the Coroner; they are usually retained and filed in the pathology department and are not included in the case folder.
(iii) *Name Index Card*	A card filed alphabetically by which the patient is identified to the unit number of his case folder.

VI. Documents and Books special to Accident and Emergency Units

(i) *Primary Accident and Emergency Record* (formerly known as the Casualty Card)	The clinical record used in the part of the Accident and Emergency Unit where patients are seen initially and are given primary treatment or investigation.
(ii) *Accident and Emergency Register* (formerly known as the Casualty Register)	A chronological list of patients attending the Accident and Emergency Unit.

VII. General Medical Service Documents Relevant to Hospital Records

(i) *Medical Record Card (GP)* (Form E.C.7 (male) or E.C.8 (female))	A card used by a general medical practitioner for recording the clinical and progress notes of a patient.
(ii) *Immunisations and Vaccinations Record* (Form E.C.7A (male) or E.C.8A (female))	A card used by a general practitioner for recording details of a patient's immunisations and vaccinations.
(iii) *Medical Record Envelope* (Form E.C.5 (male) or E.C.6 (female))	An envelope used by general practitioners for filing the medical record card and also letters and reports from hospitals and other medical practitioners about the patient.

(iv) *Maternity Co-operation Card*	A medical record card kept by a maternity patient for use by general practitioner, midwife, local authority medical officer and/or hospital for recording a summary of the clinical and progress notes of the patient.

VIII. Other Terms

(i) *Provisional Diagnosis*	Diagnosis or listing of the illness bringing the patient to hospital.
(ii) *Discharge Diagnosis*	The diagnosis which reflects the latest information available recorded at the time of the patient's discharge.
(iii) *Diagnostic Index*	A record consisting of pages or cards, each with a specific diagnostic title, listing patients treated for that condition.
(iv) *Filing by Progressive Numerical System*	The system of filing medical records in consecutive sequence of unit numbering.
(v) *Filing by Terminal Digit System*	The system of filing medical records according to the last two digits of the unit number.
(vi) *Micro-recording*	The reduction and reproduction of documents by means of film.
(vii) *Mechanical Registration*	Equipment used for printing a patient's identification details and other administrative information on medical record documents.

APPENDIX B

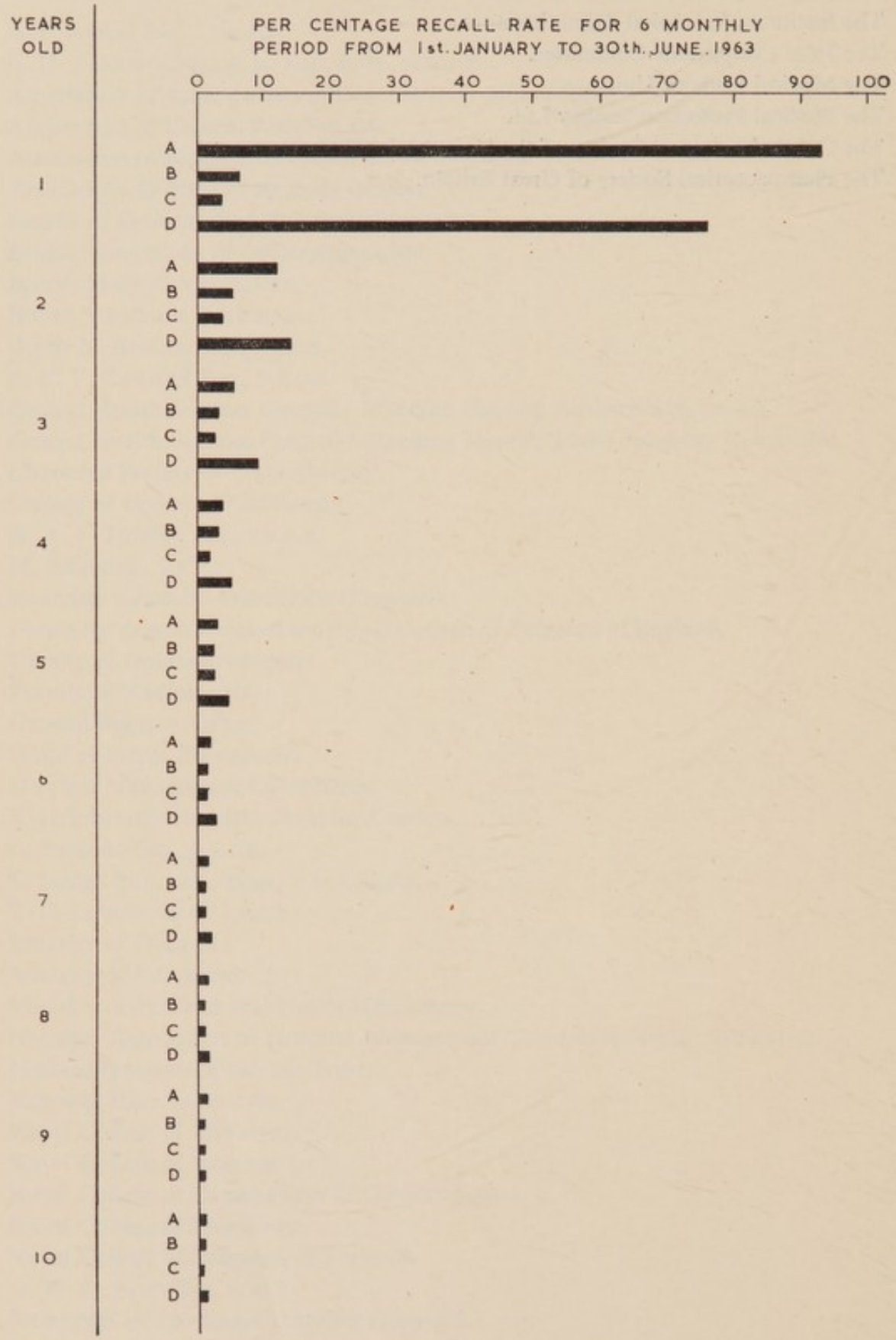
LIST OF BODIES OR INDIVIDUALS WHO WERE CONSULTED OR WHO GAVE EVIDENCE

E. P. Abson Esq., F.R.C.S.
E. D. Acheson Esq., M.A., B.M., B.Ch., M.R.C.P.
Association of Anaesthetists of Great Britain & Ireland.
Association of Clinical Pathologists.
Association of Hospital Management Committees.
Association of Medical Records Officers.
Boards of Governors of Teaching Hospitals.
British Association of Otolaryngologists.
British Medical Association.
British Standards Institution.
Bryan N. Brooke Esq., F.R.C.S.
R. C. F. Catterall Esq., F.R.C.S.
Central Health Services Council—Standing Nursing Advisory Committee.
Central Health Services Council—Standing Mental Health Advisory Committee.
Chartered Society of Physiotherapy.
College of General Practitioners.
H. A. F. Dudley Esq., F.R.C.S.
M. Ellis Esq., F.R.C.S.
Executive Councils Association (England).
Faculty of Anaesthetists of the Royal College of Surgeons of England.
Faculty of Ophthalmologists.
Faculty of Radiologists.
General Register Office.
Guild of Public Pharmacists.
Hospital Management Committees.
King Edward's Hospital Fund for London.
D. Lamont Esq., F.R.C.S.
T. Lodge Esq., M.B., Ch.B., D.M.R., F.F.R.
T. C. Lowden Esq., F.R.C.S.
Ministry of Defence.
Ministry of Education.
Ministry of Pensions and National Insurance.
National Association of Hospital Management Committee Group Secretaries.
Nuffield Provincial Hospitals Trust.
Regional Hospital Boards.
Royal College of Midwives.
Royal College of Nursing.
Royal College of Obstetricians & Gynaecologists.
Royal College of Physicians.
Royal College of Surgeons of England.
A. W. G. Scott Esq., A.M.R.
Secretaries of Provincial Teaching Hospitals.

T. Slowe Esq., A.M.R.
Society of Medical Officers of Health.
J. R. Squire Esq., M.D., F.R.C.P., Professor of Pathology, University of Birmingham.
Teaching Hospitals Association.
The Institute of Hospital Administrators.
The Joint Consultants Committee.
The Medical Defence Union.
The Medical Protection Society Ltd.
The Ophthalmological Society of the United Kingdom.
The Pharmaceutical Society of Great Britain.

APPENDIX C

SURVEY OF RECALL RATE OF MEDICAL RECORDS FROM ONE TO TEN YEARS OLD



HMR

DESCRIPTION OF FORM AND REFERENCE With Name of Hospital if Manual System is used	(Name of Hospital will be printed by the plate) UNIT NO. SURNAME (Block Letters) FIRST NAMES

FIG. I

HMR 1

IDENTIFICATION SHEET

HOSPITAL.....

UNIT No.

SURNAME

FIRST NAMES

N.H.S. NUMBER

MAIDEN NAME | OTHER PREVIOUS SURNAMES

D of B	Day	Mth	Yr	Age	Male	Female	S	M	W	Not Known
					1	2	1	2	3	4

EMPLOYER

OCCUPATION | RELIGION

Name and address of G.P.

Tel. No.

Change of G.P.

Tel. No.

ADDRESS

TEL. No.

CHANGE OF ADDRESS

TEL. No.

CHECK PRINT

Next of kin..... Relationship:.....
Name..... Tel.:.....
Address.....

Change of kin..... Relationship:.....
Name..... Tel.:.....
Address.....

Date of Admission or 1st Att. / /

Date entered on W/L / /

CONSULTANT

WARD / DEPT.

Provisional diagnosis

Discharge diagnosis—principal

—other

Operation Date / /

CODES

Date of disposal
DISCHARGE / /
DEATH

SOURCE
1. Waiting List
2. Booked
3. R.T.A.
4. Home Accident
5. Other
6. Trans. this hospital
7. Trans. other hospital
8. Born in hospital

Type of Bed
1. Priv.
2. Staff
3. Pre-C.
4. Con.
5. Other

1. Trans. this/other Hosp.
2. Trans. pre-con. bed
3. Trans. con. bed
4. Trans. other
5. Home/other
6. Died autopsy
7. Died other

G.P.s Notice

Date of Admission or 1st Att. / /

Date entered on W/L / /

CONSULTANT

WARD / DEPT.

Provisional diagnosis

Discharge diagnosis—principal

—other

Operation Date / /

CODES

Date of disposal
DISCHARGE / /
DEATH

SOURCE
1. Waiting List
2. Booked
3. R.T.A.
4. Home Accident
5. Other
6. Trans. this hospital
7. Trans. other hospital
8. Born in hospital

Type of Bed
1. Priv.
2. Staff
3. Pre-C.
4. Con.
5. Other

1. Trans. this/other Hosp.
2. Trans. pre-con. bed
3. Trans. con. bed
4. Trans. other
5. Home/other
6. Died autopsy
7. Died other

G.P.s Notice

REPEAT AS ABOVE
OR RESERVE FOR SPECIAL INVESTIGATIONS
BY HOSPITAL, REGION, OR MINISTRY.

HMR1

FIG. 2

(Fig. 3, HMR 2 not reproduced: plain sheet with left hand margin rule)

HMR 2A

Dear Dr.....

Your patient .....

(Address) .....

.....

under the care of.....

will be discharged on .....

is being transferred to.....

Diagnosis :—

Treatment and or Recommendations :—

Information given to the patient :—

An appointment has/has not been made for further attendance as an out-patient. A summary of the notes will follow.

Yours sincerely,

.....

House Physician/Surgeon.

Date.....

FIG. 4

HMR 3

TO OPEN insert knife and cut from here to here along the top edge (Hospital Clerical Staff)

Name and Address of General Practitioner.	Please make an appointment for..... N.H.S. No. ..... to attend the ..... Clinic of Dr./Mr. .....

A letter to the Consultant $\frac{\text{is enclosed}}{\text{will be sent separately.}}$

TO BE FILLED IN BY THE PATIENT
(Block letters please)

SURNAME Mr. Mrs. Miss		FIRST NAMES
ADDRESS		
Age	Date of Birth	Tel. No.

FOLD HERE →

Have you attended this Hospital before? YES/NO.
If YES please state, if possible:—

(1) In what year .....

(2) Your hospital number .....

Name and address then if different from above.

Fold this letter where indicated and seal with gummed flap.

Out-patient appointment

HMR 4

....HOSPITAL

HISTORY SHEET

UNIT No.

SURNAME (Block Letters)

FIRST NAMES

DATE	CLINICAL NOTES (Each entry must be signed)

HMR 4

FIG. 6

HMR 7

....HOSPITAL

UNIT No.
SURNAME (Block Letters)
FIRST NAMES

NURSING RECORD

Admission diagnosis

Change of diagnosis

DATE	REPORT AND RECORD (Each entry must be signed)

HMR 7

FIG. 7

HMR 100

STANDARD MOUNT SHEET

HMR 105

X-RAY REQUEST/REPORT FORM

UNIT No.

SURNAME (Block letters)

Walking
Chair
Trolley

Date

FIRST NAMES

XR

FIG. 10

HMR 101

FIG. 9

Department of Pathology. LAB./RPT. NO.

SPECIMEN:

UNIT NO. | HOSP. | WARD DEPT.

SURNAME

FIRST NAMES

DR/MR

HISTOLOGY

H. M. R. 100

FIG. 8

HMR 111

..... HOSPITAL

DRUGS

UNIT No.

SURNAME (Block Letters)

FIRST NAMES

Date ordered	DRUGS	Signature (then initials)	Date stopped (and initials)

FIG. 11

HMR 112

PHARMACY REQUEST *IN*

TOP COPY (to Pharmacist)

WARD

PRESCRIPTION

Date

SURNAME (Block Letters) Mr./Mrs./Miss

Age D M Y

FIRST NAME(S) (Block Letters)

Unit Number

Drs. Signature	Date completed (and initials)

FIG. 12

HMR 113

PHARMACY REQUEST *OUT*

TOP COPY (to Pharmacist)

Item No.	Cost	Code

PRESCRIPTION

Date

SURNAME (Block Letters) Mr./Mrs./Miss

Age D M Y

FIRST NAME(S) (Block Letters)

Unit Number

Drs. Signature	Date completed (and initials)

FIG. 13

HMR 120

.....HOSPITAL

UNIT No.

COMMUNICATION SHEET

SURNAME (Block Letters)

FIRST NAMES

Date	COMMUNICATION	Signature (then initials)	Date completed (and initials)

HMR 120

FIG. 14

HMR 200

UNIT No.

SURNAME (Block Letters)

FIRST NAMES

T. P. R. & B. P. CHART

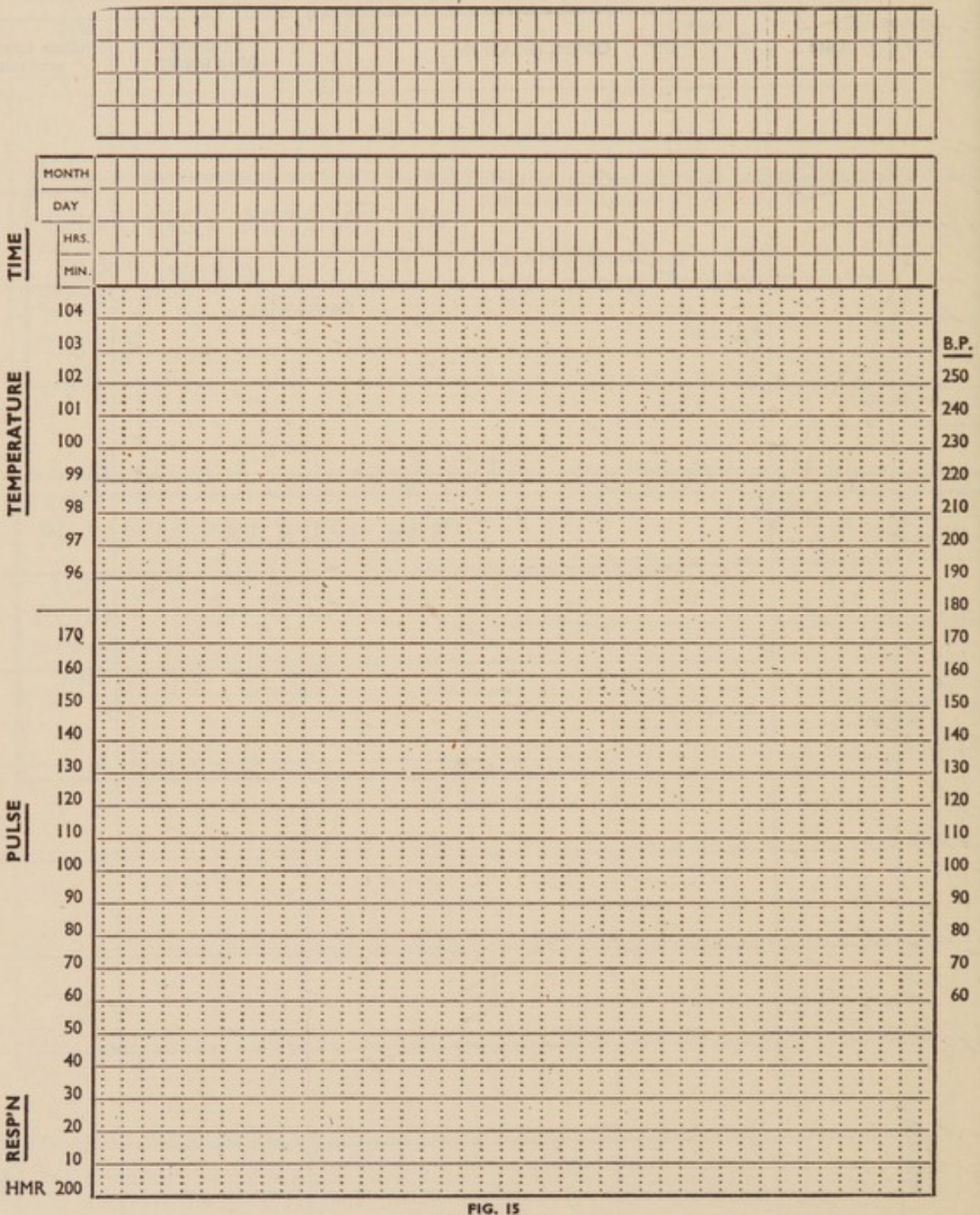


FIG. 15

H M R 300

Date.....

Dear Dr.

Routine/Emergency Admission

Your patient.....

(Address).....

.....

has been admitted to this hospital today.

(a) from the waiting list
(b) as an emergency
(c) from the O.P. clinic

A further letter or summary will be sent to you on the discharge of your patient by the consultant concerned.

You are, of course, welcome to visit your patient.

Yours sincerely,

HMR 300

Secretary.

FIG. 16

HMR F

UNIT No.....

CONFIDENTIAL

NOT TO BE TAKEN OUT OF THE HOSPITAL

FIG. 17

UNIT No.....

Published by
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