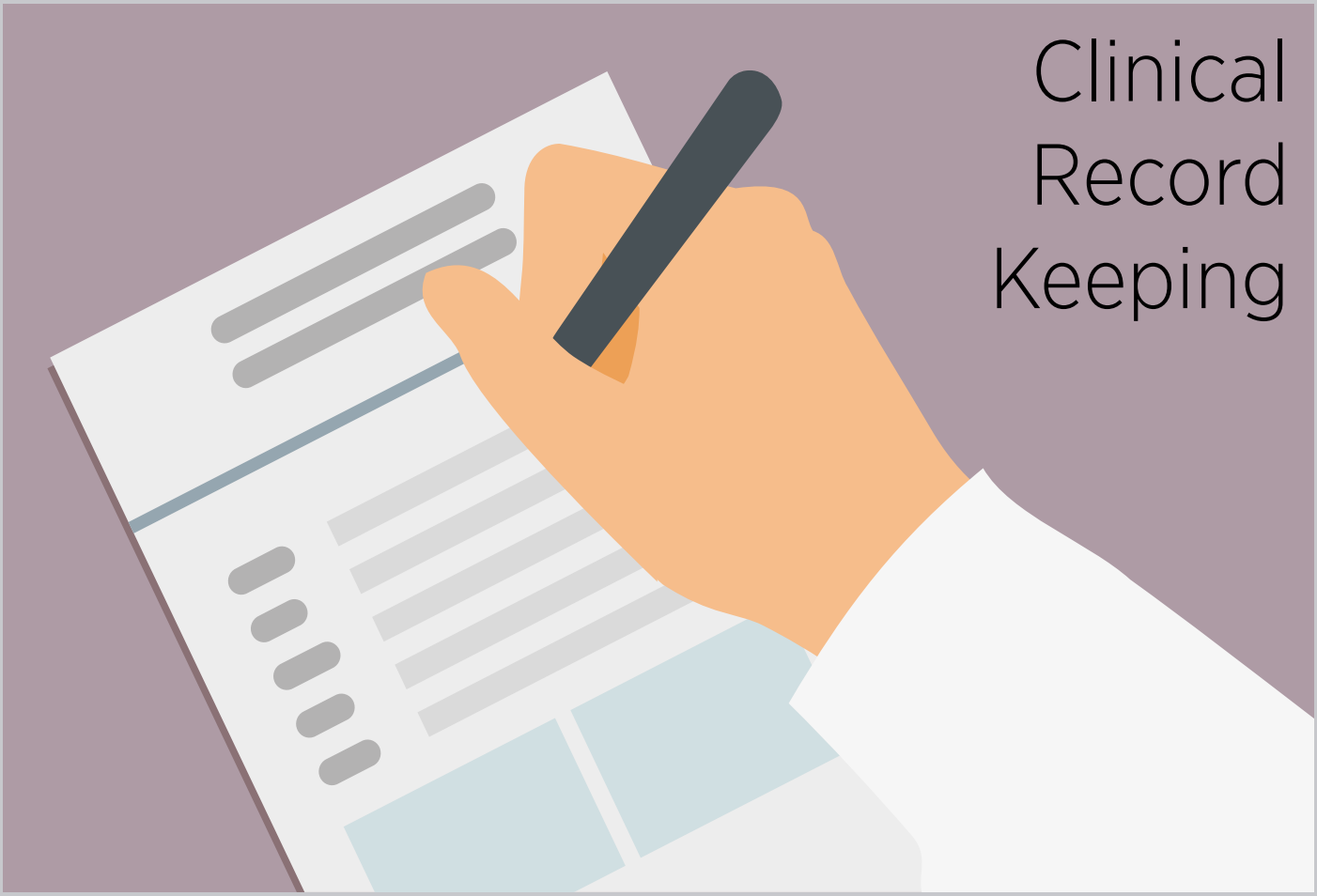
CONTINUING PROFESSIONAL UPDATE

MI PODIATRIC CPU TOOLS
Driving excellence in foot health



Clinical Record Keeping

Stuart Metcalfe
MPhil FCPodS FPodA
Consultant Podiatric Surgeon
www.footconsultant.com

Introduction

Not a very catchy title for an article I agree! I imagine few of us think very much about our clinical notes on a day-to-day basis. Whilst much is taught on biomechanics, vascular and neurological assessment, the latest developments in ultrasound and the like, the approach to clinical record keeping may seem a less deserving area for reflection.

In this article I hope to persuade you otherwise by sharing with you my experiences as both a clinician and expert witness. The NHS budget in 2022/23 was £181.7 billion of which £2.5 billion was spent on medical litigation[1]. A record 80% of claims were settled without court proceedings compared to 77% in 2021/22. Whilst this is applauded by some, others may feel it serves only to promote the escalation of litigation claims. According to a freedom of information request to NHS Resolution there were 110 Podiatry negligence claims settled in 2021/2 at a cost of £4,253,445 to the NHS. This does not include claims made against Podiatrists working within the independent sector. Compare this with Orthopaedics a larger profession undertaking highly complex surgery where there were 1,203 claims

in the same year (NHS Resolution Freedom of Information request[2]. Podiatry is by no means immune from litigation and in my experience can often be seen as an easy target.

On average, I undertake between forty and fifty medical reports annually, the majority of which involve Podiatrists who are facing a medical negligence claim within either the NHS or private sectors. You would be forgiven for thinking that the mainstay of such claims would be related to Podiatric surgery, but this is not the case. In my medico-legal practice Podiatric surgery represents around 10% - 15% of negligence claims. In an approximate rank order of claims I would estimate as follows:

- Failure to refer “at risk foot”
- Verrucae
- Nail surgery
- Foot surgery
- MSK Podiatry

If you read no further than this, then it highlights that poor record keeping plays a significant part in most of the litigation cases I see.

I recall one case from a few years back where a patient developed an infection following a local anaesthetic block. The case hinged on whether pre-injection skin cleansing had be carried out. The clinical entry had failed to record whether this had been undertaken. The absence of this simple statement resulted in a settlement as the legal team deemed the case too risky to defend.

Meticulous, well-constructed clinical notes are the linchpin of good clinical practice and underpin high-quality patient care aiding decision-making and clinical communication with other practitioners. As Podiatrists regulated by the HCPC we are required to meet three core sets of standards which include:

- Standards of proficiency
- Standards of conduct, performance, and ethics
- Standards of CPD

For the purposes of this article, we will ignore the standards of CPD and focus on those dealing with proficiency and conduct both of which address clinical record keeping (Table 1).

For those of us engaged in busy clinical practice these HCPC standards are likely to receive little attention as we battle through the demands of the day. For many practitioners the only time there will be a critique of clinical note keeping is when there is a patient complaint or a litigation claim.

KEY POINT: Meticulous, well-constructed clinical notes are the linchpin of good clinical practice and underpin high-quality patient care aiding decision-making and clinical communication with other practitioners.

Having worked in both the NHS and private sector since 1990 it is striking that there is so little clinical supervision[3] and critique of clinical practice, in particular clinical record-keeping. During my years of postgraduate surgical residency training each set of clinical notes I completed was reviewed by my supervising consultant at the end of each clinic. I am indebted to Messrs Galloway and Gilbert for the lessons learnt through their often robust critique which helped me develop a solid understanding of the value of clinical notes well before my exposure to medical litigation.

The real purpose of the clinical record is not to meet some regulatory requirement but it is a core tool in the delivery of healthcare. It is probably the most important tool you have as a clinician irrespective of your clinical discipline. A well-constructed clinical record provides a framework for your assessment; it prompts you to include key information, it can assist in unearthing key information about the patient and is the foundation of your clinical decision-making. It can also allow for evaluation of patient progress and prompt the need for timely re-evaluation.

KEY POINT: The real purpose of the clinical record is not to meet some regulatory requirement but it is a core tool in the delivery of healthcare.

Similarly, a badly constructed system of record keeping will hamper both patient assessment and delivery of care. Figure 1 shows a redacted Podiatry record card highlighting a poor record of an assessment and treatment.

Standards of Proficiency	Standards of conduct and ethics
9. Maintain records appropriately 9.1 Keep full, accurate and clear records in accordance with applicable legislation, protocols and guidelines. 9.2 Manage records and all other information in accordance with applicable legislation, protocols and guidance. 9.3 Use digital record keeping tools, where required.	10. Keep records of your work Keep accurate records 10.1 You must keep full, clear and accurate records for everyone you care for, treat, or provide other services to. 10.2 You must complete all records promptly and as soon as possible after providing care, treatment or other services. Keep records Secure 10.3 You must keep records secure by protecting them from, loss damage or inappropriate access

Table 1 Extracts from the HCPC standards relating to clinical record keeping.
Source: https://www.hcpc-uk.org/standards/meeting-our-standards/record-keeping/

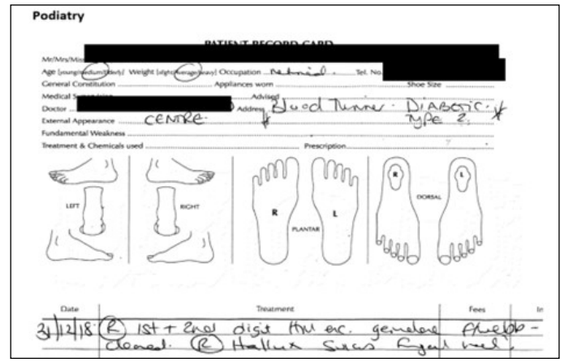


Figure 1 Case 1, Redacted Podiatry Record

CASE STUDY 1

It is probable that the practitioner has used this style of record keeping for many years without cause for reflection. In the absence of critical reflection this style of substandard assessment and record keeping has become normalised to the practitioner. This is referred to as “normalisation of deviation”[4].

Let’s assume that the practitioner graduated from a school of Podiatry which taught students to a level of clinical assessment and record keeping commensurate with the HCPC standards. Having graduated and set up in private practice a decision was made to use these A5 record cards. In the absence of ongoing critical review there is a gradual normalisation of poor assessment and note keeping in the desire to wield the scalpel with a keen eye and steady hand. In this case the patient succumbed to below knee amputation due to infection very shortly after this Podiatry treatment. The background of severe peripheral arterial disease and diabetes seemingly overlooked. It is likely that the clinician thought little about the appointment on that day as the patient left the building. The first critique of these notes most likely occurred

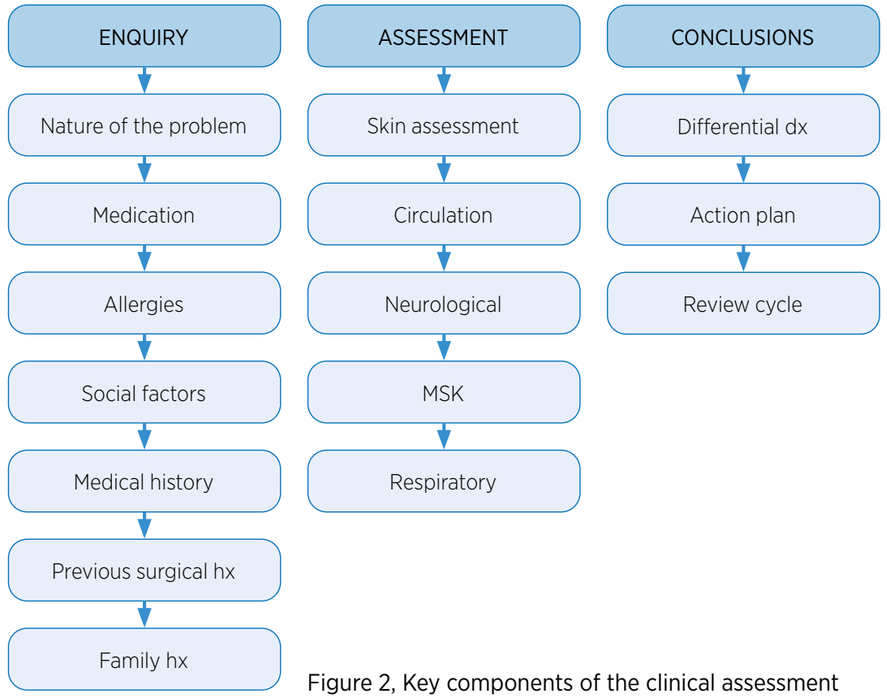


Figure 2, Key components of the clinical assessment

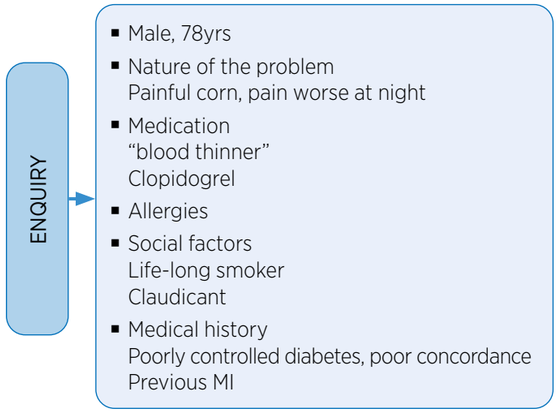


Figure 3, Information from the patient through systematic history taking (CASE 1)

when a request for the notes dropped through the letterbox on to the clinic floor. Upon receipt of the solicitor's letter (together with a signed release authorisation from the patient) I imagine there was a hasty retrieval and ponderous review of this A5 record. Upon receipt of the records the next step is for the nominated experts to review the materials and comment whether the podiatric care met a "reasonable standard".

A competent practitioner would of course have approached this patient in a more structured and comprehensive manner. This would include review, assessment and recording of the following patient domains.

Figure 2 is essentially a somewhat honed down version of the "clinical clerking model" used widely in medicine. This framework helps to ensure that key information is not overlooked. In the example above the patient had attended because of a painful corn. This much can be deduced from the clinical record card. The record card also details application of antiseptic and a dressing. One might reasonably assume that the skin was cut. Accidental haemorrhage during podiatry care is not de facto negligent. However, a failure to take appropriate action and record it might well meet the legal test for breach of duty and potential negligence. Had the practitioner followed a structured approach they would have identified several valuable key pieces of information from the initial enquiry (Figure 3). For example, questioning the patient about their glucose control may have highlighted regular hyperglycaemia increasing the risk of infection. A thorough vascular assessment would have highlighted potential peripheral vascular disease and the likelihood of poor healing.

With little medical knowledge one might begin to recognise potential red flags requiring more thought. The picture is of a patient who would benefit from professional Podiatric input. At each step of the clinical history more and more clues are gathered building a holistic understanding of the feet before us.

In assessing whether there was a breach of duty in this case, the expert is required to determine whether the Podiatrist breached the duty of care owed to a patient. In this case did the clinician fail to meet the standard of a reasonable body of other practitioners also skilled in that field. This is known as the "Bolam test" which is based on the premise of determining whether the actions of the clinician are in line with the actions of others in similar positions or undertaking similar tasks (Bolam v Friern Hospital Management Committee [1957] 1 WLR 582). Practitioners do not have to meet a "gold standard" but they must be able to demonstrate a "reasonable standard" of care in line with their "peers".

Most experts are guided by various sources of information when making these judgments. I have included some examples of the sources I would typically apply in a medical negligence matter such as the case above. The primary standards are laid out by the HCPC and play a key role in this decision-making process. Other key sources would include National Institute for Health and Care Excellence (NICE), National Patient Safety Agency (NPSA) and the Medicines and Healthcare products Regulatory Agency (MHRA). Members of the Royal College of Podiatry, for example, could use the Clinical Standards for Practice on note keeping[5]. This is not intended to be an exhaustive list but illustrates how experts will endeavour to offer objective opinion set against externally published standards, regulations, and guidance.

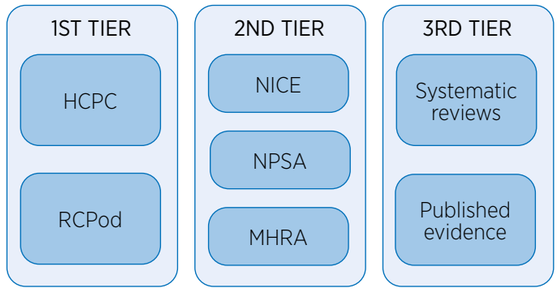


Figure 4, Examples of sources against which your practice might be judged

A point often overlooked, is that the clinical record is likely to be your only defence against a formal complaint or claim of negligence. The complainant, however, has an opportunity to formulate and refine their recollections of events over time. From my perspective the quality of these notes (Figure 1) demonstrates a failure across several of the professional standards and there was little information available on which to build a credible defence of the care provided. The litigant may not only choose to pursue you, the clinician, for damages but may also open a separate avenue of complaint directly through the HCPC.

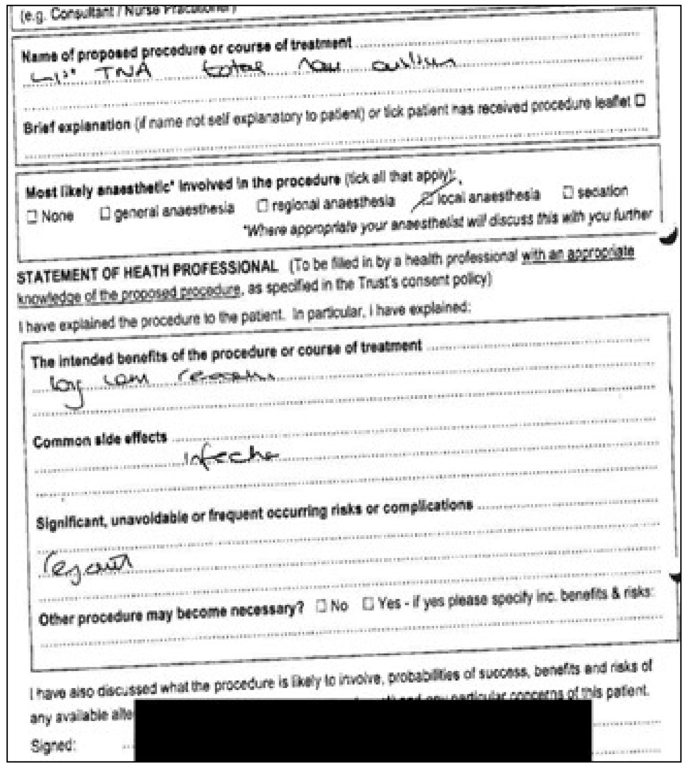
At the most basic level clinical notes need to be legible. A problem frequently encountered when reviewing negligence cases is that my copy might be a third or fourth generation photocopy and handwritten notes do not maintain their clarity. By contrast typed notes from electronic patient management systems are typically much easier to read.

HCPC STANDARD OF PROFICIENCY		COMMENT
1.1	Identify the limits of their practice and when to seek advice or refer to another professional or service	There is no indication the clinician was even aware of the patient's high-risk status.
4.2	Use their skills, knowledge and experience, and the information available to them, to make informed decisions and/or take action where necessary	No meaningful assessment was undertaken
4.3	Make reasoned decisions to initiate, continue, modify or cease treatment, or the use of techniques or procedures, and record the decisions and reasoning appropriately	In the absence of any meaningful assessment no "reasoned" decision-making was possible.
4.6	Demonstrate a logical and systematic approach to problem-solving	No evidence to support this.
7.1	Use effective and appropriate verbal and non-verbal skills to communicate with service users, carers, colleagues and others	There was no appropriate inter-agency communication.
8.1	Work in partnership with service users, carers, colleagues and others	No effective communication took place between the clinician and other healthcare professionals
9.1	Keep full, clear and accurate records in accordance with applicable legislation, protocols and guidelines	The records were simply unacceptable.
13.2	Gather appropriate information	The information gathered from the patient was substandard.
13.4	Select and use appropriate assessment techniques and equipment	No meaningful assessment was conducted.
13.5	Undertake and record a thorough, sensitive and detailed assessment	This was not done.
13.6	Undertake or arrange investigations as appropriate	This was not done

Table 2a, Evaluation of Podiatry notes (in Case 1) mapped against standards of proficiency

HCPC STANDARD CONDUCT, PERFORMANCE & ETHICS		COMMENT
2.3	You must give service users and carers the information they want or need, in a way they can understand.	The patient was not provided with adequate information about his health and risk status.
2.6	You must share relevant information, where appropriate, with colleagues involved in the care, treatment or other services provided to a service user.	No effective communication took place between the clinician and other healthcare professionals
3.2	You must refer a service user to another practitioner if the care, treatment or other services they need are beyond your scope of practice.	This was not done.
10.1	You must keep full, clear, and accurate records for everyone you care for, treat, or provide other services to.	The clinical records were unacceptable.

Table 2b, Evaluation of Podiatry notes (in Case 1) mapped against standards of conduct, performance and ethics.


(e.g. Consultant / Nurse Practitioner)

Name of proposed procedure or course of treatment
[illegible] TNA [illegible]

Brief explanation (if name not self explanatory to patient) or tick patient has received procedure leaflet ☐

Most likely anaesthetic* involved in the procedure (tick all that apply):
☐ None ☐ general anaesthesia ☐ regional anaesthesia ☑ local anaesthesia ☐ sedation
*Where appropriate your anaesthetist will discuss this with you further

STATEMENT OF HEATH PROFESSIONAL (To be filled in by a health professional with an appropriate knowledge of the proposed procedure, as specified in the Trust's consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits of the procedure or course of treatment
[illegible]

Common side effects
[illegible]

Significant, unavoidable or frequent occurring risks or complications
[illegible]

Other procedure may become necessary? ☐ No ☐ Yes - if yes please specify inc. benefits & risks:

I have also discussed what the procedure is likely to involve, probabilities of success, benefits and risks of
any available alte[redacted] concerns of this patient.
Signed: [redacted]

Figure 5, An example of a "consent" form for nail surgery

KEY POINT: The clinical record is likely to be your only defence against a formal complaint or claim of negligence. The complainant has an opportunity to formulate and refine their recollections of events over time.

Thinking About Consent

As HCPC annotated healthcare professionals we should all be familiar with "consent" in its various forms (implied, verbal, written). For more complex treatments, where potential risks are greater, the need for more robust consent processes becomes increasingly important. The word "process" is deliberately stated as "informed consent" as it is more than a signature on a printed form. Your clinical records should reflect a logical process leading to the treatment for which written consent is sought. Figure 5 is a redacted consent form in a case in which a patient sustained a severe complication following nail surgery.

KEY POINT: Keep full, clear and accurate records in accordance with legislation, protocols and guidelines .

Valid consent must be obtained before commencing treatment, physical investigation or providing personal care. Failure to respect this principle may result in legal action by the patient and action by the HCPC for failing to adhere to their standards. Furthermore, if it can demonstrated that there was a failure to obtain informed consent and a patient suffers harm because of treatment, this may be a factor in a claim of negligence against the Podiatrist. There are important nuances in the managing of consent with respect to competence and age. The Mental Capacity Act 2005, which came fully into force on 1 October 2007, sets out a statutory framework for making treatment decisions for people who lack the capacity to make such decisions themselves. This is a topic for separate discussion. Additional considerations are also necessary when managing consent and refusal of treatment by those under the age of 18. The Department of Health and Social Care provides detailed advice and guidance for 'children' (below the age of 16yrs.) and 'young people' (aged 16–17yrs).

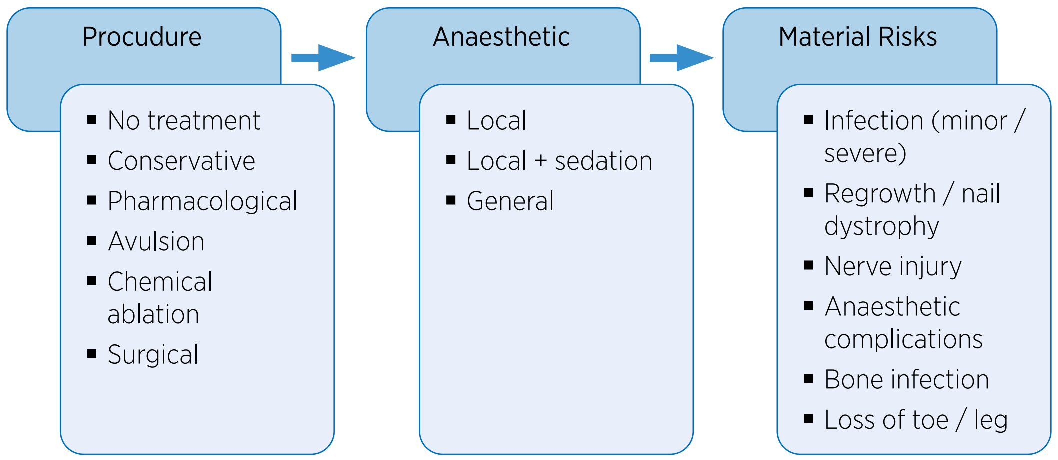


Figure 6, Considerations for a patient undergoing nail surgery.


Noula *et al. Patient Safety in Surgery* (2019) 13:44
https://doi.org/10.1186/s13037-019-0225-1

Patient Safety in Surgery

CASE REPORT Open Access

Surgical site infection leading to gangrene and amputation after ambulatory surgical care of an ingrown toenail: a case report

Check for updates

Aimé Gilbert Mbonda Noula[1], Joel Noutakdie Tochie[2*], Landry W. Tchuenkam[3], Desmond Aji Abang[4] and René Essomba[5]

Figure 7, Example of a case in the literature highlighting amputation following "routine" nail surgery.

In order for consent be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. The question of "appropriately informed" is critical in meeting this standard.
In Figure 5 above the only "side effect" listed is infection and re-growth. The height of the bar for consent has evolved beyond that arising from the case of Bolam vs Friern Hospital Management Committee in 1957. In 1977 the case Bolitho vs Hackney Health Authority resulted in a deviation from the Bolam test in so far as it was no longer sufficient for a Defence to locate a body of opinion to support the actions of a clinician, but those actions had to "withstand logical analysis". Nearly three decades later in the case of Chester vs Afshar (2004) the patient suffered a complication during back surgery which carried an estimated 1% risk, and which had not been disclosed. The patient sued the surgeon and despite it being probable that she would have proceeded with surgery in any event, the failure to disclose this significant risk led to her case being upheld. The burden placed on clinicians was increased further in 2015 in the case of Montgomery vs Lanarkshire Health Board in which it was established that:

"The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. "The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it." - Judgment in Montgomery v Lanarkshire Health Board [2015] UKSC 11, paragraph 87.

In the Podiatric setting let's consider managing a patient with an ingrown toenail.

As someone who routinely treats paediatric patients, I perform a large volume of nail surgery under general anaesthetic and can attest to the negative impact inappropriate attempts with local anaesthetic has on patients. Failing to refer on for incisional nail surgery when necessary is a not uncommon starting point for litigation. You may feel uncomfortable including risks of amputation and osteomyelitis as part of the consent process, but these are all well documented complications of "simple toenail surgery" as the academic paper in Figure 7 conveys.

In clinical practice none of us expect to be sued and indeed statistically the odds are in your favour. However, much like setting out on a boat into the ocean with no radio and no life jacket, all is well until it is not. Then it is too late to turn back to avail yourself of all the necessary protections. By the time you receive notification of a complaint or letter of claim the opportunity to review your clinical notes and management of the patient is long past.

DATE	SUMMARY OF NOTES
1-3-2019	GP appointment patient c/o painful red R1st toe Advises patient to see a Podiatrist for removal of the nail. “R1st red inflamed no pus, see Podiatry”
16-3-2019	PODIATRY “Pt. has painful R big toe. No treatment. No meds. GP suggested removing nail. Pulses o.k. Painful to pressure. Might be fungal nail as a bit thick. Plan: Removal nail with local. Pt. happy with plan”
18-3-2019	PODIATRY The nail was removed under local anaesthetic
20-3-2019	PODIATRY 1st redressing “the toe is still as painful” “wound clean – irripod, dressg with bactigras and gauze” “patient to redress and see 1 week”
1-04-2019	PODIATRY 1st redressing “the toe is still very painful” “wound clean and dry no need for further dressings” “seems tender to top. Prob healing up. Plan: Discharged as toe healed.
5-06-2019	“its still sore and the toe bed looks inflamed” “nail bed area looks a bit funny, prob fungal from prev nail infection” Plan: Adv try antifungal cream, see 3m”
20-09-2019	PODIATRY “sore now down the outside and on top” “sore to press and still looks inflamed, some nail regrowing, prob a spicule down the side” Plan: Repeat nail op to remove spicule
8-10-2019	PODIATRY Repeat nail surgery
15-10-2019	PODIATRY 1st redressing “still painful” “wound clean – irripod, dressg with bactigras and gauze” “patient to redress and see 1 week”
22-10-2019	PODIATRY 2nd redressing “still painful and my toe is still red” “wound clean – irripod, dressg with bactigras and gauze” “patient to redress and see 1 week, gave tubifoam”
4-11-2019	PODIATRY “tubifoam helped a bit but still painful” “base of nail dry but looks a bit red and discoloured” Plan: To keep wearing tubifoam & antifungal cream. SOS
8-1-2020	GP appointment “My toe is agony even after Podiatry. They told me to keep using this cream”. “R1st toe red, some discharge to ulcerated nail bed area. Discolouration to skin on nail bed.” Plan: Urgent dermatology referral.
20-1-2020	Dermatology Assessed, x-ray, biopsy
27-1-2020	Dermatology Diagnosis 1. Acral lentiginous melanoma 2. Advanced osteomyelitis terminal phalanx

Table 3, Transcript of patient case notes in CASE 2

Re-Evaluating Progress

Unless you are lucky enough to always reach the correct diagnosis and management plan first time for all your patients, reviewing a patient’s progress is a fundamental clinical skill. Timely re-evaluation offers us an opportunity to take a step back and reflect on how our patient is compared with where we expected them to be. It affords an opportunity to question both the initial diagnosis, treatment plan, patient concordance and to decide if further investigations are justified and or whether we need to review the existing treatment plan altogether.

CASE STUDY 2 WHEN IS A FUNGAL NAIL NOT A FUNGAL NAIL?

The table overleaf is a summary of the key patient notes. Mrs F, an otherwise fairly healthy lady in her mid-sixties, saw her GP in March 2019 complaining about a painful right big toe.

Here are the main draft allegations of negligence set out in this case by the Claimant’s solicitors.

- Diagnosed and treated the Claimant for presumed fungal nail infection with repeat prescriptions of medication and nail excisions when it was inappropriate to do so.
- Failed, whether promptly or at all, to take sample nail clippings and to send the same for analysis to confirm or exclude the presence of fungal infection.
- Failed promptly to refer the Claimant for further specialist assessment and treatment
- Failed to refer the Claimant to a Dermatologist for investigation and treatment promptly or at all.
- Failed to refer the Claimant for biopsy promptly or at all.
- Failed to suspect and/or investigate or diagnose nail bed malignancy promptly or at all.

There are multiple problems with the Podiatric management from the outset. However, it might be argued that the greatest impact on causation was not the initial nail surgery which took place within two days of the initial appointment but the failure to adequately re-evaluate the matter in June 2019 before repeating another unnecessary procedure.

Had the clinician thought that the Claimant’s problems were related to a fungal nail problem, then given there is a simple clinical test with good sensitivity and specificity this should have been offered. In the absence of anything being conducted, this is a potential breach of duty. No expert can realistically argue otherwise as clinical diagnosis of fungal nail infection is somewhat less reliable than formal testing. There would have been some latitude had this testing been offered but the patient declined testing perhaps because of cost. Similarly, had the test been negative but sufficient clinical justification being present for nail removal then this might well have been deemed non-negligent.

However, pain continuing after the removal of the assumed cause is atypical and should have been seen as a “red fleg”. The failure to re-consider the cause of the patient’s ongoing symptoms at the 1st April appointment was wholly inappropriate because the patient remained in pain despite removal of the nail. The failure to re-evaluate the patient resulted in repeated failures in care which in turn resulted in advancement of disease and a worsened clinical outcome, in this case amputation of the toe and unfortunately advancement of the cancer.

“If the clinical response is not what you expect, critically review your diagnosis and plan”

CASE STUDY 3 NOT EVERY PATIENT WITH HEEL PAIN HAS PLANTAR FASCIITIS

Mr JR, was an otherwise very fit and active gentleman. In August 2015 he presented to a private “MSK specialist Podiatrist “ by which time his symptoms had been present for three months. He was noted to have asymmetrical flat foot (left worse than right). His pain was correlated to physical activity. He was diagnosed with “left arch collapse due to significant flexibility in the forefoot” and provided with over-the-counter arch supports. [NOTE: there was no assessment of the patient’s ability to stand on tip toe, limb length discrepancy, muscle / tendon testing etc.]

KEY POINT: If the clinical response is not what you expect, critically review your diagnosis and plan.

A further Podiatry appointment took place 20th October 2015, where the Claimant highlighted his ongoing / increasing foot pain. He was provided with further insoles. At the same appointment the Podiatrist arranged an ultrasound scan (USS) to assess the plantar fascia. No additional clinical examination is recorded to explain the observed asymmetrical foot position and unilateral foot pain. A diagnosis of plantar fasciitis is made and the patient is sent for an ultrasound scan.

The scan results (25 November 2015) noted normal plantar fascia and he re-attended an appointment with the Podiatrist 1st December 2015 where he

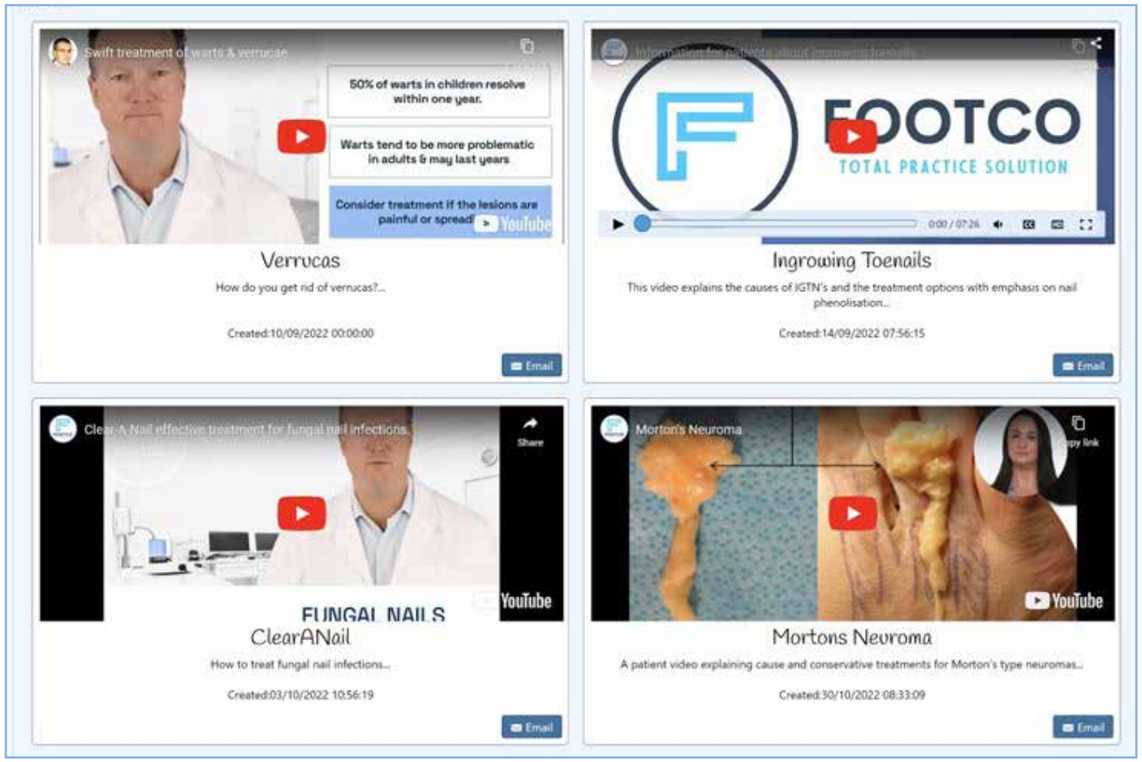


Figure 8, Premade patient information videos on a range of common topics

was provided with a night splint. He was advised no further treatment could be provided. The Claimant telephoned the Podiatrist 12th January 2016 highlighting problems with wearing the splint. The Claimant had a further telephone review with the Podiatrist 8th March 2016 when he was discharged.

The Claimant consulted his GP 11th April 2016 because of the ongoing foot pain and was signed off work for four weeks. A further GP review took place 9th May 2016 where the Claimant was signed off for a further four weeks.

The diagnosis of left sided stage III posterior tibial tendon dysfunction syndrome (PTTDS) was finally established following Orthopaedic consultation November 2016.

The use of job titles which imply specialist knowledge infer additional responsibilities and although there is no defence in law for lack of clinical experience per se, those adopting such titles which appear largely unregulated in the Podiatric world may wish to do so cautiously.

The most striking facts of this case are in my mind:

- Presence of asymmetry between foot posture
- A lack of thorough clinical assessment.

This has resulted in an incorrect diagnosis which is pursued despite both the failure to respond to the treatment plan provided and a negative ultrasound scan. Had a re-evaluation taken place in October 2015 and the correct investigations and treatment been implemented, this case would not have come to litigation. Unfortunately, despite obvious concerns from the patient, the patient was simply discharged. As noted above the diagnosis of stage III PTTDS was established with a simple ultrasound scan of the tendon which had been the source of pain all along. In this case, ignoring the substandard assessment, red flags included:

- Asymmetrical flat foot deformity with the symptomatic foot being the primary problem
- A failure to respond to treatment for the incorrectly diagnosed condition
- A negative ultrasound for plantar fasciitis.

For negligence to be held there has to be both “breach of duty” and “harm” which in this case could be argued included:

- Additional period of pain due to the delay in appropriate treatment
- Worsening of the claimant’s condition leading to a poorer prognosis
- Acceleration of injury to the other foot
- A requirement for more invasive / risky treatment than would have been otherwise required
- A reduced future capacity to work, participate in social / sport etc.

This is not an exhaustive list but is intended to highlight how the case might unfold in the legal process resulting in an award of compensation. In other words, “but for these failures” the Claimant would have been successfully treated with conservative measures with no requirement for surgery and no injury to the other foot.

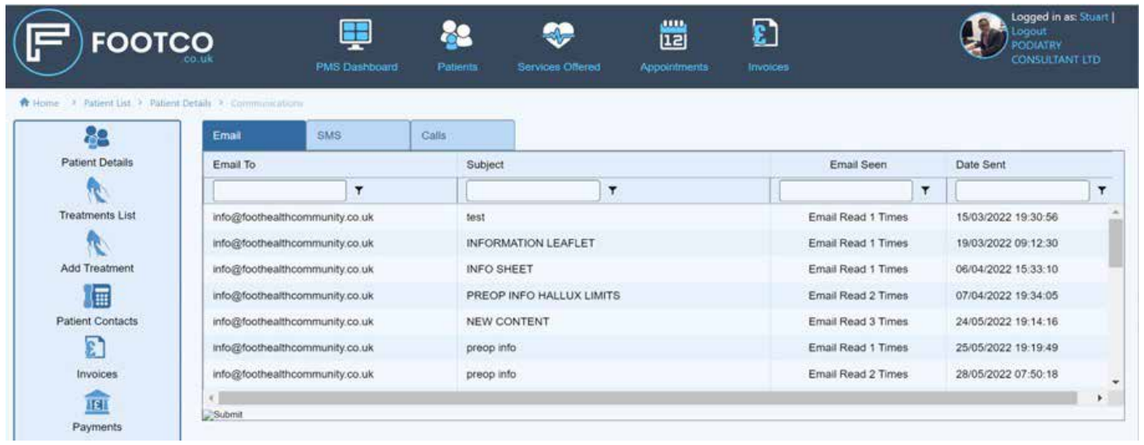


Figure 9, Audit trail for your peace of mind

TECHNOLOGY TO PROTECT

In today’s electronic age it would be my view that no practitioner should be using a paper based clinical records system. Paper notes are inefficient, pose increased issues with respect to GDPR compliance and are problematic in terms of storage and access if you have a large practice. I have used an electronic patient management system (PMS) for over fifteen years. Our current practice system (FootCo) like many other systems provides the ability to securely store your clinical notes on “the cloud” and with 2-factor authentication access to this data is protected in the event IT equipment is lost or stolen. Compare this to having your paper notes stolen or lost from your clinic or car.

The real benefit of a PMS is the ability of the system to embed additional functionality such as:

- Secure clinic diary as opposed to “Google” calendars
- Structured assessment templates
- Red flagging of medical conditions
- Direct upload of clinical photos to a patient record (not stored on your phone)
- Automated secure communications
- Podiatry based templates for common conditions
- Secure email for letters and information leaflets
- Automated audit logs

KEY POINT: Anyone still using paper records should consider transitioning to a good quality clinical management system where technology can help build a more efficient and effective practice.

The first benefit is of course I no longer have to store clinical paper notes and I can access any record from anywhere in the world where I have an internet connection. My notes are encrypted to industry standards and access is protected with 2-factor authentication. In addition, any patient photos and documents can also be stored safely and securely. The system is designed around the “SOAP” format with helpful structured sections for medical history and clinical assessment[6].

Communications between me and other key stakeholders is made easy by using letter templates, patient information sheets and videos all of which can be shared securely at the click of a button (Figure 8). What’s more, each communication is logged so there is an audit trail within my practice (Figure 9).

KEY POINT: Think of clinical record keeping as another tool in your armoury and keep your skills honed through critical reflection.

SUMMARY

Clinical record keeping is something that seems to be seldom re-visited after registration and yet it sits at the very heart of safe clinical practice. Whilst technology has advanced, many clinicians continue to employ paper record keeping systems which are fraught with danger.

Developing a systematic approach to assessment, treatment and record keeping will improve patient care and clinical outcomes. In the event you are called upon to justify your actions either through complaint or litigation, your notes are the mainstay of your defence whereas the patient will have the opportunity to develop their version of events from memory recorded in their witness statement. An expert's duty is to the Court and your practice will be judged against the standards set out by the HCPC with additional reference to other key sources.

In the 21st century I would urge anyone still using paper records to transition to a good quality clinical management system where technology can help you build a more efficient and effective practice. Think of clinical record keeping as another tool in your armoury and keep your skills honed through critical reflection.

References

1. The Kings Fund. The NHS budget and how it has changed. 2023 [cited 2024; Available from: https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-budget-nutshell#:~:text=The%20Department's%20spending%20in%202022,as%20new%20buildings%20or%20equipment.
2. NHS Resolution. Fredom of Information Request 5583. 2022; Available from: https://resolution.nhs.uk/wp-content/uploads/2022/10/FOI_5583_Podiatry_Redacted.pdf.
3. Anon., What is clinical supervision and how can it be delivered in practice? Nursing Times [online], 2022. 118(2): p. 20-23.
4. Wright, M.I., B. Polivka, J. Odom-Forren, and B.J. Christian, Normalization of Deviance: Concept Analysis. Advances in Nursing Science, 2021. 44(2).
5. Royal College of Podiatry. Clinical Standards - Record Keeping. 2020; Available from: https://membersarea.rcpod.org.uk/podiatric-practice/professional-resources-area-revised/clinical-standards.
6. Podder, V., V. Lew, and S. Ghassemzadeh. SOAP Notes. 2023 [cited 2024; Available from: https://www.ncbi.nlm.nih.gov/books/NBK482263/.

CPU article number: 014
Editorial Team: **Mike Potter, Ivan Bristow, Anthony Maher & Morwenna Potter.**
All articles are selected, commissioned, reviewed and produced independent of Canonbury Products Limited. Canonbury Products Limited kindly provide unrestricted support for the CPU series as a service to the profession.

The editorial team welcomes feedback or suggestions from readers via email: **CPUtools@canonbury.com**