Corridor consultations and the medical microbiological record: is patient safety at risk?

S R Heard, C Roberts, S J Furrows, M Kelsey, L Southgate, on behalf of the Specialty Assessment Working Group for Medical Microbiology of the GMC

The performance procedures of the General Medical Council are aimed at identifying seriously deficient performance in a doctor. The performance procedures require the medical record to be of a standard that enables the next doctor seeing the patient to give adequate care based on the available information. Setting standards for microbiological record keeping has proved difficult. Over one fifth of practising medical microbiologists (including virologists) in the UK (139 of 676) responded to a survey undertaken by the working group developing the performance procedures for microbiology, to identify current practice and to develop recommendations for agreement within the profession about the standards of the microbiological record. The cumulative frequency for the surveyed recording methods used indicated that at various times 65% (90 of 139) of respondents used a daybook, 62% (86 of 139) used the back of the clinical request card, 57% (77 of 139) used a computer record, and 22% (30 of 139) used an index card system to record microbiological advice, suggesting wide variability in relation to how medical microbiologists maintain clinical records.

Well kept medical records are an important component of good risk management and clinical governance

The performance procedures for medical microbiology the SAWG for medical microbiology has identified problems within the specialty around the medical microbiology record. Because medical microbiology is fundamentally a referral and consultative service, the patient record is not the responsibility of the medical microbiologist, but of the primary clinician. Nonetheless, the medical microbiologist is responsible for interpreting laboratory data and for making recommendations about patient management that is usually taken up by the clinician responsible for the care of the patient. This is most commonly with regard to treatment for a diagnosed or possible infection (for example, antibiotic recommendations), but may also involve infection control management and investigative advice.

It is also necessary to consider the environment in which advice is offered and the recipient of such advice. Clinical corridor or car park consultations’ cultivating in clinical advice are common. This is relevant not only in microbiological practice, but is part of the daily discourse of hospital medicine. Should all such conversations be followed by a bedside visit and a note in the patient’s record? And are telephone consultations in which clinical advice is given similarly to be regularly recorded? Given that clinical practitioners who are not medically qualified often request such advice, is it appropriate to assume in every instance that the recipient has the vocabulary and heuristic knowledge to place microbiological advice in its appropriate context?

When the SAWG came to look at the microbiological record within the context of the medical microbiology performance procedures a problem immediately became apparent—just what is the microbiological record? Whereas other specialties have been able to identify standards for the clinical record relevant to the specialty, there is less information available on how pathologists record their advice/actions at the clinical—
pathological interface. Histopathologists and cytologists provide a clear example of how their reports and advice are presented and retained. Haematologists, with dual clinical and laboratory responsibilities, successfully manage to channel laboratory advice, which may be additional to the laboratory report, into the overall patient record. The medical microbiologist is also responsible for issuing laboratory reports, but in addition to interpreting and advising on the report may be asked by a variety of clinicians, in a variety of circumstances, for clinical advice on patient care. However, this advice is recorded in a variety of ways, with medical microbiologists using a combination of daybooks, laboratory cards, index cards...

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**Figure 1** Questionnaire on the clinical microbiology/virology record.
the profession about the standards of the microbiological practice and develop recommendations for agreement among the members of the SAWG to identify current practising medical microbiologists (including virologists) was considered the way in which this can be achieved. A survey of minimum criteria set by the GMC, then the specialty needs to consistently and robustly be recorded, especially against the assumption is that microbiological clinical advice should be logical record keeping has proved to be difficult. If the day to day clinical liaison were invited to complete the survey. Included, doctors at other public health laboratories providing Public Health Laboratory Service (Colindale, UK) were not receiving the survey. Although doctors who were based at the address, or did not offer an e-mail address were excluded from currently in microbiology clinical practice, did not have a UK individual who was not medically trained or were not Pathologists’ Handbook initially identified a representative UK (fig 1). Choosing every fifth name in the Royal College of GMC was sent to 178 medical microbiologists practising in the A questionnaire developed by the microbiology SAWG of the DISCUSSION AND RECOMMENDATIONS

Eighty two per cent of questionnaire respondents (114 of 139) believed that guidelines should be developed to help microbiologists adopt a clearer and more accountable approach to the microbiology clinical record.

Table 1 shows the frequency with which respondents used one approach or another in recording advice. The cumulative frequencies for each approach indicated that 65% (90 of 139) of respondents used a daybook, 62% (86 of 139) used the back of the clinical request card, 57% (79 of 139) used a computer record, and 22% (30 of 139) used an index card system to record microbiological advice (fig 2).

Seventy two percent of respondents (100 of 139) regularly recorded advice in patients’ notes (table 2). Five respondents (3.6%) did this for all patients for whom clinical advice was given and 71% of respondents (99 of 139) recorded advice on selected patients. Approximately 25% of those surveyed did not respond to the question. Of those writing in patients’ notes, 14 did so for all patients with a positive microbiology result, four respondents never did so, and 96 did so for some patients with positive results. Thirty percent of respondents (42 of 139) always wrote in the notes of patients about whom clinical advice had been specifically requested and 55% (76 of 139) wrote in some patients’ notes when clinical advice was requested. Twenty one (15%) of those surveyed did not respond to this question.

Respondents cited several other methods of recording microbiological information. These included paper sheets, books (for example on call/ITU book, etc), letters, comments added to reports, palmtop computers, and tape recordings. Eighty two per cent of questionnaire respondents (114 of 139) believed that guidelines should be developed to help microbiologists adopt a clearer and more accountable approach to the microbiology clinical record.

Table 1 Percentage of occasions when method was used to record microbiological advice

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<th>Methodology</th>
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<td>Daybook</td>
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<tr>
<td>Request form</td>
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<td>11.5</td>
<td>5.0</td>
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Of the 178 survey requests sent out, five were returned by the post office and four were returned by doctors not practising microbiology. One hundred and thirty nine completed surveys were received, a response rate of 82% (139 of 169). The Royal College of Pathologists has identified that there are 676 practising microbiologists on its database, so that the survey responses received represent over one fifth (21%) of practising microbiologists in the UK.

Table 2 shows the frequency with which respondents used one approach or another in recording advice. The cumulative frequencies for each approach indicated that 65% (90 of 139) of respondents used a daybook, 62% (86 of 139) used the back of the clinical request card, 57% (79 of 139) used a computer record, and 22% (30 of 139) used an index card system to record microbiological advice (fig 2).

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was an impressively high response rate, perhaps because of the involvement of the GMC. A legitimate question, which was asked by several of those responding, was whether record keeping for clinical advice mattered in the context of microbiological advice. After all, the laboratory record of results stands as the outcome of the investigations of the patient. What further, one might ask, is required, given that the clinician with responsibility for the patient takes the clinical decision around further investigation, prescribing, and treatment? This cuts to the heart of the clinical role of the medical microbiologist. If the medical microbiologist is genuinely part of the clinical team contributing to the effectiveness of clinical care, then he/she must take on that responsibility fully. If the clinical advice given by the microbiologist is going to make a difference to the care a patient receives and if that advice is acting upon (or not, as the case may be), then it should become part of the record of that patient’s care. Standard 4 of the Clinical Negligence Scheme for Trusts indicates that: “A patient’s health record should inform any clinician with a responsibility for the patient of all the key features which might influence the treatment proposed.”

“Most medical microbiologists use several approaches to record clinical advice but there are no clear standards against which the documentation of this advice can be assessed”

The issue then becomes one of logistics rather than accountability—because it is difficult to do this, the importance of finding an appropriate methodology and setting standards for it should not be discounted.

Our survey demonstrates that microbiologists across the UK record clinical advice in a variety of ways. Most medical microbiologists use several approaches to record clinical advice but there are no clear standards against which the documentation of this advice can be assessed. This may become increasingly relevant in the context of multiprofessional ward rounds where advice may be given/heard not only by medical staff but also by other healthcare professionals.

The results of our survey are representative of over one fifth of practising medical microbiologists (including virologists) in the UK identify current practice.

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Take home messages

1. Microbiologists should recognise and accept the need for adequate and accessible clinical records.
2. Microbiologists should decide on the type, quantity, and quality of information that is required to reflect a clinical consultation.
3. Microbiologists should make relevant notes in patients’ records, especially in clinical situations such as endocarditis, meningitis, significant bacteraemias, intensive care infections, and nosocomial infections prolonging hospital stay.
4. Microbiologists should recognise the diverse means of recording information.
5. Microbiologists should keep a suitable laboratory record for continuity of care by fellow microbiologists that is standardised and recorded without jargon, obscure abbreviations, or acronyms. This can be in a laboratory book, using a card system, or in an electronic format.
6. Clinical advice given over the telephone or “in the corridor” should be regularly recorded. This can be in a laboratory book, using a card system, or in an electronic format.
7. Every entry should include: date/time, patient details, recipient of information, advice given, clearly printed name of microbiologist.
8. Microbiologists should develop a “sixth sense” about those patients or incidents when exceptional records will be invaluable.
9. Records of outbreaks should be kept carefully with all incidents fully documented.

The issues raised by this survey are of particular relevance to microbiologists, but also raise wider concerns for the medical profession. Clinical discussion and exchanges are part of the bread and butter of clinical life; advice about patients given in such circumstances may be taken, may be misinterpreted, or may be misunderstood. Patients may or may not benefit and often the advice may not be recorded. What are the risks of such clinical behaviours? Do patients benefit from the wider and greater breadth that such advice may afford? Should clinicians refuse to discuss patients outside the formal setting of
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