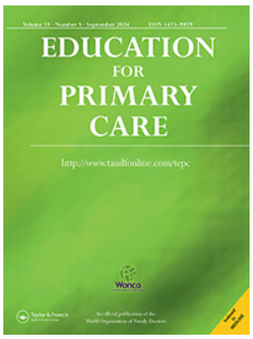

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What if the patient reads this? A student guide to writing in the GP electronic patient record

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What if the patient reads this? A student guide to writing in the GP electronic patient record

Sprake C[a], Schmitgen C[b], Brown J[c], Lefroy J[d], Graham S[a], Shepherd S C[e], Smith L[e], Ward A[f], Ward JD[g] and Weetman K On behalf of the UK Council for Clinical Communication in Undergraduate Medical Education[g]

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ABSTRACT

Background: It is common practice for senior medical students in UK General Practice to enter details of their consultations into the electronic patient record (EPR). There is evidence that students benefit educationally from writing in patient records through learning how to make good clinical entries and enhancing their clinical reasoning. In England, since 31 October 2023, patients are given full access to their EPR, including free text notes on their consultations. Despite the importance of high-quality consultation notes, guidance on writing in the patient record is rarely included in medical curricula.

Approach: With patient and public involvement, the UKCCC (UK Council for Clinical Communication in Undergraduate Medical Education) developed a guide for students on writing in patients' General Practice (GP) notes and disseminated it to all UK medical schools from August to October 2023.

Results: The utility of the guide was evaluated via student and GP tutor surveys. Students and clinical teachers valued the guidance on content, structure, and clarity of consultation notes. A lack of awareness of the guide and suboptimal access and formatting on mobile devices were raised as areas for improvement. Other survey responses, which will inform the development of the next version, suggested adding links to learning resources.

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General practice; electronic patient records; medical students; written communication skills; clinical reasoning

Background

Patients in England have access to their full General Practice (GP) electronic patient record (EPR) via the National Health Service (NHS) apps [1,2] since 31.10.23. In the devolved administrations of Wales, Scotland and Northern Ireland there has not yet been an equivalent move to automatic access, but patients have the right to request a copy of their records.

There is evidence from earlier adopter GP practices that transparent records may improve patient satisfaction, trust and safety [3,4]. Patients can benefit from the increased transparency of the interaction [5] and access to records and letters [6–8]. There has however been some disquiet from clinicians concerned that their entries may make patients more anxious and that recording fewer differential diagnoses to avoid patient concern will prevent proper interprofessional communication [9–12]. Concerns are also expressed about the time required to write notes that are more patient-centred, with clear and non-judgemental language [13–17]. As students start their journey in documenting consultations, the potential effect of these concerns is patients being viewed as barriers to efficient documentation rather than active participants in their care.

Guidance in the way information is passed on in letters to patients is already available [18–21] and can be used to inform how one writes in the EPR. Examples of important considerations and principles for best practice in clinical records are that entries should be clear, contemporaneous, accurate, and fit for purpose for both healthcare professionals and patients [22,23]. Language choices also affect readability and appropriateness, for example, whether to avoid acronyms and abbreviations or to spell them out in full on the first usage [24,25]. Balancing the details of entries to meet the dual requirements of colleagues and patients can be challenging.

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The UK Council for Clinical Communication (UKCCC) brings together clinical communication education experts from UK medical schools. The work of the council is to inform and drive forward the clinical communication curriculum for UK undergraduate medical students. The council recognised the call for more robust guidance for students on placement in General Practice. In discussions, it became apparent that written communication is not always taught explicitly, and GP tutors might now need better support to feel confident with students writing in the EPR. The development of a guide for students was seen as an important step to promote best practice and enhance good patient-centred care. This paper introduces a guide for medical students on writing in the EPR and suggests possible improvements based on initial evaluation.

Approach

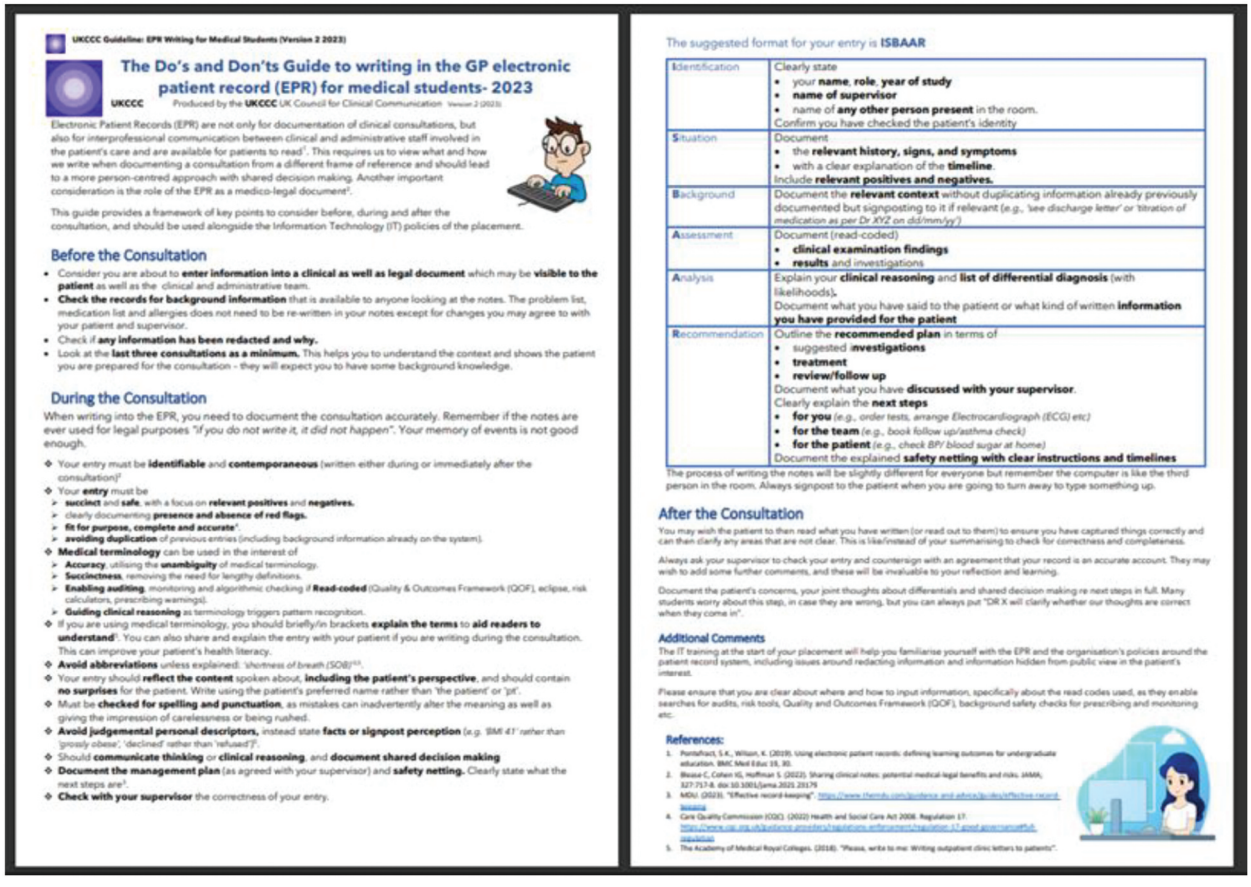
Development of the guide

The principles within the guide were developed initially in UKCCC meetings and online forum
The original guide discussions. A working group (comprising the authors of this paper) then took a draft to a 'round table' session which included patient representation. Following this, a Wakelet as a format for dissemination of the PDF guidance document was developed and the guide further refined. The Wakelet allows the collection of resources for further learning and can easily be kept up to date as an ongoing learning resource. It can be accessed here: Student guide to EPR writing - Wakelet and the student guide (Figure 1).

The Wakelet containing the guide was distributed by email to all UK medical school heads, GP heads of teaching and communication leads via the UKCCC mailing list. The educational group of the Medical Schools Council also supported the distribution of the guide via their GP heads of teaching to GP tutors and medical students on GP placement.

Evaluation of guide

All UK medical schools were invited via email and in a post to the internal UKCCC blog to participate in evaluating the guide. Recruitment within participating


UKCCC Guideline: EPR Writing for Medical Students (Version 2 2023)

The Do's and Don'ts Guide to writing in the GP electronic patient record (EPR) for medical students- 2023

UKCCC Produced by the UKCCC UK Council for Clinical Communication Version 2 (2023)

Electronic Patient Records (EPR) are not only for documentation of clinical consultations, but also for interprofessional communication between clinical and administrative staff involved in the patient's care and are available for patients to read[1]. This requires us to view what and how we write when documenting a consultation from a different frame of reference and should lead to a more person-centred approach with shared decision making. Another important consideration is the role of the EPR as a medico-legal document[2].

This guide provides a framework of key points to consider before, during and after the consultation, and should be used alongside the Information Technology (IT) policies of the placement.

Before the Consultation

- Consider you are about to **enter information into a clinical as well as legal document** which may be **visible to the patient** as well as the clinical and administrative team.
- **Check the records for background information** that is available to anyone looking at the notes. The problem list, medication list and allergies does not need to be re-written in your notes except for changes you may agree to with your patient and supervisor.
- Check if **any information has been redacted and why.**
- Look at the **last three consultations as a minimum.** This helps you to understand the context and shows the patient you are prepared for the consultation - they will expect you to have some background knowledge.

During the Consultation

When writing into the EPR, you need to document the consultation accurately. Remember if the notes are ever used for legal purposes *"if you do not write it, it did not happen"*. Your memory of events is not good enough.

- Your entry must be **identifiable** and **contemporaneous** (written either during or immediately after the consultation)[2]
- Your **entry** must be
  - **succinct** and **safe**, with a focus on **relevant positives** and **negatives.**
  - clearly documenting **presence and absence of red flags.**
  - **fit for purpose, complete and accurate**[3].
  - **avoiding duplication** of previous entries (including background information already on the system).
- **Medical terminology** can be used in the interest of
  - **Accuracy**, utilising the **unambiguity** of medical terminology.
  - **Succinctness**, removing the need for lengthy definitions.
  - **Enabling auditing**, monitoring and algorithmic checking if **Read-coded** (Quality & Outcomes Framework (QOF), eclipse, risk calculators, prescribing warnings).
  - **Guiding clinical reasoning** as terminology triggers pattern recognition.
- If you are using medical terminology, you should briefly/in brackets **explain the terms** to **aid readers to understand**[3]. You can also share and explain the entry with your patient if you are writing during the consultation. This can improve your patient's health literacy.
- **Avoid abbreviations** unless explained: *'shortness of breath (SOB)'*[3,4].
- Your entry should **reflect the content** spoken about, **including the patient's perspective**, and should contain **no surprises** for the patient. Write using the patient's preferred name rather than 'the patient' or 'pt'.
- Must be **checked for spelling and punctuation**, as mistakes can inadvertently alter the meaning as well as giving the impression of carelessness or being rushed.
- **Avoid judgemental personal descriptors,** instead state **facts or signpost perception** *(e.g. 'BMI 41' rather than 'grossly obese', 'declined' rather than 'refused')*[3].
- Should **communicate thinking** or **clinical reasoning**, and **document shared decision making**
- **Document the management plan** (as agreed with your supervisor) and **safety netting.** Clearly state what the next steps are[3].
- **Check with your supervisor** the correctness of your entry.

The suggested format for your entry is **ISBAAR**

Identification	Clearly state • your **name**, **role**, **year of study** • **name of supervisor** • name of **any other person present** in the room. Confirm you have checked the patient's identity
Situation	Document • the **relevant history, signs, and symptoms** • with a clear explanation of the **timeline**. Include **relevant positives and negatives.**
Background	Document the **relevant context** without duplicating information already previously documented but signposting to it if relevant *(e.g., 'see discharge letter' or 'titration of medication as per Dr XYZ on dd/mm/yy')*
Assessment	Document (read-coded) • **clinical examination findings** • **results** and investigations
Analysis	Explain your **clinical reasoning** and **list of differential diagnosis** (with likelihoods)**.** Document what you have said to the patient or what kind of written **information you have provided for the patient**
Recommendation	Outline the **recommended plan** in terms of • suggested **investigations** • **treatment** • **review/follow up** Document what you have **discussed with your supervisor**. Clearly explain the **next steps** • **for you** *(e.g., order tests, arrange Electrocardiograph (ECG) etc)* • **for the team** *(e.g., book follow up/asthma check)* • **for the patient** *(e.g., check BP/ blood sugar at home)* Document the explained **safety netting with clear instructions and timelines**

The process of writing the notes will be slightly different for everyone but remember the computer is like the third person in the room. Always signpost to the patient when you are going to turn away to type something up.

After the Consultation

You may wish the patient to then read what you have written (or read out to them) to ensure you have captured things correctly and can then clarify any areas that are not clear. This is like/instead of your summarising to check for correctness and completeness.

Always ask your supervisor to check your entry and countersign with an agreement that your record is an accurate account. They may wish to add some further comments, and these will be invaluable to your reflection and learning.

Document the patient's concerns, your joint thoughts about differentials and shared decision making re next steps in full. Many students worry about this step, in case they are wrong, but you can always put "DR X will clarify whether our thoughts are correct when they come in".

Additional Comments

The IT training at the start of your placement will help you familiarise yourself with the EPR and the organisation's policies around the patient record system, including issues around redacting information and information hidden from public view in the patient's interest.

Please ensure that you are clear about where and how to input information, specifically about the read codes used, as they enable searches for audits, risk tools, Quality and Outcomes Framework (QOF), background safety checks for prescribing and monitoring etc.

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1. Pornthisarn, S.K., Wilson, K. (2019). Using electronic patient records: defining learning outcomes for undergraduate education. BMC Med Educ 19, 30.
2. Blease C, Cohen IG, Hoffman S. (2022). Sharing clinical notes: potential medical-legal benefits and risks. JAMA; 327:717-8. doi:10.1001/jama.2021.23179
3. MDU. (2023). "Effective record-keeping". https://www.themdu.com/guidance-and-advice/guides/effective-record-keeping
4. Care Quality Commission (CQC). (2022) Health and Social Care Act 2008: Regulation 17: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance#full-regulation
5. The Academy of Medical Royal Colleges. (2018). "Please, write to me: Writing outpatient clinic letters to patients".

Figure 1. Screenshot of the guidance.

medical schools was via the Heads of Teaching in Primary Care who emailed the survey out between 1 and 30 November 2023 to all Year 3 to 5 students attending GP placements during the previous 3 months and all GP practices which hosted students during the same period.

To evaluate the usefulness of the guide, short surveys for students and GP teachers (box 1) were distributed after the guide had been in circulation for 3 months. The survey was sent with a link to the guide as a reminder of the document for evaluation.

The survey questions were generated to gather an understanding of students' behaviour in relation to electronic patient records from both the student and GP educator perspective. A combination of closed and open text questions was utilised (see Box 1).

Box 1. Survey questions

Student survey questions	GP tutor survey questions
1. Have you made entries in patient Electronic PRs before reading this guidance? Y/N	1. Have your students made entries in patient EPRs before reading this guidance? Y/N
2. Have you made entries in patient EPRs after reading this guidance? Y/N	2. Have your students made entries in patient EPRs after reading this guidance? Y/N
2b If not why not?	2b If not why not?
3. What difference has this guidance made to your writing in the EPR? (text box)	3. What difference has this guidance made to your students' writing in the EPR? (text box)
4. Did your patient consultations change in any other way after reading this guidance? (explain) (text box)	4. Did your students' patient consultations change in any other way after reading this guidance? (explain) (text box)
5. How could the guide be improved? (text box)	5. How could the guide be improved? (text box)

Data was entered anonymously by participants who consented to its use. Data was stored in secure drives and was password protected. No identifying information was in the survey responses. Frequency counts were used to analyse closed question survey items. Open text boxes were analysed to draw out themes. Post-analysis and publication of the data set will be made open access via the UKCCC website.

Results

Responses were received from 35 students and 42 clinical teachers across 7 medical schools.

Student use of the EPR before and after reading the guide

Most students reported previous experience of making entries into the notes, although a smaller number were given the opportunity to do so after reading the guide (see Table 1).

Responses revealed some of the students had not, or had only recently, been made aware of the guide before being sent the survey to evaluate it. A larger percentage of GP tutors reported that students were making entries in the record after exposure to the guide, with placement change, a lack of knowledge of the guide and students not reading the guide given as reasons for not using the guidance (see Table 2).

We note that neither students nor GP tutors reported avoiding/forbidding student EPR entries now that patients have access to their EPR.

Impact of the guide

Students reported the guide provided specific instructional information students had not acquired through their education so far:

> . . . ensuring I write who the patient was discussed with (e.g. which GP/ANP) at the bottom. [Student 35, Year 5]

> Including the full written plan that was agreed with safety netting information. [Student 35, Year 5]

> I stopped using as many abbreviations. [Student 3, Year 5]

Table 1. Student responses.

	Question 1 *Have you made entries in patient EPRs before reading this guidance?*		Question 2a *Have you made entries in patient EPRs after reading this guidance?*	
	Yes	No	Yes	No
Students (n = 35)	31 (89%)	4 (11%)	13 (37%)	22 (63%)

Table 2. Educator responses.

	Question 1 *Have your students made entries in patient EPRs before reading this guidance?*		Question 2a *Have your students made entries in patient EPRs after reading this guidance?*	
	Yes	No	Yes	No
GP Tutors (n = 42)	33 (79%)	9 (11%)	27 (64%)	15 (36%)

The guide also supported students to contemplate the structure they used to document, utilising the structure recommended in the guide:

> I have changed my structure to SBAR instead of the usual HPC, PMH, DHX, etc. [Student 21, Year 4]

This quote suggests the guide enhances the application of best practice principles, which are subsequently solidified through reflection and formative feedback from supervisors, drawing on the theory of scaffolding to support learner development and mastery:

> What helped me was my supervisor checking it and reassuring me whether I was writing in appropriate depth. It was particularly useful when a completely different gp [sic] I was later paired with saw a patient I had seen previously. Looking at how they used my notes and asking for their opinion on how I filled them in was helpful as I then knew if my notes provided all the clear and legible information for forward planning the patient care. [Student 2, Year 5]

GP tutors felt that after reading the guide their students were more conscious of what they were writing, more concise, had better structure and greater confidence in documenting patient notes and had greater awareness of how it might be for the patient viewing the notes.

Support for clinical teachers which is aligned to curricula is an important aspect:

> I will use the guide with future students – identified what was current practice and what should be happening. [GP 30]

The extra challenge for students of writing up their consultations may improve the depth of their learning:

> . . . they are better at remembering the information they have been asking as they know they need to write it down rather than just report it back to me. [GP 32]

However, a minority of tutors felt no difference had been made. Reasons given were that templates were already present, or students were already competent at the task.

Suggestions for improvements to the guide

Comments have been grouped into the themes of ease of access, authenticity, content of the guide and the guide as a resource for learning.

Ease of access

Both students and teachers commented on problems with ease of access and availability of the guide, with suggestions that use of a QR code might be beneficial. In addition, circulating the guide in good time prior to a student's attachment in General Practice will help. As it becomes part of their regular support documentation this should not be an issue.

Authenticity

Students writing in the EPR are mostly in the latter years of their undergraduate programmes. They regularly document their consultations as part of an authentic role, under supervision, within the clinical team. GPs and students pointed out that authenticity matters and revisions to the guidance may be necessary. They need to practice documenting notes as they will be asked to do in the future as practising clinicians and our guide needs to support this without losing the important narrative of the patient's story.

> . . . the guide contains a lot of advice on recording details that are automatically captured by clinical software. It could be made briefer and more relevant by editing these out. [GP 6]

Content of the guide

There was a desire for the guide to be shorter, more concise and to have the key ISBAAR information as a separate document. The background material can be provided as reference to the guide and in teaching on written communication.

The guide as a resource for learning

It was suggested that placing a link to reflective templates within the guide could help students to use the guide as a resource for learning the process of reflection on their clinical entries.

Conclusions and recommendations

Medical students, and General Practitioners are beginning to adapt to the new practice of sharing their notes with patients. Early positive interactions with the EPR should be encouraged. Authenticity is key, providing opportunity for students to document consultations as practitioners do, often in a time pressured environment and using IT systems with which they may be unfamiliar. Medical notes have several roles, patient communication and empowerment being the most recent additions. The guide supports this process, but there is more to be done [26–28].

- A formal curriculum on written communication underpins the background reading required and gives the learning outcomes that would be desirable for any practitioner recording in the electronic record [29]. It supports the GMC Outcomes for Graduates regarding competencies around written

communication, including in electronic records [30].
- A more concise, readily available guide, with a separate teaching guide containing supporting material, has been suggested by this evaluation.
- Development of a 'student template' for writing in the patient record, with added sections to document clinical reasoning and record supervision, may support the outcomes needed whilst ensuring the patient narrative is not lost. Countersigning the notes needs to be standard practice.

The opening up of the EPR in the UK has extended the audience and put a third person in the digital space. There is a potential relational benefit between the patient and healthcare provider due to encouragement to write in a patient centred way. This supports the development of patient-centred clinical communication for the student. However, this is an additional cognitive load for the student. Our guide supports students in ensuring entries are fit for practice in the future.

The guide should be seen as an iterative document that will evolve through feedback from patients, students and clinical teachers on its content and clarity. The use of a Wakelet to promote active collaboration between users and developers should facilitate this process. The evaluation results have indicated the guide needs to be disseminated more widely on a national level, alongside a call for more explicit teaching on written communication within the undergraduate medical curriculum. These initiatives are hoped to better enhance both patient safety and quality of care.

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Ethical review

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