KING EDWARD'S HOSPITAL FUND FOR LONDON

Some Observations on Hospital Admissions and Records

JULY 1948

Published by
GEO. BARBER & SON LTD., FURNIVAL STREET, LONDON, E.C.4

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Prepared by officers who participated in a course arranged by King Edward's Hospital Fund for London

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INDEX

INTRODUCTORY NOTES

Arrangements for the reception and registration of out-patients and in-patients, and the mechanics of an efficient system of records, are important and complicated aspects of hospital administration which have tended to be neglected in the past. A number of hospitals have recently been reviewing their admissions system, and it was felt that their experience might be of use to other hospitals and that a general exchange of views would be of benefit to all concerned.

The Fund therefore decided to establish a short course for administrative officers to enable them to study the arrangements at certain hospitals, and Mr. S. W. Barnes, House Governor of King's College Hospital, undertook the general supervision of the course. Hospitals were invited to nominate a candidate for inclusion in the course, but unfortunately it was not possible to include all those anxious to participate as it was felt that eleven was the maximum number which could be dealt with at one time. It is hoped to arrange for a further course in the winter months of 1948–1949.

Eight hospitals were visited (see page 2), and the Fund is most grateful to the staff of these hospitals. They devoted one or two days to showing the participating officers, in the greatest detail, their registration and record arrangements, and there was not an officer who did not feel that he had learnt something of value for his own hospital.

In view of the ground covered, and the detailed knowledge acquired, it was felt that it would be of great interest to other hospitals if a Report could be prepared and circulated. The officers participating in the course (see page 2), together with Mr. Scarlett, Secretary of the London Hospital, under the Chairmanship of Mr. Barnes, kindly undertook to do this. They have met seven times. Mr. Cowan, the Records Officer of the Middlesex Hospital, has attended four of the meetings, and his expert knowledge and advice have been invaluable in drawing up their Report.

It will be realised that the conclusions reached and recommendations made are necessarily tentative, and cannot be regarded as recommendations made by the King's Fund. Suggestions and criticisms will be welcomed by the Fund as a guide to the revision of the draft.

A. MURRAY,
Secretary to the Drafting Committee,
10, Old Jewry, E.C.2.

OFFICERS PARTICIPATING IN THE COURSE

Mr. A. Brett	Steward, St. Bartholomew's Hospital.
Mr. O. R. Cross	Assistant Secretary, University College Hospital.
Mrs. M. A. Glen Haig	Assistant Secretary, King's College Hospital.
Mr. W. E. Hall	Secretary and Accountant, St. George's Hospital.
Mr. C. T. Kitching	Assistant Secretary, The Middlesex Hospital.
Mr. F. S. Lee	Steward, Westminster Hospital.
*Mr. K. A. F. Miles	House Governor, Hampstead General Hospital.
*Mr. G. A. Robinson	Assistant Secretary, National Hospital, Queen Square.
Mr. H. F. Rutherford	House Governor, The Hospital for Sick Children.
Mr. R. W. Sharpington	Chief Clerk, St. Thomas's Hospital.
Mr. B. Sloley	Assistant Secretary, Metropolitan Hospital.

* Attended the Course but were not present at the meetings.

HOSPITALS WHICH WERE VISITED

The following Table shows the hospitals which were visited and gives statistical figures for 1946 :—

	Beds open	Average daily number of in-patients	Total new out-patients	Total attendances	Average number of attendances per out-patient
King's College	438.0	355.0	43,163	246,331	5.7
London	909.3	740.5	80,728	443,575	5.5
St. Bartholomew's	393.0	362.0	54,482	270,045	5.0
The Middlesex	505.0	439.0	59,328	252,653	4.3
Redhill	636.8	543.4	42,229	162,849	3.85
Hammersmith	583	550	31,003	106,980	3.45
Miller General	172.0	143.7	32,371	176,942	5.5
The Hospital for Sick Children	185.3	176.8	39,469	126,253	3.2

APPOINTMENTS

THE ADVANTAGES OF AN APPOINTMENT SYSTEM

1. The advantages of a really efficient appointment system cannot be over-emphasized. Not only does it save the patients time and trouble, but what is not so generally realised, it simplifies the work of the hospital from several different angles. Nearly every hospital has out-grown its out-patient department; an efficient appointment system saves space and avoids overcrowded clinics. The work of the records staff is facilitated as they are able to look out the patients' folders before the clinics and obtain any special reports or X-rays that have been ordered the day before the patients are due to attend* instead of hurriedly at the beginning of each clinic. The list of patients due to attend acts as a check for tracing misplaced notes and also for counting out-patient attendances. Lastly an appointment system shows which clinics are overcrowded and facilitates the work of the ancillary departments by ensuring a steady flow of patients.

2. While we are well aware of the many difficulties involved in running an appointment system, we are convinced, after studying the systems in use at the hospitals we visited, that there is no real reason why every hospital should not have such a system working efficiently, and we hope the following notes will help to explain how this can best be achieved.

CO-OPERATION WITH THE MEDICAL STAFF

3. Of the eight hospitals visited, five have appointments for both new and old patients. The system employed and the results achieved vary considerably, and it is apparent that if an appointment system is to work well, it must have the support of the medical staff. To obtain this, it is essential to have an enthusiastic and tactful officer in charge† who will study their individual needs and gain their active co-operation. This seems to have been achieved at both King's College and The Hospital for Sick Children; at St. Bartholomew's the individual approach has been carried still further as they have different clinics allocated to different girls, but this necessitates a larger staff and in the opinion of the majority of us is a less elastic arrangement.

SHOULD APPOINTMENTS BE COMPULSORY?

4. The practice adopted at the five hospitals varies. In some cases no out-patients (except for certain special clinics—see below) are seen without an appointment unless they are referred from the casualty department as urgent cases, while in others a margin of time is left at each clinic for patients arriving without appointments. We think that the former practice is the more satisfactory, as the more complete the system the more efficiently will it work, and it helps to make the general practitioners and the patients "appointment minded." This means that a patient for whom no appointment has been made arriving at hospital, either with or without a doctor's letter and saying he feels ill, must be referred to the casualty officer (see paragraph 16). If the casualty officer considers he is an urgent case and should be seen by a consultant immediately, he is of course fitted in.

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* This may be done by the records staff, the appointment staff or the clinic receptionists; it does not matter which, but it must be somebody's responsibility.

† The number of staff in the appointment offices varies between two at Redhill and eleven at King's College, where they are also responsible for registration.

CLINICS, ETC., FOR WHICH APPOINTMENTS ARE MADE

5. All clinics and departments, except casualty and V.D., should have appointments for both new and old patients. Casualty should have appointments for old patients; this is done at King's College and The Hospital for Sick Children by booking them in 15-minute blocks, time being left for absorbing new patients. At the Middlesex there are no appointments in casualty but patients are given coloured and numbered discs which keep their places for them if they want to go out while they are waiting.

WHERE AND WHEN APPOINTMENTS ARE MADE

6. Except for maternity patients and treatment departments such as physio-therapy, there should be one central appointments office for dealing with the appointments for all the clinics and departments, so as to ensure that patients' visits are co-ordinated, both as regards fitting in visits to different departments in the same day and ensuring that special reports asked for will be available before the next consultation. At King's College and at the Middlesex the appointments office has a direct telephone line to the X-ray department.

7. At King's College there is one office for appointments and registration; the same staff deal with both and it works very well, but we feel that as a general rule the appointment staff should be responsible for appointments only, so as to minimise the risks of wrong entries and mistakes. This is the practice adopted at the other four hospitals. It is essential that appointments should be made only by the appointment staff and therefore they have to be made during office hours. It follows that the doctor is less likely to make the appointment, which is a pity (see paragraph 14), but unless there is a 24-hour service in the appointment office, which would not be justified, there is no practicable alternative.

HOW APPOINTMENTS ARE MADE

8. Appointments for new patients are made by telephone* or letter by either the doctor or the patient, or by the patient personally, and doctors' letters or chits from casualty are compulsory. The patient's full name, age and address are entered in a three-monthly book† and long-term bookings are kept in a diary.

9. While in the initial stages it is easiest to make appointments in half-hourly or even hourly blocks: the aim must be to make the appointment as near as possible to the time the patient will actually see the doctor. The number of cases booked per hour must depend on the consultant concerned and that is where the individual approach is so important (see paragraph 3). Even where routine tests are required before the patient sees the doctor, these seldom take more than 15 minutes, and except in special circumstances this should be regarded as the maximum time that need be allowed before the patient is due to see the doctor; this is a point that needs careful watching as there appears to be a tendency at some hospitals to book all patients an hour before their appointments regardless of whether it is necessary or not.

10. In some cases patients are booked to an individual member of the medical or surgical firm, while in others they are booked for the clinic. Occasionally there are separate clinics

* At King's College approximately 80 per cent. and at Redhill 50 per cent. of appointments are made by telephone.

† At The Hospital for Sick Children a book with carbon copies is used; this avoids making out another list for circulation to registration, records, out-patient sister, etc., but other hospitals find that it is more satisfactory to type out fresh lists the day before clinics are held owing to unavoidable alterations and cancellations.

for new patients and old patients, but generally they are seen at the same clinics ; some doctors like to see all their new cases first, while others prefer to have them interspersed with old cases. The practice adopted depends on the staff of the hospital concerned but it is, in our opinion, essential that every new patient must be seen by a member of the specialist staff. As a general rule registrars and house officers take all the histories.

11. Patients bring a card back from the clinic saying when they need their next appointment ; at The Hospital for Sick Children the chief marks the treatment card if he wants one of his patients transferred to his assistant. Appointments for in-patients are fixed before they are discharged.

TEACHING CASES AND PERSONALLY ADDRESSED LETTERS

12. It has been suggested that the appointment system for new patients is complicated by the necessity of reserving certain cases for teaching as it is not known which will be suitable until the consultants have read the general practitioners' letters. This difficulty has been overcome at King's College and The Hospital for Sick Children by allowing the appointment clerks to open all doctors' letters. They are informed by the consultants of the type of case likely to be suitable for teaching and make the appointments accordingly. Old cases, of course, do not present any difficulty. Consultants mark the cards or folders of patients they require for teaching and this is taken into account when making subsequent appointments.

DO CLINICS GET BOOKED UP SEVERAL WEEKS AHEAD ?

13. An argument formerly advanced against the institution of an appointments system by hospitals was that there was such pressure on their out-patient department that they would have to turn patients away if they had an appointment system. There was a feeling that to see patients by appointment took longer ; this of course is not the case providing the system is efficient and there are no gaps. On the other hand, an appointment system has the advantage of spreading cases evenly and indicating which clinics are most overloaded. Patients with doctors' letters addressed to " the Surgeon " or " the Physician," and cases from casualty, unless they are referred to an individual, are fitted in to the less busy clinics. Even so, it is inevitable that some clinics will tend to get booked up several weeks ahead, and it is recommended that the following procedure should be adopted :—

(1) The consultant concerned, and the Medical Committee, should always be advised when clinics are getting booked up a long way ahead so that the position can be reviewed. It may be possible to arrange an extra clinic.

(2) A margin of time should be left at clinics so that urgent cases can be fitted in. At The Hospital for Sick Children each clinic is notified of the number of blanks for the next four weeks, and this is taken into account when the doctors mark the patients' cards for their next appointments.

14. It is most satisfactory if the general practitioner rings up for the appointment as he can indicate if the case is urgent and it must then be fitted in. If the patient makes the appointment he must be told to advise his general practitioner of any delay.*

* At Redhill, if the date of appointment is more than seven days ahead the patient is told to tell his doctor.

CASUALTY

SITUATION AND REGISTRATION

15. The situation and registration arrangements of the casualty departments of the eight hospitals we visited are either: (1) self-contained casualty departments with their own entrance and registration office; (2) casualty departments using the receiving room or in-patient entrance and registration office; or (3) casualty departments adjoining out-patients and using the out-patient entrance and registration office.* We feel that the most satisfactory arrangement is the first one and recommend its adoption, if the geography of the hospital allows, as it is an advantage to have separate entrances for (1) casualty; (2) out-patients; and (3) in-patients, both waiting list cases and emergencies (see paragraph 41). Arrangements should be such that while patients are waiting to see the casualty officer, they are under the observation of a nurse in case they are in need of immediate medical attention.

FUNCTION

16. The casualty department's primary function, as its name implies, is to deal with real casualty cases, and it must be adequately staffed day and night with a medical man always available. In practice many hospitals use it as a sieve, and if doctors' letters and appointments are compulsory for out-patients, as we think they should be, it must continue to be so used, as patients arriving at hospital without an appointment and expecting to attend a clinic should be given the option of going to casualty. It is appreciated that the casualty officer may be less experienced than the patient's own general practitioner, but the responsibility of turning away patients should not be left to lay persons, and as the casualty department is always staffed the most practical arrangement is to refer them there. The casualty officer then decides whether they should be (1) admitted as emergencies; (2) referred to the appropriate out-patient clinic; (3) referred back to their general practitioner, or (4) treated in casualty.

17. At the Middlesex there is no limit to the number of times a patient may attend the casualty department; at Redhill, on the contrary, a patient is never seen more than once in casualty, daily dressings being carried out in another department and the subsequent attendances counted as out-patients. The policy adopted at the other hospitals varies between these two extremes.

18. In our opinion, while the policy adopted depends to a certain extent on the seniority of the casualty officer, we consider that experience shows that the casualty officer should not normally see a patient more than twice (except in the case of daily dressings—see below) as if they are not then suitable for reference back to their general practitioner a consultant's opinion is required. In the past many patients have said they cannot afford to go to a general practitioner, but this no longer applies.

DAILY DRESSINGS

19. These should only be done in hospital if special facilities are required which cannot be provided by a general practitioner. Whether they are done in casualty or out-patients depends on the geography and staffing arrangements of the hospital concerned.

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* For detailed discussion of registration see page 13.

OUT-PATIENTS

SITUATION AND LAY-OUT

20. The out-patient department, perhaps more than any other department of a hospital, grows rapidly out of date. Every change in hospital practice and treatment has its repercussions on the layout of the out-patient department. The institution of an appointment system, while making the large out-patient waiting hall redundant, entails the provision of an appointments office. The change-over to the unit system means the reorganisation of the storage space for records; the provision of medical secretaries necessitates an office with dictation cubicles; more clinics need more clinic rooms; portable X-rays and pathological facilities* in the out-patient department all demand extra space. As a result of this constant change and expansion, notwithstanding the introduction of an appointment system, every hospital we visited had overflowed, or was about to overflow, out of its out-patient department proper into some other part of the hospital building. Even at Redhill and the Miller their modern departments completed in 1939 are already too small.

21. Ideally an out-patient department should have its own entrance, with separate registration and appointment offices in close proximity,† and an easily accessible record department,‡ medical secretaries' office with dictation cubicles (see paragraph 24), almoner's office or interviewing room, and, of course, an out-patients' canteen. The smooth working of the appointment system is greatly facilitated if each of the clinics has its own waiting room, and it may sometimes be practicable to partition the large central waiting hall for this purpose. On the other hand two or three of the hospitals which we visited where appointment systems have been introduced are using the surplus space in the out-patient waiting halls for records, and while this is not ideal, as the records staff need to be in a quiet room, there is often no alternative.

22. It is, of course, realised that hospitals have to manage with the space available, but there is often nothing to prevent the improvement of the appearance of the out-patient department and the provision of amenities where this has not already been done. The dreary halls in drab colours with hard benches placed in rows would be improved out of all recognition if the walls were painted a light colour, if the benches were replaced by bright coloured comfortable chairs (possibly of the stacking variety), and if an odd table or two were provided on which papers and magazines could be placed.

FUNCTION AND SOURCE

23. As already mentioned in the sections dealing with Appointments and Casualty, we recommend that appointments and doctors' letters§ should be compulsory for out-patients. We further recommend that out-patients should be confined to consultations and special

* In a large hospital with a busy out-patient department it is a great advantage if the orthopædic clinic has its own portable X-ray, and if the medical and surgical clinics have screening stands.

† At Redhill the appointments office adjoins the out-patient waiting hall and in the wall between the two there are a number of pigeon holes labelled with the names of the different clinics and opening both ways. The notes for the clinics are placed in these by the registration clerks and are then collected from the other side.

‡ At the Middlesex, the records department is immediately below and at The Hospital for Sick Children immediately above registration, and at the latter there is a chute from records to registration.

§ The practice in regard to patients with personally addressed letters varies—in some hospitals they are seen in the first place by the honorary concerned, at others they are seen by a member of the firm but not necessarily by the honorary.

treatment which cannot be given by the general practitioner. Redhill are very strict in this respect: they work in close co-operation with the doctors of the area who understand that the out-patient clinics are purely consultative. Two-thirds of their out-patients are consultations, the remaining third being cases referred from the casualty, follow-up and ante-natal departments. At Hammersmith also patients are referred back to their general practitioner after one visit unless special treatment is required. On the whole, the voluntary hospitals appeared to be less strict and it was suggested in one instance that the ordinary general practitioner case was necessary for teaching purposes, but it seems to us that the medical student might receive instruction in these cases in casualty.

MEDICAL SECRETARIES

24. It has been suggested that medical secretaries should be in attendance on each doctor at every clinic so that all notes can be typed, but we do not consider this is a practical proposition as there are often as many as five doctors working at one clinic and it would be a quite unjustifiable waste of the secretary's time. Dictaphones might prove a solution and we understand they are extensively used in America, but of the hospitals we visited, the London was the only one with dictaphones (a limited number only). We were told that they were not very popular with the doctors but that they were useful for night work. It is therefore essential to provide a medical secretaries' office with an adequate number of dictation cubicles easily accessible to out-patient clinic rooms. While it will be necessary to a certain extent to set up a typing pool, each secretary should be allocated so far as practicable to a group of doctors as it is an advantage both to them and the doctors for whom they are working to get to know each other.

CLINIC STAFF (LAY)

25. King's College have recently appointed eight clinic receptionists attached to appointments who are responsible for collecting notes, attending clinics, taking notes to special departments (see also paragraph 62) and various non-nursing duties previously undertaken by nurses. The Medical Board consider these duties are of no value to the nurse and can be more efficiently performed by a staff that is not constantly changing. The matron has welcomed the plan as she finds that it has saved the nursing staff a great deal of running about. Redhill have two years' experience of clinic receptionists (four) and find them extremely useful especially in the obstetric department where they also act as chaperones.

26. We feel that the provision of clinic receptionists acting as a liaison between appointments and records should greatly facilitate the smooth working of both these departments. At present with the majority of hospitals the duties referred to above are performed by various different departments: nurses, pre-student nurses, porters, registration clerks, appointment clerks, record clerks—it varies in every hospital—and are often nobody's real job but have to be fitted in. It may be feasible to draw clinic receptionists to a certain extent from existing staff, though at King's College this has not been possible and while they are largely part-time they are all additional appointments.

METHOD OF COUNTING NEW OUT-PATIENTS AND ATTENDANCES

27. With the exception of Redhill who claim that their system is satisfactory, the hospitals we visited are not satisfied with their method of counting new out-patients and out-patient attendances, and they feel there is a certain variation in the practice adopted at the different hospitals, particularly in regard to attendances and treatments held on the same day. As the

Ministry have a Committee (on which the King's Fund is represented) which will be going into the whole question of hospital statistics, we do not feel that any useful purpose would be served by commenting on these variations, in view of the revised recommendations which are likely to be made by the Ministry's Committee.

WAITING LISTS

PROCEDURE

28. Apart from the few cases seen outside hospital by members of the staff, no patients should be put on the waiting list without first being seen as out-patients. At the majority of hospitals " To Come In " cards marked with the degree of urgency are filled in at the out-patient clinic, and they are then sent either direct or via the almoner's department to the waiting list office.

29. Some hospitals consider that all in-patients should be seen by the almoner, while others consider this is a waste of the almoner's time and that she should only see referred cases. Our opinion is divided on this point, but we agree that if a patient is to see an almoner, the time he (or she) is most likely to need the almoner's help is when he (or she) is recommended for admission. Therefore, where only referred cases are seen, all patients when they are recommended for admission should be handed a card advising them that the almoner is available should they require her assistance and advice.

30. Various methods of filing are adopted by the different waiting list offices ; we think the most practicable is a visible index of waiting list patients under the consultants names, and an alphabetical index, for which purpose the T.C.I. cards can be used. We do not recommend the practice adopted at some hospitals whereby waiting list patients' folders are filed in the waiting list office, as we consider this leads tc confusion and complicates the issue so far as keeping track of notes is concerned.

31. When a patient is asked to attend for admission the T.C.I. card can be used as a notification to the records department, from where it should be sent with the appropriate notes to the admissions office the day before the patient is due in.

SELECTION OF PATIENTS AND CHECK-UP ON WAITING LISTS

32. The selection of patients for admission* is at most hospitals the consultant's responsibility and one which he usually delegates to his registrar or houseman. We consider however that where a hospital employs a senior Resident Medical Officer, he should be in charge of the waiting list, as in our opinion the smooth working of a hospital is greatly facilitated if all admissions are under one senior R.M.O. (see paragraphs 36 and 39).

33. But no matter who is in charge of the waiting list, it should be a matter of regular routine to report to the Management Committee and to the Medical Committee (1) the

* The selection of cases is influenced by (1) medical urgency, (2) teaching value and cases of particular interest to members of the staff, (3) operating lists, (4) social reasons, and (5) length of waiting.

number of waiting list cases under the different consultants ; (2) the number which have been waiting over, say, three months ; and (3) the number added and admitted since the last meeting.* Periodically the allocation of beds should be reviewed in relation to the state of the waiting list, though it is of course realised that many factors have to be taken into consideration, particularly in teaching hospitals, and that it cannot be a straightforward mathematical calculation.

34. We consider that hospitals should be discouraged from putting patients on their waiting list if there is no prospect of admitting them within a reasonable time, but appreciate that it is difficult to send them back to their general practitioner with no alternative suggestion. It would be helpful therefore if some central record could be kept on a time basis of the state of the hospitals' waiting lists in each area.

NOTICE GIVEN TO PATIENTS

35. We found that as a general rule patients are not given less than 48 hours' notice, but that hospitals find it difficult to give longer notice, except at the Middlesex where the surgical wards forecast their vacant beds a week ahead, and at Redhill where the varicose veins and hæmorrhoids surgeon gives admission dates up to six months ahead.

36. We think that one of the reasons why the Middlesex is able to give a week's notice on the surgical side is because the R.M.O. is in charge of all admissions and has power to borrow beds, which makes the position much more elastic. As this is done successfully at the Middlesex, we suggest it can also be done at other hospitals.

37. When patients are recommended for admission they should, where possible, be given some idea of the approximate time they may have to wait. We are however agreed that the lay staff should be instructed, and the consultants urged, to refrain from trying to reassure the patient by under-estimating the probable waiting period. If the consultant does not really know the length of his or his chief's waiting list, the patient should be referred to the office, or officer, operating the waiting list. Patients awaiting admission should also be advised to communicate with their general practitioners if their condition becomes more serious. Patients who have to wait a long time should be written to at least every three months, and on each occasion a new forecast of waiting time would be helpful.

EMERGENCY BEDS

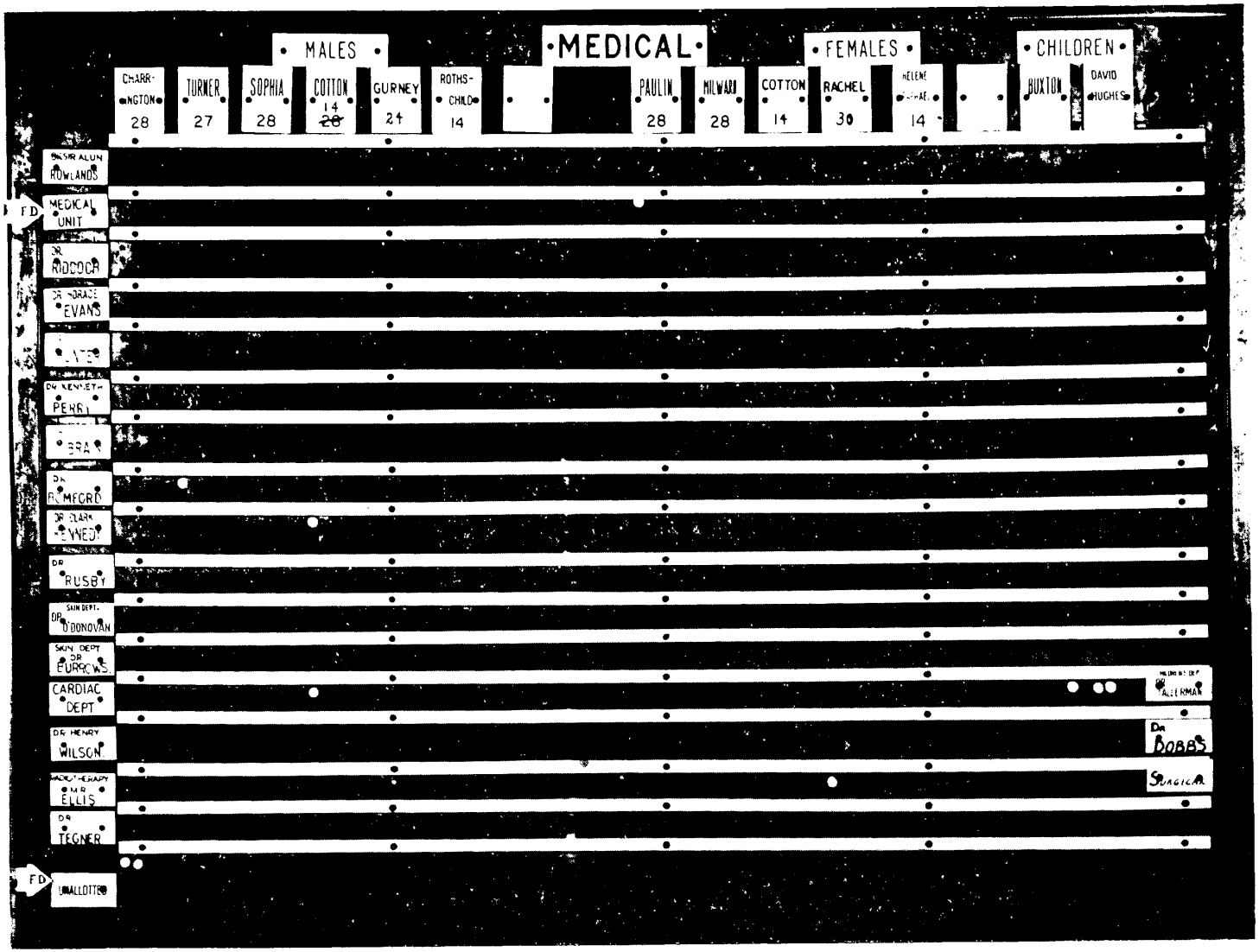
METHOD OF RESERVING BEDS

38. The following methods are adopted for reserving beds for emergencies and casualties :—

(1) A casualty ward from which patients have to be transferred after 24 hours.

(2) Full duty of firms by rota for periods of either 24 hours, three days, or a week, during which time the duty firms may stop or limit admissions from the waiting list.

* This is done at the Middlesex and many other hospitals.



BED BOARD AT THE LONDON HOSPITAL

(3) A small number of additional beds (two to four) which can be put up in a ward for emergencies.

(4) The senior resident in charge of all admissions can admit emergencies to any available bed.

While we do not feel qualified to make any firm recommendations in regard to the best method of reserving beds for emergencies, we feel that a system which has a senior resident in charge of all admissions and able to admit to any available bed must allow for the greatest elasticity and ensure the best possible use of available accommodation.

BED STATE

39. The keeping of an up-to-date running record of the bed state will be greatly facilitated if the waiting list and all admissions and discharges are under the charge of one officer, preferably the senior member of the resident staff (see paragraphs 32 and 36). Where the geography of the hospital is suitable, it will be an additional check if all patients on discharge have to report to the admissions office.

40. At the London, the admissions desk, which is in the receiving room through which all patients are admitted and discharged, has a bed board with coloured pegs which shows whether a bed is (1) empty and unallocated; (2) empty but allocated—this is known, as the admissions officer is in charge of the waiting list office; or (3) full but due to be empty—this is known, as the ward sister sends a chart down each morning which shows the beds allocated to the different consultants with a forecast as to when they are likely to become empty. This chart acts as a physical check from the ward and is in place of the usual midnight bed return. The bed board shows where the beds are and to which firm they belong, and the medical officer in charge of admissions, or the lay officer acting on his behalf, can admit to any empty bed. The patient is automatically transferred to one of the full duty officer's beds as soon as one becomes available. We were impressed with the bed board at the London and think that all hospitals should install something similar. We understand that King's College and the Middlesex are instituting a bed board which will not only show vacant beds, and beds about to be vacant, but will also give the names of the patients in the occupied beds.

IN-PATIENTS

RECEPTION

41. The method of admission will depend on the geography of the hospital. In some hospitals ambulant cases will come in at one entrance and stretcher cases at another; in some the division will be between emergency admissions and waiting list cases, and in others all in-patients will arrive at the same entrance. In our opinion the latter is preferable as it is important that there should be one office with adequate staffing arrangements whose first responsibility is that of dealing with the admission of patients. This facilitates the reception arrangements and is useful from the administrative point of view, as it enables the admissions office to keep a complete check of all admissions, except of course when cases are sent up from casualty, in which event the casualty department must be responsible for notifying the admissions office.

42. The reception of patients is, we consider, of the utmost importance both as regards emergencies and waiting list admissions. In some hospitals, possibly due to the shortage of staff, it is still the practice to direct ambulant patients to the wards. Every effort should be made to escort all patients to the wards, for when they first arrive they may well feel strange, some may be depressed, even frightened, and may need comforting and some reassurance which can well start with a sympathetic reception. As in the case of registration clerks (see paragraph 47), the choice of personnel is important.

43. In some hospitals emergency admissions are sent straight to the ward, while in others they are first examined by the casualty officer. Where the latter is the practice it is essential that there should be proper examination cubicles, and that the patients should not be left in the corridor while waiting to be examined.

FORM FILLING, ETC.

44. In addition to all the registration particulars, the aim should be for the admissions office to relieve the ward of as much clerical work as possible. The admissions office should check the administrative part of the case sheet (or if in-patient notes are separate, make out an in-patient case sheet) and the "To Come In" card; it should also deal with N.H.I. certificates and collect the ration books. The notes and the T.C.I. card* are then sent to the ward with the patient, and the cards can be clipped together and used as the sister's ward register. This is done at the London and works well.† In our opinion the ward sister must still be responsible for getting patients to sign the consent to operation form where necessary, for listing valuables and clothing, and for seeing that the appropriate resident is advised of each new admission. The ward will also have to send down a midnight bed return, or a chart as at the London (see paragraph 40).

NOTIFICATION OF RELATIVES AND TELEPHONE ENQUIRIES

45. In all the hospitals we visited the ward sister is responsible for seeing that relatives of emergency admissions have been notified, and for informing relatives of dangerously-ill patients and of deaths. We consider the provision of a room for interviews to be a necessity.

46. The practice adopted at the different hospitals in regard to telephone enquiries varies. We were surprised to find that at a number of hospitals the sisters have the calls put through to the wards as they say it is so much more comforting for the relatives to be able to speak to them rather than having to be satisfied with a message relayed from the wards, as the information given is fuller and more accurate, and that on the whole the privilege is not abused.‡ There is, of course, no doubt that it is far more satisfactory for the relatives to speak direct to the ward-unit, and as this is done in many hospitals without any great difficulty we suggest that all hospitals should introduce the practice.

* In some hospitals the T.C.I. card is used as an advance notification of admission to the wards, but where there is that close contact between the R.M.O. and the ward sister which is desirable, this should be unnecessary.

† The sisters we spoke to at the other hospitals did not seem to like this idea, but we feel it was because they had not tried it.

‡ At Redhill ward sisters reply only to doctors, parents, guardians, husbands and wives.

REGISTRATION

REGISTRATION STAFF

47. The patients' opinion of the hospital will be largely formed by the way they are treated on registration. It is probably their first personal contact with the hospital staff, and the greatest care should therefore be taken in choosing registration clerks. They need to be tactful, kind and patient, with a pleasing personality.

48. The records department and the registration office should be separate as we consider that the same staff should not be undertaking both duties.* The bustle of registration is not conducive to good filing and, equally, searching for missing folders does not encourage a calm and pleasant attitude towards patients. This does not mean that the staff should not be interchangeable. During rush hours it may be advisable for the records staff to help with the registration, and it is always an advantage to have members of the staff conversant with different aspects of hospital organisation. It makes the work more interesting, helps them to appreciate the difficulties with which other departments have to contend if they make a mistake, and allows for greater flexibility in organisation. At Redhill the clerical staff work in each department in turn as a matter of routine.

METHOD OF REGISTRATION

49. However charming and tactful the registration clerks may be, the patients' faith in the efficiency of the hospital will be shaken if they are asked for more or less the same information every time they go to a new department. If the maximum use is made of the unit system (paragraphs 60–67) it is not necessary for patients to be asked for the same information more than once. The administrative part of the case sheet and the central index card are filled in at their original registration (unless they come through casualty), and this information can be copied by other departments as required.

50. But this does not get over the difficulty whereby the same information, with slight variations, is taken down by several different departments. This irritates the patients and is a waste of manpower which we feel can be avoided, or at any rate reduced, so we have studied existing arrangements to see if a method can be devised whereby it will be possible to take sufficient copies of all the usual particulars at the original registration for circulation to the different departments likely to be interested. Ideally this information should be typed.

51. The wide variation in the methods adopted at the different hospitals we visited shows there is no easy solution. Every department needs slightly different information. When patients register it is not known how many departments they will have to visit, or whether they will eventually become in-patients. To provide all the information which might be required would be a waste of paper.

52. Some hospitals have installed a manifold machine for the registration of in-patients, as an attempt to arrive at a partial solution to the problem. The usual admission particulars are written out by hand in one operation, and five slips are produced and sent to interested departments, i.e.,Ward, Registry, Almoner, and in the case of St. Bartholomew's, the Steward's

* Of course, in a small hospital it may be necessary for the same clerk to undertake registration, records, and even appointments.

Office and the Assessment Bureau, and of the Middlesex, the Chaplain and the Resident Medical Officer. This machine is a step in the right direction though it is only used for in-patients and has obvious disadvantages :—

(1) The information is written by hand and the operator has to press hard if the bottom copy is to be distinct. Again, from the point of view of clarity, much depends on the handwriting of the operator.

(2) The slips are only flimsies and therefore not well suited for filing purposes. In any case it involves the independent preparation of an index card, and where the departments concerned have their own record sheets the information has to be copied out again.

53. An alternative and more efficient method is an attachment which can be fitted to any standard typewriter. This will type the required number of copies, the last being on a thicker substance so that it can be used as an index card. The stationery is continuous, is interleaved with carbon paper, and may be obtained in any desired form. Continuous stationery eliminates entirely the work of inserting carbons between a number of sheets and the slipping of these sheets and carbons in the machine, thus throwing the sheets out of alignment. A number of firms supply this device.

54. Some American hospitals are using a " Ditto " machine, the principle of which is quite different from the above. A master card is typed with a special ribbon and this card is placed in the machine. Depending upon the position of the card in the machine, and the covering up of certain parts of the card, all or any of the information on the master card is transferred to the various sheets as they are inserted one by one. The master card is used as the index card. Particulars of this machine are being obtained from America as so far all enquiries in Great Britain have failed to secure any information.

55. It is obvious that the whole subject (paragraphs 49–54) needs much more attention than has hitherto been given to it in view of the duplication of work at present undertaken by different departments.

CASUALTY REGISTRATION

56. Even with the unit system, the casualty department will need to keep its own card index (see paragraph 64) ; this and the casualty case card will need to be filled in on the patient's first attendance.

OUT-PATIENT REGISTRATION

57. We have already recommended that the registration staff and the records staff should be separate (paragraph 48). Where the unit system is in use, patients on their first registration as out-patients are entered in the central card index* and given (1) a folder with their name and number ; (2) a combined doctor's and attendance card (see paragraph 76) ; and (3) a case sheet. If patients are referred to a different clinic there should be no need for them to be issued with any more cards, although they will again count as new patients, as the name of the new

* King's College have a duplicate perforated registration book. The top copy goes with the notes ; the flimsy is kept as a check.

clinic can be written on the appointment card, or coloured stars can be used as at Redhill (see paragraph 80). A new case sheet is required but this is clipped on to the previous one, and it is therefore not necessary to repeat the administrative details.

IN-PATIENT REGISTRATION

58. In-patients should be registered on a manifold machine. Where patients have been sent for from the waiting list the admissions office will already have their notes, and if the unit system is in use no further administrative particulars will need to be made out, as continuation sheets will be used. One of the manifold machine admission slips will advise the records office of the admission of emergencies and of patients sent in direct by consultants. The records office will then make out the index card and case sheets and send the latter to the ward. The manifold machine flimsies used for notifying the different departments of the arrival of patients, should be filed in binders by the departments and kept as their record of patients to save making out cards. This practice has been adopted in several hospitals.

59. At Redhill, in-patient notes and out-patient cards are kept separately. On admission each patient is given an index card or an entry is made on his existing index card if he or she has been in hospital before. On discharge, in-patient notes are sent to the records office and numbered and filed in folders, pending binding in volumes. The final number for the year equals the number of patients treated to a conclusion each year, as a yearly numbering system is used.

METHOD OF KEEPING NOTES

THE UNIT SYSTEM

60. The unit system, i.e., one number for ever, one folder, and one central index, was first initiated in the U.S.A. and adopted over here originally by St. Bartholomew's and then by the Middlesex. Of the other six hospitals we visited, The Hospital for Sick Children and Hammersmith have also adopted the unit system, and King's College and the London were in the process of changing over to it. Redhill, on the contrary, consider that the unit system is extravagant in labour and material without any compensating advantages. They have out-patient cards, with in-patient abstracts attached, and this they say is all that is required in out-patients as consultants would not want to be bothered with looking through bulky folders even if they were there. They feel that having to produce folders for every clinic would mean a lot of extra work, that a folder for every out-patient and new filing cabinets would be an unjustifiable extravagance and that the separate system facilitates the weeding of notes because out-patient notes are kept only for five years. Finally they claim that if in-patient notes are bound they are less likely to be lost as volumes are booked out to borrowers and are quickly and invariably traced. Each volume contains the notes of 100 patients and is easily handled. Although much research work is done the current notes plus one bound volume are required only occasionally and two volumes together very rarely.*

61. There is no doubt that the Redhill system appeared to be very simple† and to be run with less staff than at the other hospitals‡; the cards used for out-patient notes and for

* On only about three occasions in the past year did two doctors require the same volume simultaneously.

† There are some 10,000 discharges per annum and they claim that over a 20-year period the notes of any patient are produced in less than 30 seconds.

‡ For the in-patient and out-patient records offices and the appointment office only eight persons are required.

casualty notes were filed alphabetically, which obviates the need for a card index. While we appreciate that the present-day tendency in hospital for greatly increased staff in all directions is one which must be very carefully watched to ensure that the results justify the manpower involved, we do not agree that the change-over to the unit system, once the initial reorganisation has taken place, will in itself lead to an increase in either staff or material. The Redhill arguments are largely based on the supposition that cards are used for out-patients, but the medical staff of most hospitals would not be satisfied with this. Where there are already out-patient folders, the change-over to the unit system will mean a saving in folders, and when all notes are filed in one place instead of two, it should also lead to an economy in filing staff; though in practice this has not always happened as it depends on the standard of efficiency of the old system. Hospitals which change over to the unit system often take the opportunity to improve their standard of record keeping generally, and any extra staff employed has followed from this improvement rather than from the adoption of the unit system.

62. Another argument often advanced in favour of keeping in-patient and out-patient notes separately is that the unit system necessitates the provision of additional messengers, as patients are no longer able to handle their own notes. But we do not attach any weight to this argument as we consider that patients should not be allowed to handle their own notes under any circumstances (they are not allowed to at Redhill), as while in theory patients are only handed notes with nothing frightening written on them, in practice a mistake may be made, or patients may misconstrue the medical terms. The use of sealed folders is no solution as some patients open them and read them while waiting for their clinics. We therefore think that whatever system is in use there must be sufficient messengers (clinic receptionists where these are provided, see paragraph 25) to ensure that patients never handle their own notes.*

63. We therefore recommend that hospitals should change over to the unit system. It is appreciated that this will involve a reorganisation of the storage space for records, but we feel the advantages are such that every effort should be made to adopt it. The unit system gives a complete hospital history of the patient which ensures continuity of treatment, and it also facilitates research activities. The mechanics of note keeping are simplified as all the notes belonging to each patient are in one place, and one central index makes it easier to check up whether the patient has been in hospital previously.

THE UNIT SYSTEM AND CASUALTY

64. All special departments and casualty should be included in the unit system, and there should be no subsidiary numbering system.† It would of course be too extravagant for all casualty patients to have folders, so they should have numbered casualty cards, for which a block of numbers should be allotted, e.g., at the Middlesex the numbers start with a letter and run from 1–100,000, and the numbers with the prefix "C" have been allocated to casualty. Patients referred to the out-patient department should be sent across with a chit giving a précis of the case, and the cards should remain in casualty. Casualty would need to keep its own alphabetical card index as the central index would merely have a note of the block of numbers allocated to casualty.

* In America we understand conveyor belt and pneumatic tube systems are in use in the newer hospitals for the transport of notes.

† Articles by Professor Hogben have recently appeared recommending that there should be a system of medical documentation which makes provision for identification of individual patients whatever hospital they are admitted to throughout the country, i.e., by a system of numbering based on the christian names, surname and date of birth of the patient. This is a National matter on which we do not feel qualified to give any firm opinion, but it does not appear to us to be sufficiently foolproof.

THE UNIT SYSTEM AND THE SPECIAL DEPARTMENTS

65. Patients referred to special departments are already registered, and the hospital number is used on their report forms which are filed numerically. The fact that there are gaps is of no significance as it is not intended that the unit system should be used for a check of numbers attending. The special departments would need to keep their own alphabetical index, and request cards might be used for this purpose (see paragraph 76).

66. Duplicate reports of the special departments are, of course, filed in the patient's folder, except for the almoner's department where there is a tendency to regard the notes as confidential and not of sufficient interest to file in the main folder. At the Middlesex, an abstract of the almoner's social report is now incorporated in the medical report.

THE UNIT SYSTEM AND BRANCH HOSPITALS

67. With the grouping of hospitals under Management Committees, the question arises whether all the hospitals in one group should be included in the same unit system. This will probably depend on whether the hospitals are functioning as independent units, or whether they are being used as branches of the main hospital to which patients are being transferred. In the latter case they will of course have to be included in the same system, and if they also admit direct, blocks of numbers can be allocated to them as in the case of casualty.

CURRENT AND DEAD FILES (OR ACTIVE AND INACTIVE)

68. While in theory a patient never changes his number under the unit system, in practice some hospitals renumber a patient when he reappears after a long interval* and his folder is automatically transferred to the current files. Other hospitals transfer patients' folders without renumbering them into a current file specially kept for old numbers. Both methods have certain advantages and disadvantages, and we think it is a matter for the individual hospitals to decide for themselves.

PERIOD FOR WHICH NOTES ARE KEPT AND MICROFILMING

69. The length of time notes are kept varies considerably. We feel it is a matter for the medical staff to decide though, in practice, space is often the limiting factor, and it is probable that few hospitals are able to keep notes for as long a period as the medical staff consider desirable. Very old notes are often found to contain material of great value. One solution to the problem, which has been adopted by the Middlesex, is microfilming on 16 m.m. films. The machine can be hired at a rent of £72 per annum, and each viewer costs £6 per annum. Two films are taken at the same time and the cost of microfilming each page of notes works out at .048 of a penny.

70. Opinion varies as regards the time records should be kept before being microfilmed and destroyed. At the Middlesex they are starting with patients who have been dead for over five years, and they are then going on to patients over 75 who have not attended for five years, as they want to minimise, so far as possible, the likelihood of patients, whose records have been destroyed, turning up again. It is, however, possible, if this does happen, to have enlarged photographs taken from the films† and hospitals may prefer to adopt a more straightforward

* They claim that renumbering simplifies the turning out of old notes.

† A viewer can be kept in out-patients so that the medical man concerned can look at the films and decide if he wants them photographed, but the cost of reproducing notes in any large quantity would be expensive.

policy of going through the notes from the earliest numbers and microfilming all those who have not attended in, say, the last five years.

71. The central card index continues to be used for the notes which have been microfilmed,* the card is stamped " microfilmed " and the number of the spool is entered on it. At the Middlesex two films are taken ; the first spool is left intact and used as a control ; the second spool is cut up in lengths that cover a complete set of notes and these lengths are filed numerically in envelopes marked with the notes' old folder number. They also keep a special microfilm index as an index for the spools which are not cut up. If a doctor wants a special series of cases for research, the numbers are selected from the diagnostic index in the usual way and the appropriate film sections are then taken out of the file and spliced together.

72. The microfilm can only be looked at with the aid of a viewer, but this technique is in its infancy and it is expected that great developments will shortly be made.

WEEDING NOTES

73. A difficulty of which the majority of hospitals seem to be conscious, and which particularly arises with the unit system, is the vast amount of material which accumulates in a patient's folder. We consider that in many cases four-hourly temperature charts need not be kept, and that gummed slips should be used for blood counts and pathological and X-ray reports so that these can all be stuck on to one sheet, or alternatively stuck on the case notes in chronological order. It should be the records officer's responsibility to see that this is done.

74. At the Middlesex, letters from the patients' own doctors are considered an important part of the case history ; at the other hospitals the view is that they are seldom of interest and as a rule can be destroyed. The practice adopted at the teaching hospitals in regard to students' notes also varies ; some consultants consider they are of great value and have them filed, while others have them destroyed. At the Middlesex, tinted paper is used for the students' notes, anything of value is incorporated in the abstract, and they are then returned to the student concerned. We feel that these are matters which must be decided by the medical staff of the hospitals concerned.

USE OF CARDS, STATIONERY AND FOLDERS

75. There are few hospitals which could not reduce the number of cards and slips in use, as these were often started as part of a system which has been so changed that they are no longer necessary. This is not however apparent to the people responsible for their daily use who often have little idea of what happens to the cards once they leave their own department. In this connection, as well as in many others (see paragraph 100), there is no doubt that somebody with an overall responsibility would be most helpful.

76. At the majority of hospitals there seemed to be a certain amount of duplication, two cards being used when it appeared that one would have done, i.e., a request card and an index card ; an appointment card and an attendance card. In other hospitals the request card is used as an index card by the department concerned, and the appointment card is used as an attendance card, and we recommend that these practices should be universally adopted.†

* When the central card index becomes too unwieldy it can be subdivided into a current and a non-current index.

† At The Hospital for Sick Children, patients on their first attendance are handed stiff treatment cards which the doctors use as request forms, and on which prescriptions are written. Patients take the card to the various departments with them, and hand it in at the last one. It is handed to them at all subsequent visits and the date is stamped on it every time it is reissued. It also acts as a check for the clinic nurse collecting special reports.

77. At the Middlesex, prescription slips with carbon backs are used, and these are copied on to the casualty cards and the case sheets. Before the war Westminster installed a pneumatic tube system for sending prescription slips to the dispensary but it has not proved satisfactory.

78. It is of the utmost importance that there should be a standard size for case sheets throughout the country, and we consider that the quarto size should be adopted. In regard to the standardisation of design, while we think it is desirable, but not essential, within a hospital,* we think it would be premature to consider any standardisation of design as between hospitals,† as we believe that the adoption of rigid standards for case sheets would damp all initiative and have a stultifying effect on progress. It is important that hospitals should continue to be allowed to try out new methods and new ideas if we are to avoid a common standard of mediocrity.

79. The Hospital for Sick Children have thin cardboard case sheets in the form of folders, but we consider they are too expensive and too bulky to be a practical proposition.

80. The use of coloured folders and cards to denote male and female, medical and surgical, special departments, etc., was much in evidence. We think it is useful to a limited degree, but there is a serious danger of becoming too elaborate and it has the following disadvantages: (*a*) it is difficult to ensure uniformity of tint over a period of years; and (*b*) it gives rise to difficulties in microfilming. A coloured background to the serial number on the folders is a useful aid for filing, and it is also helpful if these numbers are broken down into groups of three, a space being left where a comma would normally go. At Redhill, coloured discs are stuck on out-patient cards to denote which clinics patients are attending. They say this has the advantage that the discs can be changed or added to when patients are referred to new clinics.

81. The hospitals hold very different opinions as to the relative merits of filing notes on string hinges, by sticking, by stapling and filing loose. After carefully considering the advantages and disadvantages, the majority of us feel that the best method is for notes relating to different chapters of the patient's attendance to be stapled together, and for these to be filed loose inside the folders. Hospitals that adopt this practice report that they have no trouble with notes being lost by falling out of folders.

KEEPING TRACK OF NOTES

82. Keeping track of notes once they have left the records department is a problem which faces every hospital. The London use tracer cards and "book" notes that are given out, but most hospitals consider the double check unnecessary. Notes for appointment clinics are got out the day before, and the appointment list is used as a check. We think the important thing is to keep the system as simple as possible and to concentrate on seeing that it is enforced. In addition, we do not think that any form of double check would justify the labour involved; we therefore recommend:—

(i) that appointment lists should be used for checking notes given out to appointment clinics (see below);

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* It is a matter which might be considered by the Records Committee (see para. 87).

† This, of course, does not refer to the special report slips to which reference was made in para. 73.

(ii) that tracer cards should be used for any other notes given out of current files, and that the files should be looked through regularly to check up on notes that have been out a long time ;

(iii) that a book should be used, and a signature obtained, for notes that are wanted from the old files for research purposes.

83. One of the biggest difficulties is keeping track of notes which are not immediately returned after out-patient clinics, either because the patient has been referred to another department or because the consultant has taken them to write to the general practitioner.

84. The clinic receptionist should help to overcome these difficulties. She will have an appointments list and if notes have gone to a special department, or to the medical secretaries' room,* she should mark her list accordingly. At Hammersmith there is a rule that all notes have to go back to records immediately after a clinic. If a letter is required a large card marked DOCTOR'S LETTER is inserted in the folder, and the notes are then reissued to the medical secretary of the appropriate department. It undoubtedly facilitates keeping track of notes if there is a rule that they must not be transferred direct between departments, but have to be returned to the records department for reissue.

85. No one outside the records department should have access to the notes during office hours. After hours the records department should be kept locked ; any person requiring the notes should have to sign for the key, and in addition place a tracer card for notes taken out on top of the appropriate filing cabinet. The records department should automatically be notified the following day if anybody has had the key during the night, and if no tracer card is out they should check up with the person concerned and find out what notes have been taken.

MEDICAL RECORDS

RECORDS COMMITTEE

86. Medical records are a technical matter about which a great deal has been written in recent years, and we are in no way qualified to deal with the medical aspect excepting in so far as it affects the organisation of the records.

87. A successful records department must have the backing of the medical staff. The clinician will decide and record the data he requires and should be guided by the records officer in the best recording methods so that the record can be of the greatest use. The Medical Committee can best demonstrate its support by appointing from its members a Records Committee, to which should be added the chief administrative officer and a representative of the nursing staff, preferably a ward sister,† to ensure that the effect of any recommendations from the nursing staff point of view will be considered. We therefore recommend that every hospital should have a Records Committee. The function of the Committee, which should be led by a strong chairman, should be to define policy so far as the medical side of the records is concerned and to take such steps as may be necessary to ensure that the hospital's policy on medical records is adhered to. The Committee may find it necessary to carry out a restrictive

* An adequate supply of medical secretaries with an easily accessible office will go a long way towards removing the temptation doctors have to take the notes home with them.

† The Middlesex have such a Committee and it works very well.

function to prevent records becoming more elaborate than common-sense dictates. It must always be remembered that records are for the benefit of the hospital and not *vice versa.*

RECORDS OFFICER

88. The records should be in charge of a responsible lay officer who has the necessary experience and personality to secure the active co-operation and interest of the medical staff. This officer will act as secretary to the Records Committee. It is essential that the records officer should have a suitable background of training and experience,and it must be emphasised that it is no use appointing an amateur to take charge of what has become a highly technical branch of hospital administration. We appreciate that there is at present no recognised training for records officers, and there is a great need for some regularised course to be agreed upon. We hope that King Edward's Hospital Fund may help in this direction.

ABSTRACT

89. In all the hospitals, after in-patients are discharged their notes are returned to the records department. In some hospitals the ward sister is responsible for sending them there, in others the records department is responsible for collecting them. In some hospitals they go direct, in others via the R.M.O.'s office or the Medical Superintendent's office. This is a domestic matter which will depend on the different circumstances of the various hospitals, but we feel that all things being equal it is probably easier for the records department to keep track of the notes if it is responsible for collecting them, and from the same point of view the notes should certainly be returned to the records department before they are issued to the appropriate office for the abstract to be written.

90. In the larger hospitals the registrar of the firm concerned should be responsible for writing the abstract. This should be typed by the medical secretaries and one copy should be filed with the notes, one sent to the patient's general practitioner (with a covering letter if considered necessary), and one to the consultant concerned. The abstract should normally be completed in two or three days, and should not in any case take longer than ten days as it is important to get the notes back to the records department before the patient concerned attends out-patients.

DIAGNOSTIC INDEX

91. At the eight hospitals we visited three different classifications were used: (1) the Standard Nomenclature of Disease and Operations of the American Medical Association; (2) the M.R.C.'s Nomenclature; and (3) the Nomenclature of the Royal College of Physicians. We were most impressed with the progress made at the Middlesex in regard to medical records, and we have accepted the opinion of their Records Committee that the Standard Nomenclature of Disease and Operations is the most suitable for scientific purposes* (see Appendix). It is desirable for a uniform nomenclature to be adopted if useful comparisons are to be made.

92. At the hospitals we visited only in-patient notes were indexed, except at the Middlesex, where they have started on out-patients attending E.N.T. and skin clinics: they may ultimately include others but are of the opinion that the majority of out-patient diagnoses are too provisional

* The Ministry of Health may recommend certain standard statistics for all hospitals, but the Standard Nomenclature of Disease and Operations is so comprehensive that it can easily be broken down into any classification which may be required.

to be indexed. It has been suggested elsewhere that out-patient notes are more important than in-patient notes for indicating health trends as the latter only represent isolated incidents in people's lives; but if out-patient notes are to be used for this purpose it would also be necessary to take into account the general practitioner's notes. In any case, hospital patients in teaching hospitals are never likely to represent a true cross section of the population, as the kind of cases admitted is influenced by the particular interests of the members of the staff. The main purpose of the diagnostic index is to facilitate research into a particular kind of disease. The records officer should be responsible for keeping the diagnostic index. The diagnosis should be recorded in the index every time a patient's folder returns to the records department after a period of in-patient treatment. Special administrative arrangements must be made for recording diagnoses of out-patients when these are being indexed.

93. The Middlesex, St. Bartholomew's and the London have recently installed punch card machines.* They feel that the installation can be of great service to the medical staff as it enables the available information to be classified under a wide variety of headings, both clinical and administrative, which can greatly assist research. It can also undertake special investigations, such as research into wound infection, with a minimum of additional labour, provided the medical staff concerned decide at the outset the general scope of the proposed investigation. Special cards are then printed which are sufficiently comprehensive to reduce considerably the time spent by the doctor in referring to the notes. It is emphasised, however, that the machines can produce research material no better than the records from which it is drawn, and a successful machine installation can only be superimposed on a first-class records system. The range of usefulness of machines is very wide, but the approach must be cautious and care taken not to get carried away and produce a lot of material which will never be used.

94. Even if the punch card machine is used for general work,† only the largest hospitals or group of hospitals would be justified in installing one. An index such as the visible leaf system is excellent for indexing the Standard Nomenclature where there is no punch card machine. Coding of the usual administrative details required for ordinary statistical purposes is facilitated if the top half of the case sheet is standard for every firm.

FOLLOW-UP

95. The importance of an efficient follow-up service for certain types of cases is becoming more generally recognised. It has a threefold purpose: (i) treating the sick; (ii) teaching; and (iii) research. If full advantage is to be obtained from medical records, patients must be kept under observation so that the history of their particular illness can be followed through to the end. St. Bartholomew's and the Middlesex both have very active follow-up departments. At the latter hospital the department follows up cancer cases, non-toxic goitres, duodenal ulcers and warts.

96. The mechanics of a follow-up system should be the responsibility of the records officer. At St. Bartholomew's, as soon as a clinician makes a diagnosis which is due for follow-up, the out-patient clerk stamps the folder "refer to F.U." As an additional check all folders are gone through by the records staff and stamped "refer to F.U." or "passed by F.U." Unmarked folders are automatically gone through every time a patient attends. An all clear stamp is put on when it is found the patient is no longer suffering from the disease which is being followed up, or when the diagnosis of such a disease is not confirmed.

* At the Middlesex, the cost of installing two punching machines, one verifier and one sorter, was £2,000. They have a staff of two punch card operators, two transcribers and one shorthand-typist.

† At the Middlesex, almoners' records, anæsthetist's records and inventories are transcribed.

97. At the Middlesex the follow-up staff attend out-patients clinics concerned with their type of case. It is considered an advantage for the clerks to meet the patients with whom they will be dealing, and they register their patients, give them a green attendance card, and put a green corner on their folders. At the same time they ask the patients for the name and address of their private doctor and of two relatives.

98. A card index is kept of follow-up patients showing which group they are in and also any notes regarding special circumstances, i.e., " patient difficult, won't be followed up," etc. A site card is kept for carcinoma cases and filed under the site of carcinoma with a brief summary as a safeguard against lost notes. Once a year, or on the death of a patient, this information is entered in code on a card for transcription. Follow-up clinics are held at regular intervals, and after patients have been discharged from hospital, their doctors are written to annually and asked for a report on their condition.

CONCLUSION

99. The surprising variety in the different methods in use at the hospitals we visited, and the fact that they were themselves rarely satisfied that they had the final answer, underlines the complications of the subject and shows that no easy solution is available. The situation is fluid and it is right that hospitals should experiment. Every system must depend on factors which vary from hospital to hospital, such as tradition, geography, the kind of work undertaken, personnel, etc. The ideal system will break down with the wrong person in charge, and *vice versa*. No hard and fast rule can therefore apply. At the same time, we thought it would be more helpful to hospitals if where possible we made definite recommendations. Some of these apply to the larger hospitals only, but as a rule the larger the hospital the more complicated the problem, and we thought it better to concentrate on them in the first instance.

100. One thing that struck us very forcibly was the value of the " fresh eye " and the need for the different departments concerned to be looked at as a whole. There was a tendency for forms, etc., to be filled in because they always had been, and because it was nobody's responsibility to consider whether they were still really required ; equally, there appeared to be a certain amount of unnecessary duplication. At several of the hospitals we visited this was brought home to their officers by our questions. We therefore very strongly recommend that a senior administrative officer should be in charge of the appointments, registration, records, and medical secretaries, and should be responsible for the lay staff dealing with waiting lists, admissions and discharges. This officer should have an exact knowledge of the procedure in use not only at his own hospital but at several other hospitals undertaking comparable work : without such comparative data his supervision will be of very limited value. The appointment of a senior R.M.O. to take charge of waiting lists, admissions and discharges, which we have already recommended, should still further facilitate the co-ordination of the different departments.

S. W. BARNES,
Chairman of the Drafting Committee.

July, 1948.

SUMMARY OF RECOMMENDATIONS

APPOINTMENTS (Paragraphs 1 to 14)

Every hospital should have an appointment system for both new and old out-patients. It is essential to have an enthusiastic and tactful officer in charge who will gain the co-operation of the medical staff. Appointments should be compulsory for all out-patient clinics, with the exception of V.D. Casualty should have appointments for old patients. There should be one central appointments office for dealing with all appointments, except for maternity and treatment departments. The appointments staff should deal with appointments only and no appointments should be made by anybody else. In the initial stages appointments may be made in half-hourly blocks, but the aim must be to make the appointment as near as possible to the time the patient will see the doctor. Fifteen minutes should be regarded as the maximum time necessary for routine tests which are required before the patient sees the doctor. Every new patient must be seen by a member of the specialist staff. If clinics get booked up several weeks ahead the consultant concerned and the Medical Committee should be advised, and a margin of time should be left when booking cases for these clinics, so that urgent cases can be fitted in. If the patients make the appointments they must be told to advise their general practitioners of any delay.

CASUALTY (Paragraphs 15 to 19)

If the geography of the hospital allows, the casualty department should be self-contained with its own entrance and registration office. Patients waiting to see the casualty officer should be under the observation of a nurse.

The casualty department must be adequately staffed day and night. Patients arriving at hospital without an appointment, and expecting to attend an out-patient clinic, should be given the option of going to casualty, as the responsibility of turning away patients should not be left to lay persons.

The casualty officer should not normally see a patient more than twice, except in the case of daily dressings, which should be done in hospital only if special facilities are required which cannot be provided by a general practitioner.

OUT-PATIENTS (Paragraphs 20 to 27)

Ideally the out-patient department should have its own entrance with separate registration and appointment offices, easily accessible records department, medical secretaries' office, almoner's office, out-patient canteen and separate waiting rooms for each of the clinics. Walls should be painted a light colour and benches replaced by bright-coloured comfortable chairs.

Out-patients should be confined to consultations and special treatment which cannot be given by general practitioners, and appointments and doctors' letters should be compulsory.

As it is not practicable to provide medical secretaries for each doctor at every clinic, it is essential that the medical secretaries' office, with an adequate number of dictation cubicles, should be easily accessible to the clinic rooms.

The provision of clinic receptionists acting as a liaison between appointments and records should facilitate the smooth working of both these departments.

WAITING LISTS (Paragraphs 28 to 37)

Apart from the few cases seen outside hospital by members of the staff, no patients should be put on the waiting list without first being seen as out-patients. All patients when they are recommended for admission, if they are not automatically referred to the almoner, should be handed a card advising them that the almoner is available should they require her assistance and advice.

One of the most practical methods of filing is a visible index of waiting list patients under the consultant's name, with an alphabetical index of the " To Come In " cards. When a patient is asked to attend for admission, the " T. C. I." card can be used as a notification to records, whence it should be sent with the appropriate notes to the admissions office.

The smooth working of a hospital is greatly facilitated if there is a senior R.M.O. in charge of the waiting list and admissions. The state of the waiting list should always be reported to the Management Committee and the Medical Committee, and periodically the allocation of beds should be reviewed in relation to the waiting list. Hospitals should be discouraged from putting patients on the waiting list if there is no prospect of admitting them within a reasonable time.

When patients are recommended for admission they should be given some idea of the approximate time they have to wait and advised to communicate with their general practitioners if their condition deteriorates. They should be written to at least every three months when a new forecast of waiting time should be given. It should be possible to give surgical cases a week's notice, and other patients not less than 48 hours' notice.

EMERGENCY BEDS (Paragraphs 38 to 40)

A system which has a senior resident in charge of all admissions and able to admit to any available bed must allow for the greatest elasticity and ensure the best use of available accommodation.

A bed board giving an up-to-date record of beds (1) empty and unallocated ; (2) empty but allocated ; and (3) full, but due to be empty, should be installed at all hospitals. The keeping of an up-to-date record will be greatly facilitated if the waiting list and all admissions and discharges are under one officer.

IN-PATIENTS (Paragraphs 41 to 46)

It facilitates both the reception and administrative arrangements if all in-patients arrive at the same entrance. There should be one office whose first responsibility should be that of dealing with the admission of patients, as their reception is of the utmost importance. All patients should be escorted to the wards.

The casualty department must be responsible for notifying the admissions office of cases sent up from casualty, and, where the practice is to examine emergency admissions before sending them to the wards, examination cubicles should be provided. As much clerical work as possible should be done by the admissions office.

The ward sister must be responsible for seeing that the relatives of emergency admissions have been notified and for informing relatives of dangerously-ill patients and of deaths. The provision of a room for interviews is a necessity. Hospitals should try to make arrangements whereby relatives, telephoning to enquire about patients, are put through to the ward-unit.

REGISTRATION (Paragraphs 47 to 59)

Great care should be taken to ensure that registration clerks are tactful, kind and patient. In the larger hospitals they should be responsible for registration only.

If the unit system is used, patients need not be asked for the same information more than once. The administrative part of the case sheet and the central index card are filled in at their original registration and this information can be copied by other departments as required. When out-patients are referred to a different clinic the name of the new clinic should be written on their appointment card and the new case sheet should be clipped to the previous one, so it is not necessary to repeat the administrative details. When in-patients are registered, the usual particulars should be typed and sufficient copies should be taken for circulation to the interested departments. The copies should be filed in binders by the different departments and kept as their record of patients.

METHOD OF KEEPING NOTES (Paragraphs 60 to 85)

Whatever system is in use, arrangements must be made so that patients never handle their own notes.

The advantages of the unit system are such that every effort should be made to adopt it. All special departments and casualty should be included, and there should be no subsidiary numbering system. A block of numbers should be allotted to casualty for their casualty cards. Patients referred to special departments already have their hospital number. Both casualty and the special departments need to keep their own alphabetical indices, and in the latter the request cards should be used for this purpose. Branch hospitals can be included in the unit system, and, if they admit direct, blocks of numbers should be allocated to them.

Patients who reappear after long intervals can be dealt with by re-numbering or by the use of a current file for old numbers. The length of time notes are kept must be a matter for the medical staff to decide. Microfilming is one solution to the problem of storage space for old notes. It should be the records officer's responsibility, after consultation with the Records Committee, to see that unnecessary material is not filed with the notes.

Somebody with an overall responsibility for admissions and records should see that there is no unnecessary duplication in the use of cards and slips, e.g., request cards should be used as index cards and appointment cards as attendance cards.

The quarto size should be adopted for case sheets, and while standardisation of design is desirable within a hospital it would be a mistake as between hospitals. Colours are useful to a limited degree only. Notes relating to different chapters of a patient's attendance should be stapled together, and these should then be filed loose inside the folder.

Appointment lists should be used for checking notes given out to appointment clinics, tracer cards for any other notes taken out of current files, and a book for notes that are wanted from the old files for research purposes.

It facilitates keeping track of notes if there is a rule that they must not be transferred direct between departments but have to be returned to records for reissue. Nobody outside the records department should have access to the notes during office hours. After hours the department should be kept locked, any person requiring notes having to sign for the key.

MEDICAL RECORDS (Paragraphs 86 to 98)

Every hospital should have a Records Committee elected by the Medical Committee from amongst its members, and including the chief administrative officer of the hospital and a representative of the nursing staff. The Committee's function is to lay down the policy in regard to records. The records should be in charge of a responsible lay officer who will act as secretary to the Records Committee, and it is essential that the records officer should have a suitable background of training and experience.

Notes should be returned to the records department from the wards before being issued to the appropriate office for the abstract to be written. In the larger hositals this should be the responsibility of the registrar of the firm concerned. It should be typed by the medical secretaries and normally it should be completed in two or three days and should never take longer than ten days.

The Standard Nomenclature of Disease and Operations should be used for the diagnostic index, and the records officer should be responsible for keeping it. Punch card machines can be of great assistance to the medical staff, but only the largest hospitals would be justified in installing one. An index such as the visible leaf system is excellent for indexing the Standard Nomenclature. Coding of the usual administrative details required for ordinary statistical purposes is facilitated if the top half of the case sheet is standard for every firm.

An efficient follow-up service for certain types of cases is important and its mechanics should be the responsibility of the records officer.

APPENDIX

STANDARD NOMENCLATURE OF DISEASE AND OPERATIONS OF THE AMERICAN MEDICAL ASSOCIATION

The Medical Committee of the Middlesex Hospital are of the opinion that this Nomenclature is the most suitable for scientific purposes.

The system of classification is at the same time topographical and etiological, that is, each disease (including injury) is described and classified in terms of the tissue or organ where it is principally manifested, and in etiological terms.

Each disease entity is made up of two components ; the site and the etiological factor, because every disease is considered to be a result of a cause acting in some organ or tissue. Hence the Nomenclature consists of a series of anatomical sites each affected by certain of the causes that may produce disease.

The basis of the diagnosis is clinical. It defines the clinical process rather than the structural or functional changes which characterises the disease. This is the corollary of the etiological method.

The numerical system or code system associated with the Nomenclature has two purposes : (1) to afford a means whereby records of diseases of the same organ will fall automatically together, as well as diseases etiologically identical or similar ; and (2) to afford a brief description of the disease. An additional use of the code is to enable the records officer to arrange clinical records properly without overlapping or confusion. When the physician writes the code, he determines the absolute place of the diagnosis in the records. In this way, the making of the diagnosis and the arrangement of the files are actually dictated by the physician by means of a simple number, and the records officer is relieved of a responsibility which he should never assume.

The code may be a more exact description of the diseases than the name alone. It consists of two parts. The first half of the code, or the part before the dash, indicates the site, as for instance, Digestive System is (6), Stomach is (4), and Pylorus is (5) or 645. Thus the first part of the code gives the exact site of the disease. The numbers in the other half of the code, or beyond the dash, describe the etiology according to similar coding based on the different categories and subgroups : thus Congenital Pylorospasm would be coded 645–043. All diseases and injuries can be coded in a similar manner.

The Nomenclature is provided with an accurate index both for diseases and operations, and while an alphabetical list of eponymic diseases is given their use is not permitted for purposes of recording diagnosis.