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Clinical records: Why are they so under-utilised?

The first paper in this edition[1] reflects concerns raised by participants around what constitutes ethical, good practice in record keeping / report writing. One of the recommendations emanating from the findings was that all records on assessment findings and progress measured should be evidence-based. Providing detailed evidence in patient records is not only crucial to show the unique contribution of occupational therapy to patients' health and well-being, but more importantly, establishes meaningful and useful databases for clinical research.

It is, however, evident from our archives (and the papers featured in this edition) that most of the research submitted for publication in the SAJOT are designed prospectively with 'new' data gathered for the purpose of the study. Although some studies source their participants from existing demographic information recorded in patient records, only a few published studies utilise the information that is recorded on assessments done, interventions given, progress, and outcomes achieved before patient discharge.

The South African National Health Act[2] states that all patients should receive a written discharge summary when they are discharged. These discharge summaries should document the patient's journey from admission through to discharge, include the reason for admission as well as the different treatments received or might be needed after discharge.

The quality and content of a discharge summary depends not only on the diligence of the discharge administrator, but directly on the quality of the clinical record-keeping during treatment. The Guidelines for Record Keeping[3] published by the Health Professions Council of South Africa outlines clear criteria for documenting the evidence needed to render a records database suitable for clinical research.

What is required now is clearly to establish how our academic research community can assist clinical therapists to develop a records management strategy which will enable them to utilise their patient records to design, conduct and publish more retrospective studies on their day-to-day practice.

There is a vast, largely untapped source of valuable information out there. Let's use it!

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EDITOR IN CHIEF

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