Pat!ent
Ambassadørerne
Danish Society for Patient Safety

December 2018

Safer patient records

Recommendations from Danish “Patient Ambassadors” to healthcare professionals, to patients and their families, and to healthcare managers

How can healthcare professionals and patients jointly strengthen the safety of patient records, so as to ensure that patients are protected against errors and misunderstandings in their record?

The Patient Ambassadors, a part of WHO’s Patients for Patient Safety*, have prepared a number of recommendations for “safer patient records”. These recommendations have been prepared on the basis of a seminar – “Patient records, a healthcare working tool” – which was held in the spring of 2018.

The seminar agreed that the framework surrounding the patient interview is essential for a safe patient record. It is important to have this conversation in a safe and secure setting, including a suitable physical setting, and that mutual respect is displayed in the conversation. The outcome of the conversation will be best if both parties are well-prepared.

The healthcare professionals are responsible for ensuring that the patient record is correct and adequate; however, patients themselves and their family members can help. For example, as a patient or family member of a patient you may find inspiration in the material entitled: “Thanks for asking”, which can be found at https://godtduspoer.dk/ (in Danish).

Furthermore, healthcare managers are responsible for making the right conditions available.

These recommendations represent the thinking of the Patient Ambassadors as to how healthcare professionals, healthcare managers and patients each can contribute to a safer patient record.

**Danish Patient Ambassadors are a network of patients and/or family members of patients who have experienced detrimental treatment in healthcare. This network was established in the spring of 2007 and forms part of an international Patients for Patient Safety network under the auspices of the WHO.*

---

1. The good patient record comes out of teamwork

When the patient has contributed to the contents of the patient record and agrees with what is written in it, the chances of a good treatment outcome increases. The good patient record reflects the patient's wishes and needs.

- make sure that the contents of the patient record are correct and, as far as possible, that the patient agrees with the contents. Write in the patient record if there is something the patient disagrees with
- write in the patient record, while the patient is looking and is able to read along
- make sure that patients can read along on the screen if, as a healthcare professional, you are using a computer during the patient record conversation
- involve the patient as far as possible, but also respect if the patient does not wish to be involved
- preferably finish the conversation by going through – with the patient – what you wrote in the patient record, so that any misunderstandings and deficiencies may be corrected immediately
- make sure that the patient has understood what the diagnosis means if a diagnosis is given, and what the purpose and content of the treatment will be
- use the patient's own words, if possible
- explain the meaning to patients if it is necessary to use technical, medical terms

Recommendations for patients and their family members

- talk honestly about health history and symptoms, including any dietary supplements and alternative treatment
- before the conversation, think about the patient record to make it clear what is important for you to explain as regards the symptoms suffered
- the patient should read along on the screen as the healthcare professional writes the patient record if this makes sense to the patient
- ask that symptoms which do not seem immediately significant to the healthcare professional be entered in the patient record anyway
- point out to the healthcare professional if the patient does not want too much information

Recommendations for healthcare managers

- Contribute towards the culture in healthcare moving away from being authoritarian towards cooperation between healthcare professionals and patients, e.g. by integrating the question "What matters to you?"´

---

2. The layout of the patient record supports patient safety

When the patient record is easy to grasp, precise and well-founded, this will contribute towards supporting patient safety

---

Recommendations for healthcare professionals

- write the patient record in a brief, concise and forward-looking format without unnecessary repetitions
- design the patient record to make it easy to grasp
- write summaries of the patient pathway at suitable intervals and mark these summaries to make them clear to the reader
- make sure it is easy for new readers to find the latest summary
- make sure that the patient record contains meaningful, complete argumentation for all major decisions regarding investigation, diagnosis and treatment
- explain and give technical instructions to the patient as to how the patient can get access to reading his or her own record
- make sure that information about medication is updated and easy to grasp

Recommendations for patients and their family members

- make sure to clarify the following questions before a conversation ends (and, possibly, check what the patient record says about these questions):
- ask for a copy of the patient record and blood sample replies if they so wish
- check whether the patient records answers the following questions:
    - Why did I see the doctor?
    - What did the samples show?
    - What does that mean?
    - What is the diagnosis?
    - If a diagnosis has not been found, which examinations have been planned, so that the diagnosis may be found?
    - What happens now?
    - Who does what?
- always ask the healthcare professionals if information is thought to be missing in the patient record, or if there are words or phrases the meaning of which is unclear to the patient.

Recommendations for healthcare managers

- contribute towards ensuring that technologies support an easy-to-grasp patient record, to which patients have access, and which patients find it possible to understand
- disseminate knowledge among citizens, explaining how citizens can get access to reading their own patient records
- contribute towards technologies working correctly and appropriately also across sector boundaries

---

---

3. Incorrect information must be corrected

Incorrect information – or information which may be misunderstood – may endanger patient safety and work to the detriment of the patient in other contexts

---

Recommendations for healthcare professionals

- do their best to correct incorrect or inaccurate information in the patient record
- listen and respond if the patient or the patient's family points our errors or inaccuracies
- make sure that incorrect information is corrected, also if it has been passed on to other systems/instances

Recommendations for patients and their family members

- always read through the patient record and point out any errors or incorrect pieces of information to the healthcare professionals

Recommendations for healthcare managers

- make sure that it is technically possible to delete/correct incorrect information in the patient record and – if incorrect information has been passed on to other systems/instances – to also correct the error there
- make sure that staff members know the law in this field, including the rights of the patients to have incorrect information corrected/deleted

Recommendations for healthcare authorities

- prepare a guideline which clearly explains the rules in this field and how these rules are to be interpreted

---

---

4. Development of a more open, interactive patient record

There are several international examples of testing of new patient record systems that are not only open to patients, but where patients can also contribute actively with comments and possibly corrections

---

Recommendations for healthcare managers

- launch projects and trials, in which new, innovative patient record systems are tested and developed.