# Bear traps in record keeping – beware!

As optometric advisers we see a lot of records. A lot. We therefore thought it would be helpful to share our collective thoughts on electronic record cards and the traps to avoid when using them.

EPRs have many advantages over paper records. They are legible (no scrawly cramped handwriting to decipher), some systems can be accessed remotely and audited, and they can be backed up off site. They have disadvantages too, the most obvious one is probably that it is more difficult to draw on them than simply drawing on paper, so you end up describing clinical features more rather than simply drawing a few cortical cataract spokes on the record. However, there is another potential flaw which is what I would like to discuss and that is the seemingly ubiquitous copying buttons.

There are many things that it is useful to copy. The patient's previous prescribed spectacle prescription is probably the most obvious one, but there are also other things like the often long list of medication that the patient is taking (but remember this may have changed). This is all fine. Beware of copying ocular history if it does not have a date in it, however, as although 'px had L cataract op 2/12 ago' may be fine for one visit, it certainly isn't right at the next one! That is a give away to anyone looking at the record that you have simply pressed the copy button, and it does not encourage the reader to assume that the rest of the record is accurate.

There are two copy buttons, however, that can easily be misused. They may have been programmed to apparently make things easier, but they may have the opposite effect and – in fact – make a reader of the record question whether or not the findings are as recorded. The first one is the apparently ubiquitous 'copy right to left' button, which enables you to copy the findings you have recorded in the right eye automatically to the left eye. Before you happily click on this, make sure that the findings really ARE the same in the left eye, as otherwise it will call into question the veracity of the whole record. This is not to say that the same thing cannot happen with paper records – it can – and I have seen a big curly bracket with 'R+L' over various ocular findings when this was clearly not correct.

All this, however, pales into insignificance when you look at the 'tick everything as normal in both eyes' button. A click of this button pre-populates all the various radio buttons as 'normal', and is the electronic equivalent of 'NAD', which we know really stands for 'not actually done'. The temptation to click this button – particularly if you are running short of time – to produce what you may think is a perfectly filled in record card, complete with findings that you would not normally expect to be recorded on a record card for this patient (e.g. no AC flare on an asymptomatic patient) must be avoided at all costs. This is because, looking at a record of a routine sight test with everything filled in as normal – even if it is not necessary to do this test – will raise suspicions of a competent observer and – again – call into question the accuracy of the entire record. Again – what can be done electronically can also be done in paper, and one of us recalls a colleague producing beautifully completed paper record cards for audit. They really were a work of art. And fiction, as many tests were being recorded as having been done when they were not possible (or necessary) to be done on that particular patient. Not good....

Top tips for completing electronic records:

1. Ensure everything is filled in accurately. This may seem obvious, but beware of the copy buttons and – ideally – do not use them. Patients are not always symmetrical.
2. Ensure that findings are recorded in the right place – some records have particular fields for findings such as tonometry, and CDRs. If you fill them in in the correct place (rather than inserting them as free text elsewhere), people will know where to look for them. Similarly if you are importing images (such as scans of letters) – try and keep where you put them consistent, and ideally ask all optometrists in the practice to do the same.
3. DO NOT record results of tests you have not done. You do not need to do every conceivable test on every patient, so only complete the ones you have done. Obvious, I know, but you may be surprised what we see. It is better to record no information than false information.
4. Quantify things where possible. Saying 'accommodation normal for age' is akin to saying 'visual acuity normal for age'. If you feel the need to measure accommodation, record the measurement itself.
5. Be descriptive. For example what does media 'normal for age' mean? Does the patient have cataract or not? If so, is it significant? If the patient is young then, rather than putting 'normal for age', put 'clear'.
6. Ensure that all of the pertinent information is included if the record is sent for audit (either to NHS England or the GOC). This is something for the software developers to ensure, but it is important that all the information is included when the record is sent externally.
7. If you need to amend a record after the event (it happens....), date your entry if it is likely to be contentious, as it will be visible from the audit trail anyway.
8. As for paper records, ensure you record acuity with existing specs wherever possible as this helps you justify if a new prescription is required.

One final point to mention is that running two systems side by side (one hard copy and one electronic) is fraught with difficulties. If an electronic system is introduced all clinicians must buy into it. The opportunity for error and confusion when a paper copy and an electronic copy for one patient are floating around cannot be underestimated.