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Audit of GP Consultation Records for Quality Improvement

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Abstract **Original Research Article**

This review outlines a multi-centre quality improvement (QI) project conducted to assess the accuracy of General Practitioner (GP) consultation records across three clinical sites in Manchester, UK: Practice A, Practice B, and Practice C. The audit aimed to ensure compliance with the General Medical Council's (GMC) guidelines for good medical practice in clinical record-keeping. Three – five patient records per clinician were reviewed over a four-week period. The audit assessed the completeness of documentation concerning clinical findings, patient history, prescribed treatments, and referrals. A second audit cycle followed targeted feedback and action plans. Results showed significant improvements in the accuracy of record-keeping across all three sites, emphasising the effectiveness of regular audits and feedback. Re-audit cycles are recommended based on accuracy scores to ensure continuous improvement. This review highlights the importance of clinical audits in maintaining high standards of documentation, improving patient safety, and good record keeping.

Keywords: Clinical audit, General practice, Quality improvement, Record-keeping, Documentation accuracy, Patient safety, GMC guidelines, Feedback and action plans, Primary care.

INTRODUCTION

Accurate and comprehensive record-keeping is a cornerstone of good clinical practice. The General Medical Council (GMC) mandates that medical records must include relevant clinical findings, the decisions made and actions agreed upon, and specify who is responsible for making these decisions and agreeing to these actions. Additionally, the record must document any information provided to patients, including drugs prescribed, other investigations or treatments, and clearly identify who is making the record and when it was recorded. These records are essential for ensuring continuity of care and have significant medicolegal implications, as well-maintained records are often critical in defending clinical decisions and actions in the event of legal or professional scrutiny.

This audit comes at a timely moment, as patient access to medical records is expanding in the UK, with increasing numbers of patients now able to review their consultation records directly. To evaluate the quality of GP consultation records among a diverse patient mix, an audit was conducted across three clinical sites in Manchester, UK. It specifically aimed to assess adherence to GMC standards and implement quality improvement (QI) measures based on the findings, ensuring that records meet high standards in light of patients' enhanced ability to view and engage with their own health information.

Good record-keeping benefits not only individual patients—by supporting clear communication, shared decision-making, and consistent care—but also strengthens the overall healthcare system by promoting accurate data collection, efficient resource allocation, and improved continuity of care across providers. High-quality records contribute to patient safety, aid in the timely diagnosis and treatment of conditions, and support better health outcomes at both the individual and population levels.

This article reviews the audit process, presenting results from two audit cycles, and examines the steps taken to improve the quality of consultation records. It also discusses the implications of these findings for ongoing professional development, patient safety, and the health system as a whole, emphasising the critical role that thorough and structured record-keeping plays in clinical practice, especially from both a medicolegal perspective and as patients increasingly interact with their own health data.

METHODOLOGY

The audit was designed to evaluate consultation records from clinicians at three sites: Practice A, Practice B, and Practice C. Three - five patient records were randomly selected for each clinician from the preceding four weeks, with the first audit cycle completed in April 2023 and the second cycle in July 2023. In total, 27 records were reviewed in each cycle.

Each record was assessed against a set of criteria based on GMC guidelines for good record-keeping, including documentation of consultation date and time, clear patient history and clinical findings, appropriate diagnosis and management plans, documentation of consent, referrals, and follow-up arrangements, and safe prescribing practices aligned with clinical guidelines.

The reviewer evaluated the records using a template with "Yes," "No," or "N/A" responses for each criterion. For each clinician, the accuracy of documentation was expressed as a percentage, calculated from the total "Yes" responses out of all applicable questions. Clinicians were provided with individual action plans to address any areas needing improvement. The audit was repeated after feedback was given, with the second cycle occurring three months after the first.

RESULTS

The results from the first audit cycle revealed considerable variability in the quality of record-keeping across the three clinical sites:

Practice	Clinician 1	Clinician 2
Practice A	70%	84%
Practice B	90%	N/A*
Practice C	51%	82%

*Practice B only had 1 regular clinician working at the time of audit

These results highlighted key areas for improvement, particularly at Practice C, where one clinician scored significantly low.

Following feedback and the implementation of action plans, a second audit was conducted. The results demonstrated marked improvements:

Practice	Clinician 1	Clinician 2
Practice A	84%	90%
Practice B	96%	N/A
Practice C	81%	N/A*

*Clinician 2 at practice C had left the practice at the time of re-audit.

Overall, all clinicians who participated in both cycles showed improvement in their record-keeping accuracy, with the most significant increase seen at Practice C.

DISCUSSION

The audit revealed several important trends:

- Improvements across all sites: Targeted feedback and action plans led to substantial improvements in record-keeping. The most marked improvement occurred at Practice C, where Clinician 1's score rose from 51% to 81%, underscoring the effectiveness of structured feedback.
- Consistency in high performance: Practice B clinician consistently achieved high scores, initially scoring at 90% but with feedback this increased even further to 96% leading to excellent levels of documentation.
- Variability across clinicians: Despite the overall positive trend, the significant variation between clinicians in the first cycle suggests the need for more comprehensive and standardised training in clinical documentation.

Clinical audits have long been established as essential tools for maintaining and improving healthcare quality, particularly in primary care settings where thorough and accurate documentation is critical for patient safety. The findings of this audit align with several previously published studies that emphasize the benefits of regular audits and feedback in enhancing documentation practices. In a study by de Lusignan *et al.*, (2005), routine audits of GP records significantly improved the quality of documentation in areas such as recording vital signs, patient history, and prescribing practices. This improvement mirrors the trend observed in this audit, where targeted feedback and structured action plans led to marked improvements in record-keeping accuracy across all practices.

Similarly, a quality improvement initiative by Gray *et al.*, (2012) found that auditing and providing individualised feedback led to a notable increase in the completeness of records, particularly regarding clinical coding and safety netting. This resonates with the improvement seen at Practice C, where a clinician's record-keeping score improved from 51% to 81% following feedback and an action plan.

Moreover, systematic reviews, such as the one by O'Connor *et al.*, (2020), underscore the importance of regular audits as part of clinical governance frameworks. Their analysis demonstrated that consistent audits, especially when followed by feedback, are effective at identifying gaps in documentation and providing actionable insights for clinicians. The improvement from the first to the second audit cycle in this study is consistent with these findings, where Practice A and Practice C showed significant progress after feedback.

A key theme in the literature is that audits not only improve the quality of documentation but also contribute to improved patient safety. A study by Wager *et al.*, (2010) highlights that poor documentation is a

leading cause of medical errors, and that regular audits help mitigate this risk by ensuring that clinicians consistently record relevant clinical information. This was evident in our audit, where initial gaps in documentation were rectified in the second cycle, potentially reducing the risk of errors in patient care.

While most studies focus on the positive impact of audits, some challenges were also noted in the literature. Scobie *et al.*, (2019) pointed out that time constraints and heavy workloads often lead to incomplete records, with clinicians prioritising direct patient care over meticulous record-keeping. This challenge was also observed in our audit, particularly in the initial cycle, where time-pressured environments contributed to lower scores, such as those seen at Practice C.

Overall, the literature supports the findings of this QI project, reinforcing that regular clinical audits, when coupled with feedback and action plans, significantly improve documentation accuracy and adherence to best practice guidelines. However, it also highlights the need for ongoing training and support for clinicians, particularly in busy general practice settings, to maintain these improvements over time.

CONCLUSION

This quality improvement project demonstrates that regular audits of clinical records are an effective means of improving documentation accuracy and compliance with GMC standards. The improvements observed between audit cycles highlight the value of targeted feedback and action planning. Future audits should be embedded in routine clinical governance processes to ensure sustained improvements in documentation practices. Clinicians should be encouraged to reflect on their audit results and engage in continuous professional development to maintain high standards of patient care and safety. Going forward, re-audit intervals should be determined based on accuracy scores, with the following schedule recommended: 95% or higher: Re-audit in 12 months, 80% to 94%: Re-audit in 6 months, 70% to 79%: Re-audit in 3 months, below 70%: Re-audit in 1 month. By maintaining this cycle of audit and improvement, we can ensure that patient care continues to be enhanced through high-quality clinical documentation.

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