Introduction

Taking a clear past medical, family, drug, allergy and social history is a critical component of the clerking process. Figure 1 illustrates the system in which such information is documented at a London based hospital. Unfortunately, these are often found to be poorly completed. There may be multiple reasons for this, one of the key factors being time constraints on a busy clerking take.

Aim

To objectively quantify the extent to which a patient’s background is documented in the clerking booklets at a London based hospital. Assess whether the introduction of ‘Clerking Co-production’ improves documentation.

Methods

A retrospective analysis of 30 patient’s notes, randomly selected, was completed. A scoring system was devised based on the sections in Figure 1 as follows:

- **Past Medical History**
  1 = <50% of the patients past medical history
  2 = >50% of past medical history
  3 = all past medical history including dates

- **Family History**
  1 = family history present
  2 = including relation

- **Medications**
  Total score was summed, points as follows:
  For each medication documented: 1 point each for name/dose/route/frequency (maximum 4)

- **Allergies**
  1 = allergen
  2 = allergen + reaction

- **Social History**
  1 point for each question answered (maximum 9)

**Intervention:** Patient-doctor ‘Co-Production Clerking’ was introduced. This being the term used to signify patients and doctors co-operating to contribute towards a patient’s management.

As patients were added to the medical take, they were given an explanatory leaflet and a sticky label copy of page 2 of the clerking booklet (Figure 1) to fill out. Stickers were completed in the period between the patient being added to the medical take list and clerked.

A re-audit of medical notes of the patients involved in ‘Clerking Co-Production’ was completed using the scoring system above.

The scores for each section were summed and represented as a percentage of the gold standard (100% complete clerking). The mean average of percentages for each section pre and post intervention were taken.

Results

Analysis has shown that ‘clerking co-production’ improved clerking documentation across all sections. This is illustrated in Figure 2. Thirty patients were included pre and post intervention. Demographics of the pre-intervention population: age range 25-94 (average 70.5). Of the 30, 6 could not speak English. Post intervention, the age ranged from 20-85 (average 62); 8 could not speak English.

Furthermore, patients may not be prepared for the questions asked on page 2; our intervention gives them time to consider this beforehand.

As this was a pilot, only 30 patients pre and post intervention were included in the study. To improve reliability patient number could be increased. Another important consideration is that doctors were not blinded to the intervention. However, data was gathered over a period of two weeks enabling us to capture a variety of doctors clerking.

More patients than expected were found to be unable to read or speak English, with no family/carers present, or confused and could not be included. This limited the population of patients that this intervention was used on.

A potential benefit of co-production is reducing clerking time; this may be measured in further studies. Furthermore Co-Production enables patients to be more involved in their medical management.

Discussion

This pilot scheme demonstrates ‘Clerking Co-production’ has a substantial improvement on clerking. This may be due to a number of factors, one of which is the presence of family/carers as patients arrive to A&E, who have commonly left by the time medical clerking has begun. This is especially helpful for patients who cannot speak English or may be confused.

Conclusion

Patient co-production is not a relatively new concept, however, one which has scope to be incorporated into the clerking process. Our pilot demonstrates this with a positive result.