Record Keeping Standards

(Incorporating CORP/COMM 15 v.1 – Clinical Audit Procedure for NHS-LA and CNST Casenote Audit)

Name of author
Tracy Evans-Phillips, IPOC Manager
Julie Robinson, Health Records Manager

Date written/revised
April 2012

Approved by (Committee/Group)
Clinical Audit and Effectiveness Group
Clinical Records Committee

Date of approval
May 2012

Date issued
21 June 2012

Review date
May 2015 – Extended to May 2016

Target audience
Trust-wide

WARNING: Always ensure that you are using the most up to date approved procedural document. If you are unsure, you can check that it is the most up to date version by looking on the Trust Website: www.dbh.nhs.uk under the headings → ‘Freedom of Information’ → ‘Information Classes’ → ‘Policies and Procedures’
# Record Keeping Standards

## Amendment Form

Brief details of the changes made:

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<th>Version</th>
<th>Date</th>
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| Version 1 | May 2012  | • This is a new document, incorporating CORP/COMM 15 v.1 – Clinical Audit Procedure for NHS-LA and CNST Casenote Audit – please read in full. | Tracy Evans-Phillips  
Julie Robinson          |
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1. **INTRODUCTION**

1.1 Effective monitoring of clinical care with high quality systems for clinical record keeping and the collection of relevant information was one of the four main components of clinical governance quoted in HSC 199C9/065.

1.2 Any document which records any aspect of the care of a patient can be required as evidence before a coroner’s court, a court of law or before the Professional Conduct Committee of the Nursing and Midwifery Council, or other similar regulatory bodies for the health and social care professionals. The legal approach to record keeping tends to be “if it is not recorded it has not been done”. This is particularly relevant where the patient/client condition is stable and no record is made of care delivered.

1.3 Clinical records are the most basic of clinical tools and are involved in almost every consultation. They are there to give a clear and accurate account of the care and treatment of patients and to assist in making sure they receive the best possible clinical care. They form a permanent record of individual considerations and the reasons for decisions. They help health care professionals to communicate with other health care professionals and with themselves. They are essential to ensure that an individual’s assessed needs are met comprehensively and in good time. The record is a health care professional’s main defence if assessments or decisions are scrutinised.

1.4 The duties and responsibilities of doctors, as set out by the General Medical Council, include the keeping of clear, accurate and relevant medical records that can be understood by colleagues. The Nursing & Midwifery Council states that good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. Other healthcare professions have similar statements in their codes of practice.

1.5 The NHS Litigation Authority has issued standards for clinical record keeping that are set out in section 5 of this policy, and which underpin the whole ethos of the policy, to reduce the risks of entries in records made by clinical professionals.

1.6 There are published documents that provide guidance on good record keeping practice.

**CORP/REC 5 Clinical Records Policy**
Doncaster and Bassetlaw Hospitals NHS Foundation Trust, 2012

**Generic Medical Record-Keeping Standards**
Royal College of Physicians and NHS Connecting for Health, 2007

**Good Medical Practice**
General Medical Council, 2006

**Guidelines for Records and Record Keeping**
Nursing and Midwifery Council, 2005

**NHSLA Risk Management Standards for Acute Trusts**
NHS Litigation Authority, 2012 - 13
These National Standards used as evidence in this policy will be reviewed and checked for updates on an annual basis. Any changes will be approved at Clinical Records Committee and attached as an addendum to this policy.

2. **PURPOSE**

2.1 The purpose of the Clinical Record Keeping Standards Policy is to provide standards for the entries made by healthcare professionals in the records against which compliance can be measured and against which continual improvement can take place.

2.2 This policy describes the generic medical record keeping standards that apply to all records made by medical, nursing and allied health professionals.

2.3 This document outlines:

- The purpose for good record keeping
3. DEFINITIONS

Casenotes
A corporate folder which holds the health record

Clinical Audit
“Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes”

New Principles of Best Practice in Clinical Audit
HQIP January 2011
Clinical Negligence Scheme for Trusts (CNST)
A risk-pooling scheme in respect of clinical claims arising from incidents on or after 1 April 1995

Contemporaneous
Occurring in the same period of time, ie. Writing of notes during or immediately after the care, treatment or conversation has taken place.

NHS Litigation Authority (NHS-LA)
A special Health Authority established in 1995 to administer the Clinical Negligence Scheme for Trusts (CNST) and thereby provide a means for NHS organisations to fund the cost of clinical negligence claims

Record Keeping
The process of writing information on treatment, conversations etc as a record of evidence that the action has taken place

4. EQUALITY IMPACT ASSESSMENT

4.1 This procedural document has been assessed for equality and diversity as described in CORP/EMP 27.

5. LEGAL OBLIGATIONS AND GOOD PRACTICE

5.1 NHS-LA 1.8 Health Record-Keeping Standards
The Trust has an approved documented process for managing the risks associated with the quality of paper and electronic health records that is implemented and monitored.

5.2 Level 1
Your documented process must include:
 a) basic record-keeping standards, which must be used by all staff
 b) process for making sure a contemporaneous record of care is completed
 c) how the organisation trains staff, in line with the training needs analysis
 d) how the organisation monitors compliance with all of the above.
5.3 **Level 2**
You must evidence implementation of your documented process in relation to:
— basic record-keeping standards, which must be used by all staff.

The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10% of all daily admission numbers.

To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet the above minimum requirement.

5.4 **Level 3**
You must evidence monitoring of your documented process in relation to:
— basic record-keeping standards, which must be used by all staff.

Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.

The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation’s monitoring results. This will typically be equivalent to 10% of all daily admission numbers.

If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.

6. **ROLES AND RESPONSIBILITIES**

6.1 **Clinical Records Committee**
The Clinical Records Committee is responsible for developing and maintaining the currency of both the Clinical Records Policy and the Clinical Record Keeping Standards Policy and monitoring compliance to them. The Committee reports to the Clinical Governance Committee.

6.2 **Health Records Manager**
The Health Records Manager is responsible for the storage of casenotes in the Medical Records Library and for effective and efficient systems for making such casenotes available to clinical staff when and where they are needed for treatment as inpatients or outpatients. The Health Records Manager is a source of advice and expertise to all areas maintaining separate patient records. Guidance is provided in the Clinical Records Policy (CORP/REC 5).

6.3 **Medical Director**
It is the role of the Medical Director to ensure all Medical Staff are aware of this policy and that they need to document all care given, conversations and treatment contemporaneously in the relevant health record.

6.4 **Director of Nursing and Quality**
It is the Director of Nursing and Quality’s responsibility to ensure that all Nursing Staff are aware of this policy and that they need to document all care given, conversations and treatment contemporaneously in the relevant health record.
6.5 **Director of Clinical Therapy**  
It is the Director of Clinical Therapy's responsibility to ensure that all Clinical Therapy Staff are aware of this policy and that they need to document all care given, conversations and treatment contemporaneously in the relevant health record.

6.6 **All Healthcare Professionals**  
It is an individual's responsibility to ensure that they have read, understood and applied this policy in everyday practice. This includes all main health records, departmental records and records written in any other form of documentation (i.e. health reports, health records from other centres etc).

7 **KEY AUDITABLE STANDARDS**

7.1 The quality of record keeping is the reflection of the standard of professional practice. Good record keeping is the mark of the skilled and safe practitioner while careless or incompetent record keeping often highlights wider problems with the individual's practice (NMC, 2005).

7.2 Good record-keeping is essential to:
- Help to improve accountability
- Show how decisions related to patient care were made
- Support the delivery of services
- Support effective clinical judgements and decisions
- Support high quality patient care and communications
- Enable continuity of care throughout the patient journey
- Enable better communication and dissemination of information between members of the multiprofessional healthcare team, patients, relatives and carers
- Provide a clear, accurate account of treatment, care planning and delivery of care
- Help identify risks and enable the detection of complications, such as changes in the patient's condition, at an early stage
- Support clinical audit, research, allocation of resources and performance planning
- Enable patients, who have the right to see their own records, to understand and participate in their own healthcare (see CORP/REC 3, Procedure for Providing Subject Access to Health Records Under the Data Protection Act, 1998, for further information)
- Meet medico-legal requirements, including requests from patients under the Data Protection Act, Access to Health Records Act, complaints, litigation, investigation of adverse events and the requirements of Coroners’ Inquests or other enquiries.

7.3 All records should be maintained in accordance with professional standards for record-keeping. For Healthcare professionals to satisfy legal requirements documents must be legible, permanent, free from abbreviations or jargon, errors or alterations, and should be accurately dated, timed and signed. Records should also be factual, comprehensive, suitably frequent and contemporary (Anderson E, 2000)

7.4 Essence of Care, published in 2010, includes a record-keeping benchmark focussed on meeting patients' needs. The benchmark stresses the importance of:
- People are able to access their care records in a format that meets their needs
People have a single, lifelong, multi-professional and multi-agency (where appropriate) care record which supports integrated care

People’s care records demonstrate that their care is evidence-based

People’s care records are safeguarded

7.5 All documentation to be contained within the health record must be approved by the Clinical Records Committee and will be issued with a filing and document reference number (WPR). (Appendix 1)

7.6 Properly structured and well-maintained records will:

- Ensure that records are written, whenever possible, with the involvement of the patient or their carer/relative. Their feedback / comments regarding the assessment, treatment and plan of care should be noted.
- Provide ‘protection’ for staff against any future complaint that may be made. *Complaint and litigation correspondence must not be filed in the health record*

7.7 Record content:

7.7.1 *Clear Identification of the patient*

- Clear identification of the patient on every page (or the first page of an IPOC) which must include the patient’s first and last name, identification number (District / NHS), date of birth and the location in the hospital (ie. Ward / Department).
- A patient label may be used for this purpose, a set of which should be found in every set of casenotes. The label does not include the patient location, as this is not standard demographic information and can change between and within hospital episodes.
- In all cases clinical transactions and consequent records should be recorded against the correct patient, by undertaking checks against the patient identity before filing or inputting information.

7.7.2 *Chronology, accurate and complete records*

- Demonstrate the chronology of events and all significant consultations, conversations, assessments, observations, decisions, interventions and outcomes contemporaneously
- Accurately record information given to patients in respect of treatment choices and risks in such a way that the meaning is clear, including being intelligible to the patients.
- Records must not be falsified.
- Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation, coded expressions of sarcasm or humorous abbreviations to describe patients or carers.
- Abbreviations must never be used on consent forms
- It is a matter of professional judgement to decide what is relevant and what should be recorded, but, in general, clinical records, both inpatient and outpatient, should include the types of information described below.
- An initial patient history with previous medical history, known allergies, the social context of the illness, where appropriate
- Details of medication
- Details of any initial physical examination, including the patient’s weight and height
• History and examination findings clearly dated and signed
• Details of information given to the patient about care and treatment, including health education / promotion provided to the patient or family

For outpatient consultations
• A medical or nursing entry in the casenotes must be made in the history sheet stating at least any procedures undertaken and the outcome of the consultation in relation to the reconciliation slips
• The main communication from an outpatient attendance is a clinic letter or discharge summary. To ensure the consistent completion of a the letter/summary the following minimum data set has been established:
  • Patient identifier
  • Date of appointment
  • Diagnosis
  • Operations / procedures relevant to the appointment
  • Key test results (including MRSA / C. Diff if available at time of writing)
  • A full list of medicines being taken at the time of the clinical appointment
  • Details of medicines (current at clinic) that have been stopped during the appointment together with the reason why.
  • Details of medicines that have been started during the clinical appointment including the clinical indication for which they were prescribed and suggestion as to the intended duration of treatment of the new medicine if the new medicine is to be continued in primary care.
  • Actions and future plans
  • If follow-up by the hospital is required, and reason why.

For inpatient care
• A working diagnosis and care / treatment plan which should be signed by the most appropriate clinician
• Continuation notes with reports of all investigations and treatments
• Any risks or problems that have arisen should be identified, and the action taken to deal with them documented

7.7.3 Attribution of entries
Every entry in the health record should be:
• Dated
• Timed (24 hour clock, Inpatients and Obstetric outpatient consultations). If this is not possible the date and time of the event and the date and time of the entry must be recorded
• Written clearly, legibly (entries should never be made in pencil) in black ink (or agreed alternative), to enable it to be photocopied if necessary
• Signed by the person making the entry
• The name, position and designation of the person making the entry should be legibly printed against their signature
• Entries made by student nurses and health care (support) workers must be countersigned by a registered health professional
• Include the name and position of the practitioner on dictated correspondence and entries; these must be checked and corrected, if necessary, and then signed by the practitioner who dictated them
• Only contain alterations that have been made by scoring out with a single line, signed, dated and timed by the entry maker, in order to be auditable. Corrections to errors must be written underneath and also dated, timed and
signed. Correction fluid must not be used. Sheets containing errors must not be rewritten or the originals removed from the clinical record. No other information in the records must be changed, especially after notification of a complaint or claim

- Only contain reports and results that have been seen, evaluated and signed by a clinician before being filed on or behind the appropriate divider.
- Made of interviews, telephone conversations with the patient or anyone else regarding the patient and their care

7.7.4 Contemporaneous entries
- Entries to the clinical record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round, investigation) and before the relevant staff member goes off duty. In cases where the latter is not possible, the time of the event and the reason for the delay should be recorded.

7.7.5 Recording of responsibility
- The making of an entry in the clinical record means that responsibility is accepted for the entry and for the care it describes. As stated above, all entries must be attributable to a health care professional. Entries in the clinical record relating to ward rounds should identify the most senior doctor present (who is responsible for decision making) at the time the entry is made. Where multidisciplinary meetings or assessment forms are documented, all present should be identified, since responsibility is shared.

7.7.6 Transfers of responsibility
- On each occasion that the consultant responsible for the patient’s care changes, the name of the new responsible consultant and the date and time of the agreed transfer of care, should be recorded both in the casenotes and on computer systems (PAS). With regard to nursing and midwifery records, the handover between shifts/professionals should be clearly documented.

7.7.7 Frequency of entries
- An entry should be made in the clinical record whenever a patient is seen by a clinician. This standard is equally applicable to both manual and electronic clinical records. It is expected that there will be a medical entry at least daily, a nursing entry morning, afternoon and night and a midwifery entry every hour during labour. On the occasions where there is no entry in the hospital record of care provided by medical staff for more than four days (weekend plus bank holidays), the next entry should explain why. Four days is thus the maximum acceptable interval between medical entries in the record where patients are classed as receiving acute medical care, and are not fit for discharge. Where patients are medically fit for discharge and remain in hospital receiving long stay continuing care, it is acceptable for the gap between entries to be up to seven days. Other healthcare professionals will make entries at the time that their involvement in the patient’s care is provided.

7.7.8 Discharge planning
- The discharge summary (on JACS) and the From Admission to Discharge documentation should be commenced at the time the patient is admitted to hospital.
7.7.9 **Advance Decisions, Consent, DNACPR**

- Advance Decisions to Refuse Treatment, Do Not Attempt Cardio-Pulmonary Resuscitation decisions (DNACPR) and Consent to treatment must be clearly recorded in the casenotes, and should be signed, dated and timed with clear designation, as standard.
- In circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney. The content of these entries and process by which they are made are detailed in the specific policies governing these events.

8 **ELECTRONIC RECORDS**

8.1 With regard to clinical records that are maintained electronically, an entry will be made at each clinical contact and will document the assessments, tests and treatments given, as set out in the computer system, which provides the structure as to what should be recorded. All fields relevant to the contact should be completed, except where the department concerned has documented reasons, approved by the Clinical Records Committee, for not doing so at a departmental level, e.g. because this aspect of service is not provided by the Trust. Any free text entries must abide by the general principles concerning jargon and abbreviations detailed above.

8.2 In addition, when using electronic documentation, there must be procedures to ensure:
   - Physical security / equipment security
   - Access / access level control
   - User password management
   - Computer virus control
   - Data back-up
   - Computer network management
   - Data and software exchange
   - Validation
   - Adequate training for all users
   - Data is not transferred to home computers, data sticks, flash drives or unencrypted laptops etc
   - Data is not destroyed for foreseeable future
   - Systems are able to print out a hard copy
   - Data is only emailed by approved means to approved recipients using password protection enabled
   - Data is held on a network drive not a PC hard drive (C:)

8.3 Where both computer and paper systems are maintained, the information held must be consistent to ensure that a complete health record is available at the point of need.

9. **PATIENT HELD RECORDS**

9.1 Patient-held records are used in certain areas eg. Patient-held antenatal records, which contain details of the ongoing antenatal care, blood test results and thromboprophylaxis risk assessment forms.
9.2 Patient-held records comprise part of the patient’s health records and remain hospital property. It is essential that they are retrieved and retained at the conclusion of treatment as they are the sole record of much of the care given.

9.3 It is the responsibility of the department from where the records originated to ensure the safe return of the patient held records into the health records.

10 TRAINING AND EDUCATION

10.1 Increasing knowledge and awareness in relation to good record keeping is an integral part of patient care within the organisation.

10.2 Good record keeping standards training is available through the training department via the training Manual in line with the Training Needs Analysis. Attendance and non-attendance at this training is recorded on the OLM database. It is the responsibility of the CSU / Department managers to ensure their staff have been trained to the appropriate level.

11 MONITORING COMPLIANCE AND EFFECTIVENESS

11.1 As part of the NHS-LA and CNST requirements and the need to ensure this policy is adhered to, a mandatory programme of audit is implemented.

11.2 Documentation To support CSUs with this project the NHS-LA Casenote Audit is available electronically; this is split by inpatient and outpatient episodes.

11.3 Instruction

- Each CSU is to audit 100 sets of casenotes per annum. This MUST be the current episode of care or the latest Outpatient entry. 50 sets of casenotes must be completed by each CSU by the end of September and the remaining 50 sets of casenotes by the end of March each year.
- These casenotes need to be a representative sample of the workload for that CSU, split by activity levels (ie. 90% OPD 10% IP) and per site (ie. 50% Doncaster, 30% Bassetlaw, 10% Montagu, 10% Tickhill Road).
- The audit can be accessed on the Clinical Audit Page on the Intranet, or type the links below into the address field on the internet: https://www.surveymonkey.com/s/NHSLACasenoteAuditINPATIENT https://www.surveymonkey.com/s/NHSLACasenoteAuditOUTPATIENT
- Reports will be issued to the Clinical Audit Lead for the CSU, copied to the Clinical Director and the Clinical Governance Lead by the end of October and April each year.
- Responsibilities for the reports are below.
- Should an action plan highlight a need for re-audit, the Department of Clinical Audit and Effectiveness will negotiate with the specialty and support the re-audit process.

11.4 Audit Responsibilities

11.4.1 Clinical Director

It is the ultimate responsibility of the Clinical Director to ensure that the NHS-LA Casenote Audit is completed in accordance with the rolling programme.
11.4.2 Clinician
It is the Clinician’s responsibility to adhere to the mandatory NHS-LA Casenote Audit, complete the audit proforma in a timely manner and contribute to an action plan and recommendations to improve the quality of record-keeping.

11.4.3 Clinical Audit / Clinical Governance Leads
It is the responsibility of the Clinical Audit Lead to ensure that the audit is completed and submitted on time. The Leads should ensure that the audit reports are fed back to the CSUs via the audit and governance half day. Following discussion of results, an action plan together with a copy of the minutes of the meeting are to be returned to the Department of Clinical Audit and Effectiveness for logging and monitoring.

11.4.4 Department of Clinical Audit and Effectiveness
The CA&E Department will produce reports for each CSU twice yearly (October and April) and overall report twice yearly for the Clinical Records Committee and Clinical Audit and Effectiveness Committee and annual report for the Patient Safety Review Group which will include details of records audits undertaken and a summary of significant action undertaken across the Trust.

11.4.5 Clinical Service Units (CSUs)
CSUs are expected to review the action plans and undertake any identified actions as they feel are appropriate.

11.4.6 Clinical Records Committee (CRC)
CRC is expected to review the reports and action plans, twice per year, and undertake any actions they feel appropriate.

11.4.7 Corporate
The Department of CA&E will produce an annual report for the Patient Safety Review Group which will include the findings from the records audits. Should any of the records audits produce evidence of major significance these will be reported by exception.

12 NON-COMPLIANCE

12.1 CSUs not submitting data as required will be contacted to ascertain the reason for non-compliance. Lack of capacity is not grounds for non-compliance.

12.2 All non-compliance will be reported to the Patient Safety Review Group.

12.3 Patient Safety Review Group to action all non-compliance with this policy.
Clinical Records Committee

Process for ALL clinical documentation (new & amended/updated)
for use within Doncaster & Bassetlaw Hospitals

- Requesters to speak to IPOC Manager
  
  - Develop documentation (Typeset by Graphics staff)
    
    - IPOC Manager discusses documentation containing medication and prescriptions with Pharmacy
      
      - Discussed at Drug and Therapeutics Committee
        
        - IPOC Manager authorises simple revisions/documents
          
          - Complex documentation
            
            - IPOC & Health Records Managers discuss & review
              
              - If not resolved CRC to approve or dismiss
                
                - DISMISSED explanation given to requester
                  
                  - APPROVED documentation
                    
                    - Graphics for WPR allocation & print preparation
                      
                      - IPOC Manager to notify Requester of WPR number
                        
                        - Supplies add new document to Staff Brief Bulletin
NHS-LA Casenote Audit - INPATIENT

NHS-LA Casenote Audit Tool - INPATIENT

1. Site:

2. Clinical Service Unit

3. NHS / District Number

Clear Identification of Patients

Are the following unique identification of patients on each page (1st page of each IPOC) for this episode:

4. Are the following unique identifiers recorded:

<table>
<thead>
<tr>
<th></th>
<th>Yes all pages</th>
<th>Yes some pages</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Patient's first name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient's surname</td>
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<td></td>
<td></td>
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<tr>
<td>NHS / District Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
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<td></td>
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<tr>
<td>Location in hospital</td>
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Entries made by Doctors

Complete the following questions on entries made by doctors

5. Was the patient seen by a doctor?
   - [ ] Yes
   - [ ] No

6. Which grade of doctor has written in this patient episode? (tick all that apply)
   - [ ] Consultant
   - [ ] Staff Grade
   - [ ] Registrar
   - [ ] Junior Doctor

7. Are all entries dated?
   - [ ] Yes
   - [ ] No
### NHS-LA Casenote Audit - INPATIENT

8. Are all entries timed?
- [ ] Yes
- [ ] No

9. Have the times been written using:
- [ ] 24-hour clock
- [ ] Other notation eg. am/pm
- [ ] Both

10. Are all entries legible?
- [ ] Yes
- [ ] No

11. Are all entries signed by the professional making the entry?
- [ ] Yes
- [ ] No

12. Are all signatures accompanied by printed name?
- [ ] Yes
- [ ] No

13. Are all signatures accompanied by designation?
- [ ] Yes
- [ ] No

14. Are all entries in black ink?
- [ ] Yes
- [ ] No

### Entries made by Nurses

Complete the following questions on entries made by nurses

15. Was the patient seen by a nurse?
- [ ] Yes
- [ ] No

16. Are all entries dated?
- [ ] Yes
- [ ] No
### NHS-LA Casenote Audit - INPATIENT

**17. Are all entries timed?**
- Yes
- No

**18. Have the times been written using:**
- 24-hour clock
- Other notation eg. am/pm
- Both

**19. Are all entries legible?**
- Yes
- No

**20. Are all entries signed by the professional making the entry?**
- Yes
- No

**21. Are all signatures accompanied by printed name?**
- Yes
- No

**22. Are all signatures accompanied by designation?**
- Yes
- No

**23. Are all entries in black ink?**
- Yes
- No

### Entries made by Clinical Therapy

Complete the following questions on entries made by clinical therapy

**24. Was the patient seen by a clinical therapist?**
- Yes
- No
**NHS-LA Casenote Audit - INPATIENT**

**25. Which clinical therapists were audited in this episode?**

- [ ] Physiotherapy
- [ ] Occupational Therapy
- [ ] Dietetics
- [ ] Speech and language Therapy
- [x] Other (please specify) [ ]

**26. Are all entries dated?**

- [ ] Yes
- [ ] No

**27. Are all entries timed?**

- [ ] Yes
- [ ] No

**28. Have the times been written using:**

- [ ] 24-hour clock
- [ ] Other notation eg. am/pm
- [ ] Both

**29. Are all entries legible?**

- [ ] Yes
- [ ] No

**30. Are all entries signed by the professional making the entry?**

- [ ] Yes
- [ ] No

**31. Are all signatures accompanied by printed name?**

- [ ] Yes
- [ ] No

**32. Are all signatures accompanied by designation?**

- [ ] Yes
- [ ] No
NHS-LA Casenote Audit - INPATIENT

33. Are all entries in black ink?
   - Yes
   - No

---

Please complete the remaining sections of the data collection tool considering all entries made in the casenotes for this episode of care

Deleted / Altered entries

34. Were any deletions or alterations made?
   - Yes
   - No

35. Were they all made in accordance with policy requirements?
   
<table>
<thead>
<tr>
<th>Action</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crossed through with a single line</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correction fluid used</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Chronological, accurate and complete records

36. Are episode documentation and continuation notes viewable in chronological order?
   - Yes
   - No

37. Were unnecessary clinical abbreviations used within the episode of care?
   - Yes
   - No

38. Were the abbreviations used written out in full the first time that they were used within the episode of care?
   - Yes
   - No

---

Contemporaneous entries
### NHS-LA Casenote Audit - INPATIENT

39. Are any entries documented as being made in 'Retrospect'?  
- [ ] Yes
- [ ] No

40. For each entry was the time of the event recorded?  
- [ ] Yes
- [ ] No

41. Is there a significant delay in restrospective entries being made?  
- [ ] Yes
- [ ] No

42. Is the reason for the significant delay recorded?  
- [ ] Yes
- [ ] No

### Recording of Responsibility

43. Is this episode Inpatient or Outpatient?  
- [ ] Inpatient
- [ ] Outpatient

44. Was it recorded that entries were written during ward rounds?  
- [ ] Yes
- [ ] No

45. Was the most senior doctor present identified for the entry?  
- [ ] Yes
- [ ] No

### Transfer of responsibility

46. During the episode of care, did the Consultant for the patient’s care change?  
- [ ] Yes
- [ ] No
NHS-LA Casenote Audit - INPATIENT

47. Were the following recorded in the casenotes?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of agreed transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time of agreed transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of new responsible Consultant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Frequency of entries

48. Please indicate whether the patient was:

- Acute Medical Care patient
- Long Stay Continuing Care patient

49. Was an entry made in the medical notes every day during the episode of care?

- Yes
- No

50. If no,

- The nursing entries were maintained 3 times per day
- An entry was recorded within 4 days (Acute medical patients)
- An entry was recorded within 7 days (Long Stay patients)
- The next entry explained the delay?

Advance Decisions, Consent and DNACPRs

51. Are there any statements to Advance Directives recorded during this episode of care?

- Yes
- No

52. Was the patient the decision maker?

- Yes
- No

53. Was the decision maker clearly identified?

- Yes
- No

54. Was there a DNACPR active for this episode?

- Yes
- No
## NHS-LA Casenote Audit - INPATIENT

### 55. Is the DNACPR Status clearly documented in the casenotes?
- [ ] Yes
- [ ] No

### 56. Was the patient put on the Care of the Dying IPOC?
- [ ] Yes
- [ ] No
- [ ] Not appropriate at this time
### NHS-LA Casenote Audit - OUTPATIENT

#### NHS-LA Casenote Audit Tool - OUTPATIENT

1. **Site:**
   
2. **Clinical Service Unit:**
   
3. **NHS / District Number:**

#### 4. Type of clinic appointment:
- New
- Follow-up

#### 5. Minimum dataset:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient identifier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operations / procedures relevant to the appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key test results (including MRSA / C. Diff if available at time of writing)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 6. Medication

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>A full list of medicines being taken at the time of the clinical appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Details of medicines (current at clinic) that have been stopped during the appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The reason why medicines have been stopped</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Details of medicines that have been started during the clinical appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The clinical indication for which the new medicines were prescribed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The intended duration of treatment of the new medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the new medicine is to be continued in primary care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 7. Action plan and future

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions and future plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If follow-up by the hospital is required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason why follow-up is required</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Page 1

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Page 24 of 36
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence Base</th>
<th>Standards</th>
</tr>
</thead>
</table>
| 1. The clinical record contains the following identification data on each clinical sheet, 1st page of an IPOC, radiology requests and on the casenote itself: | **CORP/REC 5 Clinical Records Policy, DBH NHSFT** (2007)  
**Generic Medical Record Keeping Standards Royal College of Physicians and NHS Connecting for Health** (2007)  
**Good Medical Practice, General Medical Council** (2006)  
**Guidelines for Records and Record Keeping, Nursing and Midwifery Council** (2005)  
**Good Surgical Practice, Royal College of Surgeons of England** (2008)  
**Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy** (2005)  
**Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists** (2002)  
**Professional Standards for Occupational Therapy Practice, College of Occupational Therapists** (2007) | 100% of documentation in clinical records contains a full patient name  
100% of documentation in clinical records contains a unique identifier |
| 2. The clinical record contains a referral source (including contact name / number if applicable) | **CORP/REC 5 Clinical Records Policy, DBH NHSFT** (2007)  
**Professional Standards for Occupational Therapy Practice, College of Occupational Therapists** (2007) | 100% of clinical records have a referral source recorded  
100% of Radiology Requests have Name and signature of referred and contact details |
3. The name of the consultant in charge for the episode of care must be recorded (where applicable).

   CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)
   Generic Medical Record Keeping Standards Royal College of Physicians and NHS Connecting for Health (2007)
   Guidelines for records and record keeping, Nursing and Midwifery Council, (2005)
   Good Surgical Practice, Royal College of Surgeons of England (2008)

4. Initial patient contacts and all subsequent entries must be dated and timed

   CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)
   Generic Medical Record Keeping Standards Royal College of Physicians and NHS Connecting for Health (2007)
   Guidelines for records and record keeping, Nursing and Midwifery Council, (2005)
   Good Surgical Practice, Royal College of Surgeons of England (2008)
   Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy (2005)
   Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists (2002)
   Professional Standards for Occupational Therapy Practice, College of Occupational Therapists (2007)

   100% of records should contain the name of the consultant in charge of the patient.

   100% of entries should be dated.
   100% of entries should be timed.
5. Within the initial patient contact there should be recorded evidence of the presenting problem and a list of problems.

<table>
<thead>
<tr>
<th>5.</th>
<th>CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic Medical Record Keeping Standards Royal College of Physicians and NHS Connecting for Health (2007)</td>
</tr>
<tr>
<td></td>
<td>Good Medical Practice, General Medical Council (2006)</td>
</tr>
<tr>
<td></td>
<td>Guidelines for Records and Record Keeping, Nursing and Midwifery Council. (2005)</td>
</tr>
<tr>
<td></td>
<td>Good Surgical Practice, Royal College of Surgeons of England (2008)</td>
</tr>
<tr>
<td></td>
<td>Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy (2005)</td>
</tr>
<tr>
<td></td>
<td>Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists (2002)</td>
</tr>
<tr>
<td></td>
<td>Professional Standards for Occupational Therapy Practice, College of Occupational Therapists (2007)</td>
</tr>
<tr>
<td></td>
<td>100% of entries state a presenting problem</td>
</tr>
<tr>
<td></td>
<td>100% of entries contain a problem list</td>
</tr>
</tbody>
</table>

6. There should be clear evidence of the provisional diagnosis and subsequent management plan.

<table>
<thead>
<tr>
<th>6.</th>
<th>CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic Medical Record Keeping Standards Royal College of Physicians and NHS Connecting for Health (2007)</td>
</tr>
<tr>
<td></td>
<td>Good Medical Practice, General Medical Council (2006)</td>
</tr>
<tr>
<td></td>
<td>Guidelines for Records and Record Keeping, Nursing and Midwifery Council. (2005)</td>
</tr>
<tr>
<td></td>
<td>Good Surgical Practice, Royal College of Surgeons of England (2008)</td>
</tr>
<tr>
<td></td>
<td>Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy (2005)</td>
</tr>
<tr>
<td></td>
<td>Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists (2002)</td>
</tr>
<tr>
<td></td>
<td>Professional Standards for Occupational Therapy Practice, College of Occupational Therapists (2007)</td>
</tr>
<tr>
<td></td>
<td>100% of records should have documented evidence of the suspected diagnosis.</td>
</tr>
<tr>
<td></td>
<td>100% of records should have documented evidence of a treatment plan.</td>
</tr>
</tbody>
</table>
| 7. All alerts and sensitivities are recorded within the casenotes | CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)  
Generic Medical Record Keeping Standards Royal College of Physicians and NHS Connecting for Health (2007)  
Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy (2005)  
Good Practice: A Guide for Departments of Anaesthesia, Critical Care and Pain Management, The Royal College of Anaesthetists and The Association of Anaesthetists of Great Britain and Ireland (2006) | 100% of allergies and drug sensitivities are recorded on the Alert / Hazard Notification in the casenotes  
100% of allergies and drug sensitivities are recorded at initial patient contact  
100% of allergies and drug sensitivities are recorded on the Anaesthetic Record in the pre-operative assessment  
100% of allergies and drug sensitivities are recorded on the Prescription Chart |
|---|---|---|
| 8. Investigation(s) (intention and result) should be recorded in the casenotes for initial patient contact | CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)  
Generic Medical Record Keeping Standards Royal College of Physicians and NHS Connecting for Health (2007)  
Good Medical Practice, General Medical Council (2006)  
Good Surgical Practice, Royal College of Surgeons of England (2008)  
Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy (2005) | 100% of investigations intention and results is stated in the casenotes at initial patient contact (where investigations are required) |
| 9. When making an entry the clinician should sign, print their full name and grade/designation at the end of their entry | **CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)**  
**Generic Medical Record Keeping Standards Royal College of Physicians and NHS Connecting for Health (2007)**  
**Guidelines for Records and Record Keeping, Nursing and Midwifery Council, (2005)**  
**Good Surgical Practice, Royal College of Surgeons of England (2008)**  
**Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy (2005)**  
**Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists (2002)**  
**Guidance of Standards for Records and Record Keeping, Joint BDA / Dietitians Board (2003)**  
**Professional Standards for Occupational Therapy Practice, College of Occupational Therapists (2007)** | 100% of clinical staff should sign each entry made in the clinical notes  
100% of clinical staff should print their full name after each entry made in the clinical notes  
100% of clinical staff should state their grade / designation after each entry in the clinical notes |
|---|---|
| 10. Bleep number (if a bleep is held) should be recorded after every entry in the casenotes | **CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)**  
**Handbook for Junior Medical Staff, DBHNHSFT (2006)** | 100% of records should contain a bleep number if the clinician holds a bleep |
| 11. Prescription  
Each patient will have a prescription chart or electronic record for the current episode of care (if applicable) | **Prescribing Standards DBHNHSFT (2008)** | 100% of appropriate patients have either an electronic or paper prescription record |
12. **Prescription**
Discontinued medications are deleted with a single line, signed, dated and timed.

**Prescribing Standards DBHNHSFT (2008)**

100% of discontinued medications are scored out with a single line
100% of discontinued medications are signed
100% of discontinued medications are dated
100% of discontinued medications are timed

13. **Prescription**
Each entry for prescribed medication will have a start date

**Prescribing Standards DBHNHSFT (2008)**

100% of prescribed medication have a start date

14. **Prescription**
Each entry for prescribed medication will be signed

**Prescribing Standards DBHNHSFT (2008)**

100% of prescribed medication are signed

15. The record is written indelibly, in black ink (or agreed alternative), to enable it to be photocopied if necessary and are legible

**CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)**
**Generic Medical Record Keeping Standards Royal College of Physicians and NHS Connecting for Health (2007)**
**Good Medical Practice, General Medical Council (2006)**
**Guidelines for Records and Record Keeping, Nursing and Midwifery Council, (2005)**
**Good Surgical Practice, Royal College of Surgeons of England (2008)**
**Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy (2005)**
**Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists (2002)**
**Guidance of Standards for Records and Record Keeping, Joint BDA / Dietitians Board (2003)**
**Professional Standards for Occupational Therapy Practice, College of Occupational Therapists (2007)**
**British National Formulary, British Medical Association (2007)**
**Handbook for Junior Medical Staff, DBHNHSFT (2006)**

100% of entries are made in black ink or agreed alternative
100% of entries made within the casenotes are legible
100% of medication entries made on the prescription chart are written in black ink
100% of amended entries on the prescription chart are in green ink
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 16. All entries are written in plain English (in a way a patient can understand) | **CORP/REC 5 Clinical Records Policy, DBHNHSFT** (2007)  
Generic Medical Record Keeping Standards  
Royal College of Physicians and NHS Connecting for Health (2007)  
Guidelines for Records and Record Keeping, Nursing and Midwifery Council, (2005)  
Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy (2005)  
Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists (2002)  
Professional Standards for Occupational Therapy Practice, College of Occupational Therapists (2007)  
British National Formulary, British Medical Association (2007) | 100% of records are written in plain English and only contain abbreviations that are recognised and accepted. |
| 17. The record should demonstrate an accurate chronology of the patient's progress | **CORP/REC 5 Clinical Records Policy, DBHNHSFT** (2007)  
Generic Medical Record Keeping Standards  
Royal College of Physicians and NHS Connecting for Health (2007)  
Guidelines for Records and Record Keeping, Nursing and Midwifery Council, (2005)  
Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy (2005)  
Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists (2002)  
Professional Standards for Occupational Therapy Practice, College of Occupational Therapists (2007) | 100% of records should provide a chronological account of the patient's progress. |
| 18. The record does not contain blank lines or empty space. Where entries are made on documents that result in blank space under an entry, this space should be crossed through with a line. | **CORP/REC 5 Clinical Records Policy, DBHNHSFT** (2007)  
Guidelines for Records and Record Keeping, Nursing and Midwifery Council, (2005)  
Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists (2002) | 100% of blank spaces have a line crossed through to prevent entries being made retrospectively. |
19. The record is written contemporaneously

| **CORP/REC 5 Clinical Records Policy, DBHNHSFT** (2007) |
| **Generic Medical Record Keeping Standards** Royal College of Physicians and NHS Connecting for Health (2007) |
| **Good Medical Practice, General Medical Council** (2006) |
| **Guidelines for Records and Record Keeping, Nursing and Midwifery Council** (2005) |
| **Good Surgical Practice, Royal College of Surgeons of England** (2008) |
| **Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy** (2005) |
| **Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists** (2002) |
| **Professional Standards for Occupational Therapy Practice, College of Occupational Therapists** (2007) |

100% of entries are written at the time of the event or as soon as possible afterwards.

20. Medical entries are made once each 24 hours (5 day week) for acute conditions and at least twice per week for rehab.

| **CORP/REC 5 Clinical Records Policy, DBHNHSFT** (2007) |
| **Generic Medical Record Keeping Standards** Royal College of Physicians and NHS Connecting for Health (2007) |
| **Guidelines for Records and Record Keeping, Nursing and Midwifery Council** (2005) |

100% of medical entries adhere to guidance.

Nursing entries have been made at least once per shift in 100% of cases.

21. Any alteration is scored out with a single line, signed, dated and timed.

| **CORP/REC 5 Clinical Records Policy, DBHNHSFT** (2007) |
| **Guidelines for Records and Record Keeping, Nursing and Midwifery Council** (2005) |
| **Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy** (2005) |
| **Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists** (2002) |
| **Professional Standards for Occupational Therapy Practice, College of Occupational Therapists** (2007) |

100% of alterations are scored out with a single line so that the original entry can still be read.

100% of alterations are signed

100% of alterations are dated

100% of alterations are timed
| 22. All interventions / procedures should be written fully and detailed in the casenotes | CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)  
Generic Medical Record Keeping Standards Royal College of Physicians and NHS Connecting for Health (2007)  
Guidelines for Records and Record Keeping, Nursing and Midwifery Council, (2005)  
Good Surgical Practice, Royal College of Surgeons of England (2008)  
Core Standards of Physiotherapy Practice, The Chartered Society of Physiotherapy (2005)  
Guidelines for Best Practice No 3: Clinical Records, British Association of Prosthetists and Orthotists (2002)  
Professional Standards for Occupational Therapy Practice, College of Occupational Therapists (2007)  
Reference Guide to Consent for Examination or Treatment, Department of Health (2001) | 100% of interventions / procedures carried out by clinical staff have been written in full (planned or carried out) |
|---|---|---|
| 23. Surgical Team Only  
Details of operation are written legibly and in full | CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)  
Good Surgical Practice, Royal College of Surgeons of England (2008)  
Reference Guide to Consent for Examination or Treatment, Department of Health (2001) | 100% of operations are written in full  
100% of operations are written legibly |
| 24. Surgical Patient Only  
All consent forms will be signed by a suitably trained and qualified clinician | CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)  
Reference Guide to Consent for Examination or Treatment, Department of Health (2001) | 100% of consent forms are signed by a suitably trained and qualified clinician |
| 25. Surgical Patient Only  
All consent forms will be signed by the patient (where they are fit and able to do so) | CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)  
Good Surgical Practice, Royal College of Surgeons of England (2008)  
Reference Guide to Consent for Examination or Treatment, Department of Health (2001) | 100% of consent forms have been signed by a patient |
| 26. Surgical Patient Only  
All consent forms should be written legibly | CORP/REC 5 Clinical Records Policy, DBHNHSFT (2007)  
Good Surgical Practice, Royal College of Surgeons of England (2008)  
Reference Guide to Consent for Examination or Treatment, Department of Health (2001) | 100% of consent forms are legible |
REPORT TEMPLATE (Available electronically from the Department of CA&E)

Project Title: Audit of Patient Records in .........................................................

Project Lead(s): ........................................................................................................

Aims & Objectives: (suggested text)

The main aim of this project was to examine current record keeping at DBH NHSFT and look at ways in which existing practice could be improved.

The objectives were to:
- identify adherence to the Trust's record keeping standards
- identify factors that may be contributing to any failures in meeting the standards
- make recommendations for future practice at DBH

Methods:

20 sets of casenotes were audited retrospectively using the NHS-LA Casenote Audit Proforma.

Key Results: INSERT YOUR RESULTS SHEET HERE

Actions and Recommendations: INSERT YOUR ACTION PLAN DOCUMENT HERE
**Recommendations and Action Plan**: Please list all recommendations from the results and give a summary of the action plan developed to implement the recommendations.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Action</th>
<th>Timescale</th>
<th>Person responsible for implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please continue on a separate sheet if necessary.*