Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Record Keeping Standards

This procedural document supersedes: Record Keeping Standards CORP/REC 6 v.1

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Name of author	Judy Lane – Patient Services Manager
Date written/revised	June 2017
Approved by (Committee/Group)	Policy Approval and Compliance Group
Date of approval	5 July 2017
Date issued	4 April 2018
Next Review date	June 2020
Target audience	Trust-wide

Amendment Form

Brief details of the changes made:

Version	Date Issued	Brief Summary of Changes	Author
Version 2	4 April 2018	• Changes made throughout to reflect the changeover from total care PAS to CaMIS PAS. • Updated to Medical Records Manager/Patient Services Manager throughout. • Format updated. • Changed appendices from A, B, C to 1, 2, 3. • Removed NHSLA Audit tool	Judy Lane
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

Contents

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 1999/065.

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.

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
- The standards of good record keeping
- Monitoring of the policy

3. DEFINITIONS

Casenotes
A corporate folder which holds the Medical 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 2016
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.

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

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (see Appendix 3).

5. ROLES AND RESPONSIBILITIES

5.1 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.

5.2 Patient Services Manager
The Patient Services 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 Patient Services 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).

5.3 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.

5.4 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 an treatment contemporaneously in the relevant health record.

5.5 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 an treatment contemporaneously in the relevant health record.

5.6 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.)

6 KEY AUDITABLE STANDARDS

6.1 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).

6.2 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, Processing Requests for Access in Health Records Procedure, 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.

6.3 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).

6.4 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).

6.5 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 <u>must not</u> be filed in the health record***

6.6 **<u>RECORD CONTENT</u>**:

6.6.1 ***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 (i.e. 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.

6.6.2 ***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 **<u>never</u>** 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.
    1. An initial patient history with previous medical history, known allergies, the social context of the illness, where appropriate.

2. Details of medication
3. Details of any initial physical examination, including the patient's weight and height.
4. History and examination findings clearly dated and signed.
5. 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 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:
    1. Patient identifier
    2. Date of appointment
    3. Diagnosis
    4. Operations / procedures relevant to the appointment
    5. Key test results (including MRSA / C. Diff if available at time of writing)
    6. A full list of medicines being taken at the time of the clinical appointment
    7. Details of medicines (current at clinic) that have been stopped during the appointment together with the reason why.
    8. 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.
    9. Actions and future plans.
    10. 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.

6.6.3 ***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.
- Interviews, telephone conversations with the patient or anyone else regarding the patient and their care

6.6.4 ***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.

6.6.5 ***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 multi-disciplinary meetings or assessment forms are documented, all present should be identified, since responsibility is shared.

6.6.6 ***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.

6.6.7 ***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.

6.6.8 ***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.

6.6.9 ***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.


2017 Casenote Review Audit - Data c

7. ELECTRONIC RECORDS

7.1 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.

7.2 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

7.3 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.

8. PATIENT HELD RECORDS

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.

8.1 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.

8.2 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.

9. TRAINING AND EDUCATION

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

9.2 It is the responsibility of the Care Group/ Department managers to ensure their staff have been trained to the appropriate level.

10. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
The quality of the content of patient casenotes	Clinical Audit --- Medical Records	Monthly --- Weekly	Audit and Effectiveness Forum --- Supervisors review and address with staff
The standards of record keeping	Clinical Audit --- Medical Records	Monthly --- Weekly	Audit and Effectiveness Forum --- Supervisors review and address with staff

11. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

CORP/REC 1 - Order of Filing in Hospital Casenotes Policy
CORP/REC 2 - Safeguarding Patient Records held Separately from Medical Records Libraries and in Transit Policy
CORP/REC 3 – Processing Requests for Access to Health Records Procedure

CORP/REC 4 - Requesting, Locating and Tracking Patient Records Policy
CORP/REC 5 - Clinical Records Policy
CORP/REC 8 - Legal Retention and Destruction of Hospital Patient Medical Records
CORP/ICT 7 - Data Protection Policy
CORP/ICT 10 – Confidentiality - Code of Conduct
CORP/ICT 14 – Information Records Management – Code of Practice

12. REFERENCE

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

CORP/REC 5 Clinical Records Policy
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, 2016

Generic Medical Record-Keeping Standards
Royal College of Physicians and NHS Connecting for Health, 2009

Good Medical Practice
General Medical Council, 2014

Guidelines for Records and Record Keeping
Nursing and Midwifery Council, 2009

CNST Maternity Record Management Standards
NHS Litigation Authority, March 2013

Good Surgical Practice
Royal College of Surgeons of England, 2014

Core Standard of Physiotherapy Practice
The Chartered Society of Physiotherapy, 2012

A Guide to Good Medical Practice for Clinical Radiologists
The Royal College of Radiologists, 2004

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

Guidelines for Best Practice No 3.4 Clinical Records
British Association of Prosthetists and Orthotists, 2013

Guidance on Standards for Records and Record Keeping
Joint BDA / Dietitians Board, 2016

Professional Standards for Occupational Therapy Practice
College of Occupational Therapists, 2017

Reference Guide to Consent for Examination or Treatment

Department of Health, 2009

British National Formulary
British Medical Association, 2017 73rd Edition

Local Clinical Guideline for Junior Medical Staff
Clinical Guidelines accessed via the Intranet and the IGNAZ app.

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.

APPENDIX 1 – SUBMISSION FORM 1 REQUEST FOR NEW CLINICAL DOCUMENTATION

The Clinical Records Committee has been created to recommend and support that all patients have a written multi-disciplinary record which conforms to all current standards agreed nationally and locally. This Committee ensures that all requests received to either change or create clinical documentation which will be seen and/or used by patients and clinical staff will ensure high-quality publications, safeguarding against duplication, aiming for economies of scale and making sure that language and style are consistent with the Trust's corporate style.
This request form should be completed and sent, together with your proposed text and illustrations via email to: IPOC@dbh.nhs.uk. All proposed text and illustrations must be typed, handwritten documents will be returned to the author. In addition, the author must support the submission of the new document at the Clinical Records Committee. Any documents submitted without the presence of the author will not be discussed.
The final draft and publication of the document must be signed off by the author who then has the sole responsibility of the document.

TO BE COMPLETED BY THE PERSON CREATING THE DOCUMENT

Proposed name of publication:

Description (e.g. leaflet, information film, display board):

Name of author(s):

Job title:

Department: Care Group:

Ext. No: Email address:

Date publication required:

Reason/Background: (i.e. new service, new evidence (e.g. NICE))

Have you researched to detect if there are any other documents within the Trust of a similar nature?

Is there another department that uses, or may need, a similar publication?
If 'Yes', state which:

Have you liaised with Pharmacy about this document?

Have you researched nationally any standards which should be considered?

What is the target audience?

Is it a Trust-wide publication?

Has the document been through the required approval process i.e.

- **Local Clinical Governance**
- **Patient Safety Group, Care Group Clinical Director**
- **Care Group General Manager**

If so, please provide their name, details and date approved:

Has the development/review of this publication involved service users (e.g. patients, carers)?
If so, please enclose evidence showing how you have done this i.e. Information for Services Users Group.

Special Instructions: (e.g. size, colour, material – paper, card or carbonated paper)

Estimated Usage (monthly/yearly)

Cost

Please be aware that if you are requesting your document to be carbonated or be printed on colour paper, the cost of printing will be increased on average by 25%.

As part of the Trust's contract the printers can hold up to three months' stock on their shelves of a document. This means that each time a document is replaced/removed/ altered or changed; this will incur a cost to destroy any stock which has already been printed.

WPR number

Any piece of clinical documentation that is filed in a patient's casenotes **MUST** be registered and officially approved, officially typeset and allocated a WPR number. The WPR number is a unique identifier. Every time a document is updated the WPR number will go up by a digit for version control. This number can be in the left hand margin of the document.

Any document that has been created within a department/ward which has not gone through the above process is **STRICTLY PROHIBITED**. This also includes photocopied forms

APPENDIX 2 – SUBMISSION FORM 2 REQUEST TO AMEND/ALTER EXISTING CLINICAL DOCUMENTATION

The Clinical Records Committee has been created to recommend and support that all patients have a written multi-disciplinary record which conforms to all current standards agreed nationally and locally. This Committee ensures that all requests received to either change or create clinical documentation which will be seen and/or used by patients and clinical staff will ensure high-quality publications, safeguarding against duplication, aiming for economies of scale and making sure that language and style are consistent with the Trust's corporate style.

This request form should be completed and sent, together with your proposed text and illustrations via email to: IPOC@dbh.nhs.uk. All proposed text and illustrations must be typed, handwritten documents will be returned to the author**.** In addition, the author must support the submission of the proposed changed document at the Clinical Records Committee. Any documents submitted without the presence of the author will not be discussed, unless the change is not requiring adding or removing any text. i.e. Adding a signature or date box.

The final draft and publication of the document must be signed off by the author who then has the sole responsibility of the document.

TO BE COMPLETED BY THE PERSON CREATING THE DOCUMENT

Proposed name of publication:

Description (e.g. leaflet, information film, display board):

Name of author(s):

Job title:

Department: Care Group:

Ext. No: Email address:

Date publication required:

Have you researched to detect if there are any other documents within the Trust of a similar nature?

Is there another department that uses, or may need, a similar publication?
If 'Yes', state which:

Have you researched nationally any standards which should be considered?

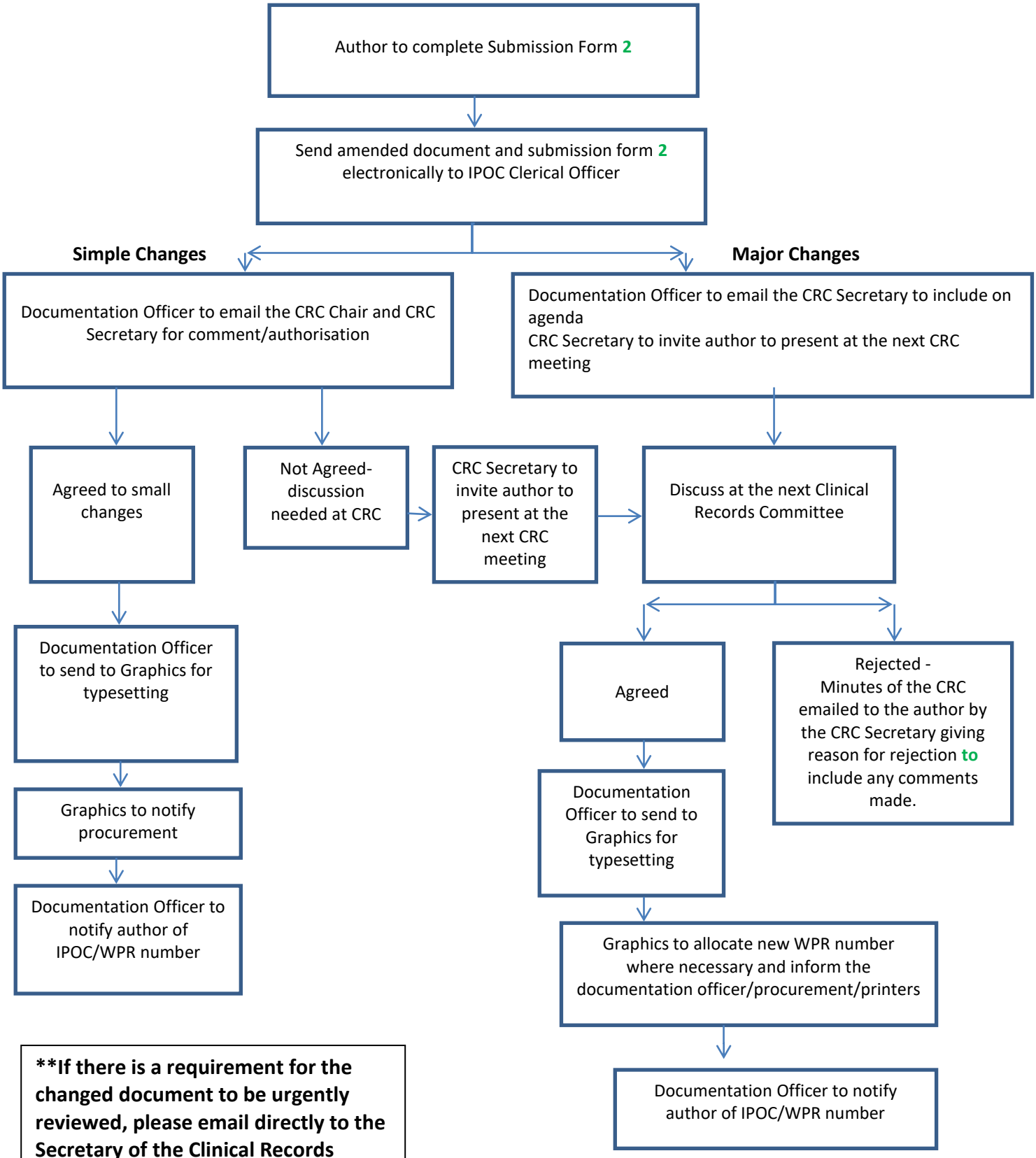
What is the target audience?

Is it a Trust-wide publication?

Has the development/review of this publication involved service users (e.g. patients, carers)?
If so, please enclose evidence showing how you have done this.

Have the changes been agreed with the Care Group Clinical Governance group and/or service lead? If so, please provide their name, details and date approved with the Care Group:

Process for requests to **amend/alter** existing clinical documentation for use within Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust



****If there is a requirement for the changed document to be urgently reviewed, please email directly to the Secretary of the Clinical Records Committee**

APPENDIX 3 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Record Keeping Standards	Corporate - Performance	Judy Lane	Existing	June 2017

1) Who is responsible for this policy? Name of Care Group/Directorate: Performance & The Department of CA&E

2) Describe the purpose of the service / function / policy / project/ strategy? To provide standards for the entries made by healthcare professionals in the records against which compliance can be measured

3) Are there any associated objectives? National and local guidelines and standards

4) What factors contribute or detract from achieving intended outcomes? Non-compliance

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact n/a**

6) Is there any scope for new measures which would promote equality? No

7) Are any of the following groups adversely affected by the policy? No

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 √	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: June 2020

Checked by: Judy Lane **Date: June 2017**