

Clinical Record Keeping Policy

Document Reference	MD3.CRK.V3.1
Document Status	Final
Target Audience	All professional staff
Date Ratified	26 May 2011
Ratified By	Board of Directors
Release Date	June 2011
Review Date	June 2014
Sponsor	Mike Galloway, Deputy Medical Director

Version Control

Version	Release	Author	Update comments
1.0	November 2007	Gary Schuster Clinical Governance Manager	
2.0	July 2008	Barbara Chambers Clinical Governance Facilitator	Revision in line with the NHSLA general risk management standards (2007)
2.0	23 July 2008	Executive Board	Approved
2.1	September 2008	Barbara Chambers Clinical Governance Facilitator	Revision in line with Trust Impact assessment.
3.0	April 2011	Barbara Chambers Clinical Governance Facilitator	Revision in line with revised NHSLA general standards (Jan 2011)
3.1	June 2011	Les Boobis Medical Director	Reference now made to Information Governance and referencing corrected following Board of Directors' meeting May 2011.

CONTENTS	Page
Introduction	3
1. Scope of Policy	4
2. Definition	4
3. Purpose of clinical record keeping	4
4. Roles and responsibility	5
5. Common problems with record keeping	6
6. Standards of record keeping	6
6.1 Minimum standards of making	6
6.2 Content of the clinical record	7
7. Security and confidentiality	8
8. Caldicott	8
9. Legal aspects	9
10. Audit of clinical records	9
11.1 Roles and responsibilities	9
11.2 Audit procedure	9
11 Format of audit report	10
12 Training	10
13 Process for monitoring	11
11. References	11
15. Associated Documents	11
Appendix 1 Generic Documentation Audit Proforma	13
Appendix 2 Clinical record keeping audit report table	14
Appendix 3 Record Keeping Action Plan	16
Appendix 4 Flow chart of Record Keeping audit process	17
Appendix 5 Plain English guide of policy for clinical record keeping	18
Appendix 6 Health Records standards Aide Memoire	21
Appendix 7 Schedule of Clinical Record Keeping Audits	22

INTRODUCTION

This policy applies to all clinical staff employed by City Hospitals Sunderland NHS Foundation Trust (CHS). The policy does not replace standards set by professional organisations but are complementary to them and should be used in conjunction with the CHS Records Management Policy.

Where local/professional variations from this policy occur it is essential they are agreed by the professional group and disseminated to all relevant staff.

Record keeping is an integral part of professional practice and is a tool to support the care process.

Failure to record information accurately in health records can have serious consequences for patients and their relatives. These failures may result in reduced quality of care and litigation. Poor record keeping is a major factor in litigation cases. This in turn hinders the defence of defensible cases.

Good record keeping helps to protect the welfare of patients and clients by promoting:

- High standards of clinical care
- Continuity of care
- Better communication and dissemination of information between members of the multi – disciplinary health care team
- An accurate account of treatment and care planning and delivery
- The ability to detect problems, such as changes in the patient or client's condition at an early stage.

Good record keeping enables health care professionals to attain all of the above listed objectives as well as:

- Meet legal requirements
- Protect staff in legal situations
- Meet professional statutory requirements
- Comply with the Trust's Information Governance and Confidentiality policies
- Support clinical audit

There are a number of health care models and a number of key principles which underpin safe and effective record keeping. These principles include content, style and legal aspects. It is hoped that these standards can be developed and enhanced within each Directorate to reflect the specific needs of the clinical records within each service.

The principles apply across all care settings and apply to both manual and computer records. All records are retained in line with Department of Health guidance⁵, the Human Rights Act 1998⁹ and the Caldicott Report, 1997¹.

1. SCOPE OF THE POLICY

- 1.1 This policy applies to all staff that make entries into clinical health records; including clinical agency and bank staff. All staff should be advised about Trust requirements as part of the induction programme. Temporary/Bank staff should also be advised about Trust requirements.
- 1.2 It is the policy of CHS that all health care records must provide accurate, contemporaneous, comprehensive and concise information regarding the condition and treatment of the patient and comply with professional, statutory and national guidelines and standards described in:
- The Caldicott Report (1997)¹
 - Human Rights Act (1998)⁹
 - Good Medical Practice (2006) Regulating Doctors; Ensuring Good Medical Practice. General Medical Council⁸
 - The Data Protection Act (1998)⁴
 - HSC 1999/053 For the Record (1999)⁵
 - Professional Standards for Occupational Therapy Practice, College of Occupational Therapists (2003)³
 - Guidelines on Patient Records, The Society of Chiropractors and Podiatrists (2004)¹³
 - Chartered Society of Physiotherapy Standards of Practice (2005)²
 - Guidelines for Records and Record Keeping, Nursing & Midwifery Council (2005)¹¹
 - NHSLA Risk Management Standards for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Independent Sector Providers of NHS Care. NHS Litigation Authority (2011)⁷
 - Department of Health (2006) Good Doctors, Safer Patients, DoH⁶
 - Generic medical record keeping standards RCP (2009)¹²
 - The Mental Capacity Act (2005)¹⁰

2. DEFINITION

- 2.1 The health care record is defined as any document (both paper or electronic) holding information about the care of the patient and includes for example, care plans, diaries and birth plans. All health care records held by all AHPs are also subject to this policy.

3. PURPOSE OF CLINICAL RECORD KEEPING

- 3.1 To provide an accurate and comprehensive account of patient care with clear treatment plans and the relevant interventions by professional practitioners
- 3.2 To record the chronology of events, any problems that arise, and the action taken in response to them.
- 3.3 To assist the continuity of care amongst professionals and provide written evidence that the service has been delivered.
- 3.4 To meet legal, professional and statutory requirements.

- 3.5 To provide information for quality assurance, clinical audit, research and evaluation and the investigation of complaints.
- 3.6 To provide evidence of care before a court of law or before the Preliminary Proceedings Committee of Professional Conduct Committee's of the NMC, GMC, HPC or equivalent.

4. ROLES, RESPONSIBILITIES AND DUTIES

4.1 Board of Directors

The Board of Directors is responsible for ensuring that there is a robust system of Corporate Governance within the organisation. This includes having a systematic process for the development, authorisation and management of this policy

4.2 Chief Executive

The Chief Executive is ultimately responsible for ensuring effective Corporate Governance within the organisation and has overall accountability for the management of records within the Trust, therefore, supports the Trust wide implementation of this policy.

4.3 Director of Corporate Affairs

The Director of Corporate Affairs has delegated responsibility for ensuring an effective, robust system is in place for the development, management and authorisation of all policies within the Trust.

4.4 Divisional General Managers/Clinical Directors

All Divisional General Managers/Clinical Directors who are sponsor or lead on the development; implementation and review of Trust policies must ensure that they comply with this policy.

4.5 Policy Leads

All persons who have been given responsibility by the sponsor for the development, management, implementation and review of a policy must ensure that they comply with this policy.

4.6 Line Managers and Supervisors

Line managers and supervisors must ensure that all clinical staff are trained in relevant aspect of clinical record keeping, and that there is compliance with Trust policies and procedures. This should be in the form of induction training, internal induction by the line manager of the department and update training as reflected in staff personal training needs analysis, when required.

4.7 All Staff

All health care professionals have a legal duty of care and are responsible for any records (both paper and electronic) they may create or use. This responsibility is established and defined by the law. Safeguarding the confidentiality of records is detailed in the Data Protection Act (1998)⁴ and an individual's responsibility to information governance is highlighted in the Trust's Information Governance Framework Document.

This policy applies to all staff that makes entries into the health records, and includes Doctors, Nurses, and Allied Health Professionals. All clinical entries are the legal

and professional responsibility of qualified clinical staff and as such, he/she must recognise their personal accountability for entries to records by students or others under their supervision.

All staff including locums, agency and staff on honorary contracts and volunteers (where appropriate), are responsible for ensuring that the principles outlined within this policy are appropriately applied.

5. COMMON PROBLEMS WITH RECORD KEEPING

5.1 Common problems associated with poor record keeping include:

- Absence of clarity, use of ambiguous terms and too much jargon.
- Failure to record action taken when problem identified, e.g. 'is suffering increasing pain' then no record of action taken.
- Missing information, e.g. administration of a drug not documented.
- Inaccurate records, e.g. when the patient had not received the recorded treatment.
- Failure to document conversations with patient or the family.
- Failure to document care given and any special needs.
- Failures in communication between healthcare professionals, especially at points of transition of care.

6. STANDARDS OF RECORD KEEPING

6.1. Standards for making entries, into patient and clients records:

- All entries must be dated and timed, using the 24 hour clock
- Entries must be made soon as practicably possible after the events described. In the case of electronic records all entries are automatically dated and timed. If there is a delay, the time of the event and the delay should be recorded, providing contemporaneous information on the care and condition of the patient or client.
- Clearly identify the patient/client by name and X number and/or NHS number or date of birth (if X number and/or NHS number not available) on each page of the record.
- Identify the patient/client ethnicity.
- Record each patient/client contact – either direct or indirect contact.
- Be factual, consistent and accurate.
- Records should be consecutive, to reflect the continuum of patient care and should be viewed in chronological order.
- Write clearly and legibly and in such a manner that the text cannot be erased.
- Write in permanent black ink.
- Any alterations must be scored through with a single line, dated, timed (using the 24 hour clock) and initialled, so that the original entry can still be read clearly. A note should be made in the margin that the entry was made in error.
- Correction fluid e.g. Tippex or highlighter pen must not be used in patient records.
- Do not include jargon meaningless phrases, irrelevant speculation and offensive subjective statements.
- Records must be readable on any photocopies and faxes.
- Blank spaces or empty lines will not be left between entries; remove any blank spaces by drawing neat lines through them.

- Do not include abbreviations that are not nationally recognised or where they are used, a clear explanation is easily accessible in a locally agreed abbreviations glossary.
- Copies of letters sharing patient information with other agencies are sent to the patient where appropriate in accordance with the Trust's Copying Letters to Patient Policy.
- Any papers removed from the clinical file (for photocopying purposes) must be returned and filed immediately.
- On each occasion when the lead professional 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.
- An entry should be made in the medical record whenever the patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long stay continuing care, the next entry should explain why.
- Entries must be signed with the printed name and designation of the signatory alongside the first entry.
- Written information given to patients and carers must be noted along with details of any verbal instructions given.

6.2 Content of the clinical record

As a minimum the content of the in patient clinical record should contain the following components:

- A detailed account of the patient's assessment.
- The patient's name and X number and/or NHS number or date of birth should be entered on to each page.
- Diagnosis.
- Treatment plan.
- Operation details.
- Anaesthetic details.
- A clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient ensuring that any written entries and the signature are clear and legible.
- Health professionals must clearly countersign the signature of any student who is being supervised in the administration of medicines.
- Health education provided to the patient or family should be documented, including instruction on care, medications, treatments, dietary requirements and referral information. It should be noted if any written information is given to the patient or family.
- Discharge arrangements.
- Details of instructions relating to Do Not Resuscitate Orders, advanced directives and living wills should be located in the patient's records where it is clearly visible, ensuring that all health professionals are aware of the patient's wishes.
- Completed written consent forms, signed by the patient and health professional.
- When a death certificate is completed, an entry should be made stating the cause of death as appearing on the death certificate; whether a cremation form has been completed; whether and how the deceased relatives have been or will be informed.

- Follow-up entries should clearly record patient care and events since the previous entry, the assessment of the patient's condition, the new management plan, and documentation of any information given to the patient.

7. SECURITY AND CONFIDENTIALITY

Patient records must be kept safely at all times. How and where records are stored and who has access to them all impact on maintaining confidentiality of patient records. All staff have a duty to act in accordance with the Data Protection Act (1998)⁴ in maintaining patient confidentiality.

7.1 Records should routinely be:

- Stored safely in a secure base
- Filed in a systematic way to facilitate easy retrieval and should be returned to their place of storage as soon as possible after use, following the Trust's filing policy and sequence at all times. Records used by community nursing, therapy staff, medical or other staff on domiciliary visits must store all notes in staff bases/records stores overnight.

Under no circumstances must the notes be taken home with the practitioner or left unattended in staff vehicles. Records must not be visible within the car.

8 CALDICOTT

All staff have a duty to protect the confidentiality of the patient record. This is governed by the Caldicott principles¹ which include the following:

- Justify the purpose for using patient information
- Only use patient information when absolutely necessary
- Use the minimum information required
- Access to patient information should be on a strictly 'need to know' basis.
- All staff handling patient information should understand their responsibilities
- All staff handling patient information should understand and comply with the law relating to patient information

9. LEGAL ASPECTS

The principle of health records being factual, accurate and contemporaneous is paramount. This applies to whoever makes an entry in the record; any record entry will be held as a valid account of the patient/client contact.

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.

It must be assumed that any entry made in a patient or client record will be scrutinised at some point.

9.1 All staff have both a professional and a legal duty of care. The record keeping should therefore be able to demonstrate:

- A full account of the assessment and care that has been planned and provided
- Relevant information about the condition of the patient or client at any given time and the measures you have taken to respond to their needs
- Evidence that you have understood and honoured your duty of care, that you have taken all reasonable steps to care for the patient and that any actions or omissions on you or part have not compromised their safety in any way
- A record of any arrangements you have made for continuing care of a patient
- Use of professional judgement to determine the frequency of entries and decisions about what is relevant to record (NMC 2005)¹¹

9.2 Health professionals are professionally accountable for ensuring any duties they delegate to members of the health care team, who are not registered practitioners eg students or HCAs, are completed to a reasonable standard; they must be adequately supervised and competent to perform the task.

- Where duties, including record keeping, have been delegated to a healthcare assistant or other support assistant you must ensure they are competent to perform the task. There must be arrangements in place for reporting changes and regular review by the professional involved on at least a 3 monthly basis
- Where duties have been supervised (this includes all pre-registration students) the patient's clinical record must be countersigned to show that the supervisor has read through the documentation, verified the signature of the person the work has been delegated to and that the person was competent to carry out the duties delegated to them. The supervisor is professionally accountable for consequences of the record entry
- When working with clients who are subject to mental health legislation, the health professional must ensure that they have a thorough working knowledge of the statutory powers as applied to your particular area of practice. When making entries in records for these patients/clients you must comply as appropriate with the guidance given by the mental health commission for England and Wales and the Mental Capacity Act 2005¹⁰

10. **AUDIT OF CLINICAL RECORDS**

10.1 **Roles and responsibilities**

All clinical wards or teams that hold healthcare records should ensure that records are audited annually according to the standards set out in this policy.

The line manager for each clinical area is responsible for ensuring that records are kept to the standards set by the policy and that an audit of clinical records is undertaken annually.

The speciality or directorate clinical governance group has overall responsibility for ensuring local compliance with the policy. All completed audits should be written up and presented to the local clinical governance group. The outcomes of the audit should also be forwarded to the Clinical Governance Department for archive on the Trust Q drive. (A flow diagram of the process can be found in appendix 4)

10.2 **Audit procedure**

A minimum sample size of 10 sets of records should be audited for each clinical area. This should be considered as an absolute minimum.

The records should be selected randomly, although it should be ensured that a representative proportion is selected from different consultants' teams and include all Health Care professionals across this area.

The ward or clinical team should not audit their own records but agree a local working arrangement that promotes integrity and objectivity in the auditing process.

The Trust generic audit tool is available as appendix 1 and also available on the Clinical Governance Intranet site. The Trust tool can be adapted for local variation but must not compromise the benefits of the audit and must have the approval of the Clinical Governance Department. Alternatively, audit tools promoted (and validated for use) by professional bodies may be used but a specimen copy of the tool should be forwarded to the Clinical Governance Department.

11. **FORMAT OF AUDIT RECORD**

The audit report should contain the following as a minimum reporting set (A sample copy attached appendix 2):

- Methodology, must give precise details of the auditor/s and a clear description of the methods used.
- Findings, must give precise details of the recorded data percentages.
- Recommendations, must give a clear summary and recommendations for further work or training issues, which may have been highlighted through the audit.
- Action Plan. Generic action plan can be found on Appendix 3. Any action plan with clear development/learning outcomes must be filed with Clinical Governance with a proposed re audit date. A review of any action plan re audit must be carried out, reported, discussed and minutes filed at the local Clinical Governance meetings within the stated time scale. A full report must be submitted to the Clinical Governance department within the given timescales or a maximum of 6 months.

12. **TRAINING**

All healthcare professionals receive healthcare record keeping training within their professional basic training. On induction to the Trust they will receive an aide memoire of expected standards taken from the Trust policy and further training can be given if identified at appraisal by their line manager. Evidence of all induction and training will be held on ESR. Any subsequent updates to the policy will be communicated through the dissemination of information via an all user email and team briefings.

13. PROCESS FOR MONITORING

- 13.1 To ensure a continuous and complete record of care the Clinical Governance Department will ensure that a rolling programme of specialty or/and directorate record keeping audits are undertaken on an annual basis and are part of the specialty or/and directorate audit programme (appendix 7), evidence of audits will be filed on the Trust Q drive.
- 13.2 The reports and action plans of the audit will be discussed and reviewed by the local/directorate Clinical Governance group. The findings are to be disseminated to all staff groups with minutes of meetings stored on the Trust Q drive. As audits are completed by Speciality or/and directorates they will be submitted to the Clinical Governance Steering Group as part of their Clinical Governance review process.
- 13.3 Where directorates/specialties have failed to return, or have returned a non compliant audit, then this group will be asked to submit a letter/document explaining the reasons, action plans with specifically identified personnel responsible for carrying out the action plan and clear timescales for re audit.

The policy will be reviewed in 3 years by the Clinical Governance Department.

14. REFERENCES

1. Caldicott Report (1997) Department of Health.
2. Chartered Society of Physiotherapy (2005) Standards of Physiotherapy Practice, Chartered Society of Physiotherapy.
3. College of Occupational Therapists (2003) Professional Standards for Occupational Therapy Practice, College of Occupational Therapists.
4. Data Protection Act (1998) HMSO.
5. Department of Health (1999) For the record HSC 1999/053, Department of Health.
6. Department of Health (2006) Good Doctors, Safer Patients, DoH
7. NHSLA Risk Management Standards for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Independent Sector Providers of NHS Care (2011). NHS Litigation Authority
8. Good Medical Practice (2006) Regulating Doctors; Ensuring Good Medical Practice. General Medical Council
9. Human Rights Act (1998)
10. Mental Capacity Act (2005).

11. Nursing & Midwifery Council (2005) Guidelines for record keeping, Nursing & Midwifery Council.
12. Royal college of Physicians (2009) Generic medical record Keeping standards
13. Society of Chiropractors and Podiatrists (2004) Guidelines on Patient Records.

15. ASSOCIATED DOCUMENTATION

1. CHS Records Management Policy
2. CHS Copying Letters to Patient Policy
3. CHS Resuscitation Policy
4. Training Needs Analysis Policy
5. Induction Policy
6. CHS Confidentiality Policy
7. CHS Information Governance Framework Document

Appendix 1 Generic Documentation Audit proforma

Generic Record Keeping/documentation audit tool

Date of audit: / / / Site/Base:

Name of data collector: _____

Designation: _____

Records being audited: _____

NA = Not Applicable

1. Identification Data

Does the record contain:	YES	NO	NA
a The patient/client's name	<input type="checkbox"/>	<input type="checkbox"/>	
b Patient/client Address	<input type="checkbox"/>	<input type="checkbox"/>	
c Patient/client name on every page	<input type="checkbox"/>	<input type="checkbox"/>	
d Patient/client Identification Number (ID) on every page	<input type="checkbox"/>	<input type="checkbox"/>	
e Patient/client Date of Birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Details of next of kin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g Name(s) of professionals involved in patient/client's care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h Contact details of professional(s) involved in patient/client's care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Chronological order

	YES	NO
a Does the record provide a chronological account of the patient/client's care and progress?	<input type="checkbox"/>	<input type="checkbox"/>
(entries documented in date order)		

3. Legibility/Enhancement of Accuracy

	YES	NO	NA
a All entries written in permanent black ink?	<input type="checkbox"/>	<input type="checkbox"/>	
b Is the record free from blank spaces?	<input type="checkbox"/>	<input type="checkbox"/>	
c Is the record free from correction fluid and highlighter?	<input type="checkbox"/>	<input type="checkbox"/>	
d Are entries free from abbreviations/symbols?	<input type="checkbox"/>	<input type="checkbox"/>	
e Have errors been scored out with a single line?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Have errors been initialled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g Have errors been dated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h Have errors been timed using the 24 hour clock?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Legibility/Enhancement of Accuracy continued.....

	YES	NO	NA
i Are photocopies/faxes legible?	<input type="checkbox"/>	<input type="checkbox"/>	
j Are all written entries legible?	<input type="checkbox"/>	<input type="checkbox"/>	
k Are all written entries free of offensive, subjective statements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l Is there evidence that consent has been gained from the patient/client to share the information with other agencies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m Is there evidence that consent has been gained from the patient/client for copies of letters to be sent to them where appropriate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n Is there evidence of agreed consent from the individual to their planned intervention, care or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
o Are all entries written in terms that the patient/client can understand?	<input type="checkbox"/>	<input type="checkbox"/>	

4. Dates and Signatures

	YES	NO	NA
a Is there an area in the record or a register that identifies each user's signature?	<input type="checkbox"/>	<input type="checkbox"/>	
b Is there an area in the record or a register that contains each user's printed name?	<input type="checkbox"/>	<input type="checkbox"/>	
c Is there an area in the record or a register that identifies each user's designation?	<input type="checkbox"/>	<input type="checkbox"/>	
d Have all entries in the notes been signed?	<input type="checkbox"/>	<input type="checkbox"/>	
e Have all entries in the notes been dated?	<input type="checkbox"/>	<input type="checkbox"/>	
f Have all entries in the notes been timed using 24 hr clock?	<input type="checkbox"/>	<input type="checkbox"/>	
g Have entries by unqualified staff been countersigned by an appropriate professional?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Storage of Records

	YES	NO
a Are records kept in a place that ensures confidentiality will be upheld?	<input type="checkbox"/>	<input type="checkbox"/>
b Are filing cabinets lockable?	<input type="checkbox"/>	<input type="checkbox"/>
c Are records filed in alphabetical order?	<input type="checkbox"/>	<input type="checkbox"/>

Please use this area for comments on any of the above:

CLINICAL RECORD KEEPING AUDIT REPORT TABLE

Directorate of	– Dept of		
Title:	Annual audit of record keeping		
Aim	To assess the current standards of record keeping with in Speciality/directorate		
Standards	As per CHS Trust record keeping policy. Accepted standard is 100%		
Method	Retrospective data collection. A random selection of (number audited, min 10) notes were audited and drawn from(current patient's on the ward/patient's notes who are currently attending for treatment. The notes were audited byusing the CHS Trust generic audit tool. Staff to expand this section for individual audits		
Results	Section 1	current audit	Previous audit's
	A	%	% %
	B	%	% %
	Etc.		
	Section 2		
	A		
	Section 3		
	A		
	B		
	Etc.		
	Section 4		
	A		
	B		
	Etc.		
	Section 5		
	A		
	B		
	C		
Limitations			
Conclusions	The record keeping within thespecialty/department has been audited and found to be compliant/non compliant with the record keeping policy		
Recommendations	It is recommended that an action plan should be drawn up covering areas that have been highlighted as poor compliance. This action plan must include the names of individuals who will take the work forward and a specific review date of the action plan. (recommended review date of 6 months)		

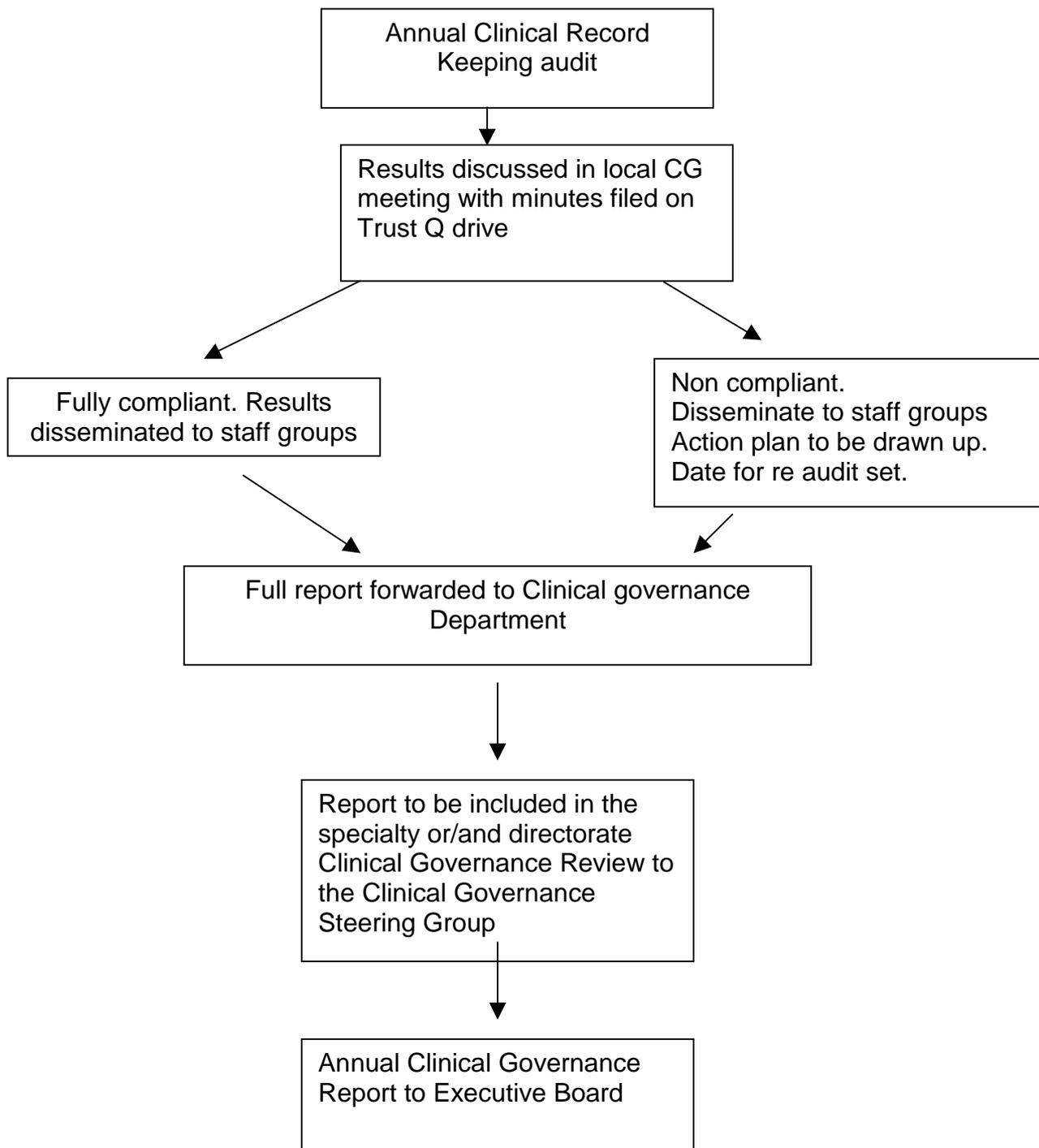
Name

Date

RECORD KEEPING AUDIT ACTION PLAN

Date of audit	Section number	Reason for failure to comply	Action to be taken/learning outcomes	Person Responsible	6 month Review date

Process of Clinical Record Keeping Audit Process



APPENDIX 5

PLAIN ENGLISH GUIDE OF POLICY FOR CLINICAL RECORD KEEPING

What is the policy for?

This policy explains how we must record accurate clinical records of our patients.

What does the policy say?

LEGAL ASPECTS

If you contribute to the care of a patient you have a legal duty to provide a clear written accurate account of any care given to the patient.

- The legal approach tends to be “ if it’s not written down it didn’t happen”
- This applies to all medical records both electronic and paper notes.

STANDARDS OF RECORD KEEPING.

The minimum standards for making written or electronic entries into the patient’s records are as follows:

- All entries must be dated and timed using the 24hour clock (i.e. 4.30pm would read 16.30).
- The patient’s name and X number and/or NHS number or date of birth (if X number and/or NHS number not available) must be written on every page of the record.
- All entries must be in permanent black ink.
- All entries must be made soon as possible after the events described. In the case of electronic records all entries are automatically dated and times. If there is a delay, the time of the event and the delay should be recorded.
- Write clearly and legibly.
- Records must be based on the actual facts of the event, be consistent and accurate.
- Records must show the continued care of the patient and must be viewed in date order.
- All alterations/mistakes must have a single line through and be dated and timed (using the 24 hour clock) and initialled, The original entry must still be seen. A note in the margin should be made explaining that the entry was made in error.

- Correction fluid (tippex or highlighter pen) must not be used in patient's records.
- Do not use jargon, comments or statements which do not exactly explain the patient's care.
- All faxes or photocopies must be clear and readable.
- Do not leave any blank spaces. All blank spaces must have a neat line drawn through them.
- You can only use the abbreviations that are agreed both nationally or locally.
- Any letters which are sent to the patient and other agencies must follow the trusts copying letters to patient's policy. Any papers removed from the patients file for photocopying must be returned and filed immediately.
- When the lead professional responsible for the patient's care changes, the name of the new lead /consultant will be recorded in the patients notes along with the date and time of agreed transfer of care.
- Each time the patient is seen by the doctor an entry should be made in their medical records. When there is no entry in the hospital record for more than 4 days for acute medical care or 7 days for long stay continuing care, the next entry should explain why.
- Every entry in the patient's notes must be signed including your role for example HCA and dated.
- Any information given to patients and relatives whether written or verbal must be recorded in the notes.

SECURITY AND CONFIDENTIALITY

Patient's records must be kept safe at all times. All staff have a duty to follow the Data Protection Act (1998) in maintaining patient confidentiality.

- All records must be stored in a secure base.
- Any Records used by community nursing staff, medical or other staff on home visits must store notes in the staff base overnight, unless they are kept in the patient's homes.

Under no circumstances must the notes be taken home with the practitioner or be left unattended in staff vehicles. Records must not be visible within the car.

AUDIT OF CLINICAL RECORDS

All clinical wards or teams that hold patient healthcare records will ensure that records are audited once a year.

All of the completed audits must be written up and presented to the local Clinical Governance group.

PROCESS FOR MONITORING

The Clinical Governance Department will ensure that a rolling programme of specialty/directorate record keeping audits is carried out on a yearly basis. The results, reports and action plans of the audit will be discussed and reviewed by the local/directorate Clinical Governance group.

Any concerns or questions please ring Clinical Governance Department on 42163.

Aide memoire for clinical record keeping

Standards for making entries, into patient and clients records:

- All entries must be dated and timed, using the 24 hour clock
- Entries must be made soon as practicably possible after the events described. In the case of electronic records all entries are automatically dated and timed. If there is a delay, the time of the event and the delay should be recorded, providing contemporaneous information on the care and condition of the patient or client.
- Clearly identify the patient/client by name and X number or date of birth (if X number not available) on each page of the record.
- Identify the patient/client's ethnicity.
- Record each patient/client contact – either direct or indirect contact.
- Be factual, consistent and accurate.
- Records should be consecutive, to reflect the continuum of patient care and should be viewed in chronological order.
- Write clearly and legibly and in such a manner that the text cannot be erased.
- Write in permanent black ink.
- Any alterations must be scored through with a single line, dated, timed (using the 24 hour clock) and initialled, so that the original entry can still be read clearly. A note should be made in the margin that the entry was made in error.
- Correction fluid e.g. Tippex or highlighter pen must not be used in patient records.
- Do not include jargon meaningless phrases, irrelevant speculation and offensive subjective statements.
- Records must be readable on any photocopies and faxes.
- Blank spaces or empty lines will not be left between entries; remove any blank spaces by drawing neat lines through them.
- Do not include abbreviations that are not nationally recognised or where they are used, a clear explanation is easily accessible in a locally agreed abbreviations glossary.
- Copies of letters sharing patient information with other agencies are sent to the patient where appropriate in accordance with the Trust's Copying Letters To Patient Policy.
- Any papers removed from the clinical file (for photocopying purposes) must be returned and filed immediately.
- On each occasion when the lead professional 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.
- An entry should be made in the medical record whenever the patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long stay continuing care, the next entry should explain why.
- Entries must be signed with the printed name and designation of the signatory alongside the first entry.
- Written information given to patients and carers must be noted along with details of any verbal instructions given.

Schedule of Clinical Record Keeping Audits 2011

Division of Medicine	
Neurology	Feb 2011
Care of the Elderly	Sept 2011
Rheumatology	Aug 2011
Cardiology	Sep 2011
Met Med	June 2011
Thoracic Med	Oct 2011
Gastro	June 2011
Oncology	Aug 2011
Haematology	Oct 2011
Renal	July 2011
A&E	Nov 2011
AMU	Nov 2011
Division of surgery	
General Surgery	June 2011
Urology	July 2011
Ophthalmology	Aug 2011
ENT	Feb 2011
Oral & Facial	Sep 2011
T&O	June 2011
Division of Family Care	
Gynaecology	Aug 2011
Obstetrics	Aug 2011
Paediatrics	Mar 2011
Neonatal	April 2011
CAMHS	Oct 2011
Contraceptive Services	June 2011
GUM	June 2011
Division of Clinical Support	
Pharmacy	Sep 2011
SALT	Feb 2011
Physiotherapy	April 2011
Podiatry	Feb 2011
Occ Therapy	Feb 2011
Community Stroke Team	April 2011
Dietetics	Feb 2011
Radiology	Aug 2011
ICCU	July 2011
Anaesthetics	Aug 2011