Trust Policy

Plymouth Hospitals NHS
NHS Trust

Clinical Record Keeping Policy

Issue Date	Review Date	Version
August 2017	**August 2022**	**5**

Purpose

Health records should provide an accurate, legible and contemporaneous record of patient care. It is essential that health records:

- Are accurate, complete and up to date;
- Maximise patient safety;
- Document and support the delivery of high quality of patient care;
- Support professional best practice; and
- Ensure compliance with key legislation such as:
    - Health and Social Care Act 2008 (Regulated Activities).
    - Data Protection Act 1998.
    - Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

The Trust must be assured that patient care is not compromised as a result of poor quality health records.

To ensure that the health record is of a sufficient standard to justify clinical decisions made, assist with complaint and incident investigations and to support litigation proceedings. Inaccurate or incomplete records may have serious consequences if required for legal purposes such as Court of Law or Coroner's inquest.

This policy describes the required clinical content of electronic and paper health records and not the physical structure, accessibility or administrative processes such as filing, tracking or storage.

Who should read this document?

All staff who contribute to the clinical content of patient health records.

Key Messages

The failure to maintain health record standards may also result in Trust and professional body disciplinary action.

All records must be:

- Complete;
- Legible;
- Permanent;
- Accurate and up to date; and
- Signed, with date and time documented

For each contribution to the health records, individuals are required to clearly identify themselves with the following information:

- Full name;
- Job title;
- Professional registration number and/or contact number/bleep and designated location;
- Signature

The time (in 24 hour format), date and location must also be recorded for each entry.

Core accountabilities	
Owner	Assistant Medical Director for Quality
Review	Assistant Medical Director for Quality/Deputy Audit, Assurance and Effectiveness Manager
Ratification	Medical Director
Dissemination	Clinical Effectiveness Group
Compliance	Clinical Effectiveness Group

Links to other policies and procedures
Health Records Policy Data Quality Policy Data Protection Policy Enhanced Observation of Patients Policy Essential Adult Inpatient - Observations, Reporting and Escalation Policy APNs (Administrative Procedure Notes)

Version History		
V1.1	16 Apr 2008	Reviewed & Amended Deputy Director of Professional Practice & Director of Nursing
V1.2	30 Apr 2008	Reviewed & Amended by HRC
V1.3	Sept 2008	CGSG & CGC approved
V1.4	Sept 2008	Published on Public Folders
V2.1	June 2009	Reviewed with minor amendments to Audit Process and APN Changes
V2.2	Feb 2010	Minor Amendments to incorporate new NHSLA Standards (approved by HRC March 2010)
V3	July 2012	Full review of content and format change. Reviewed by Health Records Steering Group and Effective Care Group.
V4	Sept 2012	Minor amendment to incorporate Appendices 4, 5 and 6 – Procedure for the Development of Patient Forms
V5	August 2017	Full review

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

Contents

1 Introduction

Good record keeping improves patient safety and maintains the quality of care provided to our patients. Patient care must not be compromised due to poor quality of health records.

Accurate health records can determine accountability, justify clinical decision making, improve patient care through clear communication of the treatment rationale and help defend complaints or legal proceedings.

The failure to maintain record keeping standards can lead to a patient's care being adversely affected by one or more of the following scenarios:

- Failures in continuity of care;
- Inadequate or inappropriate management of a patient;
- Increased risk of medication and treatment errors;
- Communication problems between staff, patient, relatives and carers

2 Purpose

This policy describes the required clinical content of electronic and paper health records and not the physical structure, accessibility or administrative processes such as filing, tracking or storage.

Health records should provide an accurate, legible and contemporaneous record of patient care. It is essential that health records:

- Are accurate, complete and up to date;
- Maximise patient safety;
- Ensure high quality of patient care is delivered;
- Support professional best practice; and
- Ensure compliance with key legislation such as:
    - Health and Social Care Act 2008 (Regulated Activities).
    - Data Protection Act 1998.
    - Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).

The Trust must be assured that patient care is not compromised as a result of poor quality health records.

The health record may be used to justify clinical decisions made or to support litigation proceedings. Inaccurate or incomplete records may have serious consequences if required for legal purposes such as Court of Law or Coroner's inquest.

The failure to maintain health record standards may also result in in Trust and professional body disciplinary action.

3 Definitions

Health Record - The Data Protection Act 1998 describes the health record as "consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual". A health record is not specifically the paper casenotes but any clinical entry relating to patients' healthcare.

Record-keeping standards – The Royal College of Physicians published 12 generic record keeping standards in 2007 that define good practice for clinical record keeping **(Appendix 1)**

Professional registration – The majority of health care professions are required to become members of a professional body such as the General Medical Council (GMC) or Nursing and

Midwifery Council (NMC). Individuals are also required to demonstrate their competency and adherence to the relevant professional body code of practice at regularly registration reviews known as revalidation.

4 Duties

Chief Executive
The Chief Executive has overall accountability for standards of clinical record keeping.

Medical Director and Chief Nurse
The Medical Director and Chief Nurse have delegated responsibility for ensuring adherence to the record standards outlined in this policy for their areas of responsibility.

Service Line and Care Group Management Teams
The Service Line and Care Group Management teams are responsible for:

- Promoting high standards of record keeping;
- Assuring the standard of clinical record keeping through clinical record audits;
- Reviewing and acting on incidents reported relating to the quality of health records;
- Staff receiving appropriate training; and
- Implementing and monitoring action plans where improvement in clinical record keeping has been identified.

Deputy Audit, Assurance and Effectiveness Manager
The Deputy Audit, Assurance and Effectiveness Manager is responsible for the management of the clinical audit plan which encompasses clinical record keeping audits. In addition, for ensuring that the clinical record keeping audit results are made available to support the evidence submission for Information Governance Toolkit requirement 404.

Clinical Effectiveness Group
The Clinical Effectiveness Group is responsible for the review of this policy and monitoring compliance via the clinical record keeping audits.

Data Quality Team
The Data Quality Team is responsible for reviewing and monitoring the quality of information in the creation, accuracy and management of electronic records on the Trust patient administration system using a suite of data quality reports.

Registered Nurses
All Registered Nurses have a responsibility to countersign observation charts and patient casenotes at least once per shift and at each new patient takeover.

All staff
All staff that contribute to the content of clinical records have a personal duty to ensure that all clinical record entries made adhere to the Data Protection Act 1998 and that they are accurate, relevant and up to date.

All staff are responsible for reporting incidents relating to the quality of health records on Datix.

5 Basic principles and Trust policy

The Royal College of Physicians generic record keeping standards detailed at **Appendix 1** are regarded as best practice. All staff are therefore expected to adhere to these as a minimum.

The basic principles are that:

- All entries must be made as soon as possible after an event and any delays in documentation must be recorded.
- All entries must be clearly dated DD/MM/YYYY.

- All entries must have the time recorded in 24 hour clock format HH:MM.
- Errors require single strikethrough followed by date, time and signature.
- All entries must be in chronological order.
  - Individuals must be clearly identified for each entry:
    - Full name;
    - Job title;
    - Professional registration number and/or contact number; and
    - Signature.
  - Entries made by students must be countersigned by the Supervisor.
  - Use of correction fluids, tapes or marker pens is prohibited.
  - Pages must not be torn from the health record or electronic entries deleted.

Use of professional registration stamp
The use of a professional registration stamp is permitted within the clinical record but the entry must be accompanied with time, date and a signature.

Documenting patient observations
The first set of observations to be documented upon arrival or through transfer must be undertaken by a Registered Nurse.

Subsequent observations and entries within the patient casenotes undertaken by Health Care Assistants, Student Nurses and Trainee Nursing Associates must be countersigned by a Registered Nurse at least once per shift.

Nursing staff that are covering a ward must state the name of their dedicated ward location and locum staff must state the name of the agency.

Countersigning
All student entries must be countersigned by the supervisor.

Ink colour
All health record entries must be written in permanent ink such as **black** or **blue** ballpoint to ensure that the record cannot be erased. Fountain or gel based pens are not considered appropriate because they may become illegible through smudging or fading over time. The use of **red** ink on surgical records is acceptable practice now that previous concerns relating to health record copying for subject access requests has been mitigated by advances in photocopying technology.

Pharmacists and Pharmacy Technicians are permitted to use **green** indelible ink for drug charts and within the patient casenotes.

The use of pencil is not permitted.

Use of abbreviations
The use of abbreviations and acronyms in clinical records can lead to variability in understanding, lead to misinterpretations across specialties and place patients at risk of clinical harm.

All abbreviations used must be documented in full in the first instance e.g. Lower Left Lung (LLL).

Abbreviations must never be used in a derogatory way to describe patients.

6 Regulatory and professional registration requirements

Documentation of clinical evaluation (Ionising Radiation (Medical Exposure) Regulations 2000)
It is a legal requirement that a written clinical interpretation of the outcome and implications of, and of the information resulting from, a medical exposure are clearly documented in the health record.

This is the case whether the images are reported by Imaging or auto-reported.

Reporting is routinely undertaken by the Imaging Service Line with the exception of unreported images which are the responsibility of the areas that have taken them *(auto-reporting)*. In this case Imaging has compiled a list of agreed self-reported images.

Dispute with the accuracy of the clinical record
The Information Commissioner's Office states that:
"A mis-diagnosis of a medical condition must continue to be held as part of a patient's clinical record even after the diagnosis because it is relevant for the purpose of explaining treatment given to the patient, or to additional health problems.

Individuals sometimes want the initial diagnosis to be deleted on the grounds that it was, or proved to be, inaccurate. However, if the patient's records accurately reflect the doctor's diagnosis at the time, the records are not inaccurate, because they accurately reflect a particular doctor's opinion at a particular time. Moreover, the record of the doctor's initial diagnosis may help those treating the patient later"

It is therefore good practice to record a patient dispute within the health record and it is essential that any corrections are clearly documented.

If the information being disputed has been released to a third party organisation as part of a regulatory requirement or with patient consent, such as the Driver and Vehicle Licensing Agency (DVLA) or to a solicitor, the 3rd party organisation must be informed that there is a dispute and the nature of the dispute.

General Medical Council (GMC)– Good Medical Practice
"Record your work clearly, accurately and legibly"
- Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.
- You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection requirements.
- Clinical records should include:
  - relevant clinical findings;
  - decisions made and actions agreed, and who is making the decisions and agreeing the actions;
  - information given to patients;
  - drugs prescribed or other investigation or treatment; and
  - who is making the record and when.

Nursing and Midwifery Council (NMC) - The Code for nurses and midwives
"Keep clear and accurate records relevant to your practice"
To achieve this, you must:
- Complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event.
- Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.
- Complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.
- Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.
- Take all steps to make sure that all records are kept securely.
- Collect, treat and store all data and research findings appropriately.

Health and Care Professions Council (HCPC)
"Keep records of your work"

- You must keep full, clear, and accurate records for everyone you care for, treat, or provide other services to.
- You must complete all records promptly and as soon as possible after providing care, treatment or other services.

7 Overall Responsibility for the Document

The Assistant Medical Director for Quality and Safety has overall responsibility for this document under delegated authority of the Medical Director.

8 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal Documents.
The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.
This document has been reviewed by the Clinical Effectiveness Group and ratified by the Medical Director.
Non-significant amendments to this document may be made, under delegated authority from the Medical Director, by the nominated owner. These must be ratified by the Clinical Effectiveness Group.
Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades that are directly affected by the proposed changes.

9 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

This policy will also be distributed to Service Line and Care Group Management Teams.

10 Monitoring Compliance and Effectiveness

Quality Assurance Committee
The Quality Assurance Committee acts as the lead executive forum for seeking assurance on delivery of the Trust's 'Quality Care' aim. The Clinical Record Keeping topic compliance assessment is reviewed annually through the committee. The Quality Assurance Committee provides assurance and escalates any significant issues to the **Safety and Quality Committee**.

Clinical Effectiveness Group
The Clinical Effectiveness Group acts as the lead executive forum for monitoring the progress of corporate audit priorities such as clinical record keeping. The group also reviews audit results of significance.

There is a corporate priority audit requirement to undertake regular clinical record keeping audits. This is overseen by the Audit, Assurance and Effectiveness Team.

The evidence of the clinical record keeping audits is submitted to the Information Governance Toolkit on a twice yearly basis.

A quarterly activity report is presented to the Clinical Effectiveness Group and an annual clinical audit report is published on StaffNET.

11 References and Associated Documentation

Information Commissioners Office guidance, Principle four of the Data Protection Act - https://ico.org.uk/for-organisations/guide-to-data-protection/principle-4-accuracy/

Record Keeping Standards | Appendix 1

Generic medical record keeping standards define good practice for medical records and address the broad requirements that apply to all clinical note keeping. These standards were developed by the Health Informatics Unit of the Royal College of Physicians following review of published standards and wide consultation. They were first published in 2007.

Standard	Description
1	The patient's complete medical record should be available at all times during their stay in hospital
2	Every page in the medical record should include the patient's name, identification number (NHS number) and location in the hospital
3	The contents of the medical record should have a standardised structure and layout
4	Documentation within the medical record should reflect the continuum of patient care and should be viewable in chronological order
5	Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma
6	Every entry in the medical record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature. Deletions and alterations should be countersigned, dated and timed
7	Entries to the medical 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. If there is a delay, the time of the event and the delay should be recorded
8	Every entry in medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made
9	On each occasion 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
10	An entry should be made in the medical record whenever a 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
11	The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital
12	Advanced Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decisions must be clearly recorded in the medical record. In circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney

Dissemination Plan and Review Checklist	Appendix 2

Dissemination Plan	
Document Title	Clinical Record Keeping Policy
Date Finalised	July 2017
Previous Documents	
Action to retrieve old copies	Remove from StaffNET Trust document library

Dissemination Plan			
Recipient(s)	**When**	**How**	**Responsibility**
All Trust staff	August 2017	Vital Signs	Information Governance Team
Service Line and Care Group Management Teams	August 2017	Email	Deputy Audit, Assurance and Effectiveness Manager

Review Checklist		
Title	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
Rationale	Are reasons for development of the document stated?	Yes
Development Process	Is the method described in brief?	Yes
	Are people involved in the development identified?	Yes
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	Yes
Content	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
Evidence Base	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	Yes
	Are supporting documents referenced?	Yes
Approval	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes
	Does the document identify which Executive Director will ratify it?	Yes
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	Yes
Document Control	Does the document identify where it will be held?	Yes
	Have archiving arrangements for superseded documents been addressed?	Yes
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes
	Is there a plan to review or audit compliance with the document?	Yes
Review Date	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	Yes
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

Equalities and Human Rights Impact Assessment	Appendix 3

Core Information	
Date	August 2017
Title	Clinical Record Keeping Policy
What are the aims, objectives & projected outcomes?	It is intended to inform staff who record information in the hospital case note of the requirements around the standard of record keeping expected both legally and by the Trust to ensure the highest standards of record keeping.

Scope of the assessment
This assessment will highlight any areas of inequality with the implementation of this policy.

Collecting data	
Race	This is mitigated as the Policy is available in other languages
Religion	The document has no impact in this area.
Disability	This is mitigated as the document is available in various formats.
Sex	The document has no impact in this area.
Gender Identity	The document has no impact in this area.
Sexual Orientation	The document has no impact in this area.
Age	The document has no impact in this area.
Socio-Economic	The document has no impact in this area.
Human Rights	The document has no impact in this area.
What are the overall trends/patterns in the above data?	There are no trends or patterns in the above data.
Specific issues and data gaps that may need to be addressed through consultation or further research	Trustwide documents can be made available in various different languages and formats.

Involving and consulting stakeholders	
Internal involvement and consultation	The policy has been developed by the Assistant Medical Director for Quality and Safety supported by the Deputy Audit, Assurance and Effectiveness Manager. All staff groups have been consulted during the policy revision.
External involvement and consultation	The document has been considered in line with all legal, professional and regulatory bodies requirements
Impact Assessment	
Overall assessment and analysis of the evidence	The potential impact on race and disability groups has been mitigated through the availability of copies in alternative languages and formats.

Action Plan

Action	Owner	Risks	Completion Date	Progress update
To disseminate policy to all staff groups	Katie Hooper	None	August 2017	