Mid Essex Hospital Services NHS
NHS Trust

CLINICAL RECORD KEEPING STANDARDS	**Policy** **Register No: 08086** **Status: Public**

Developed in response to:	Information Governance Toolkit Code of Practice for Records Management Best practice
Fundamental Standards	4 & 21

Consulted With:	**Individual/Body:**	**Date:**
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Professionally Approved By:		
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Author/Contact for Information	Su Ames, Patient Safety Manager
Policy to be followed by (target staff)	All Staff making entries in clinical medical records
Distribution Method	Intranet & Website
Related Trust Policies (to be read in conjunction with)	04080 Consent Policy 09100 Incident Policy 08020 Retention and Destruction schedule 04084 Records Management Strategy 10080 Adult Observations Policy 05182 Adult Do not attempt resuscitation policy 08076 Clinical Audit Strategy & Policy 05111 Resuscitation Policy 11001 Mental Capacity Act Policy 07011 Confidentiality Policy 07010 Data Protection Strategy 08063 Being Open Policy 04086 Access to Records Policy 06036 Record Keeping in Maternity

Document Review History:

Review No:	**Reviewed by:**	**Issue Date:**
1.0	Helen Clarke	23rd March 2011
2.0	Helen Clarke	7th November 2011
2.1	Helen Clarke – clarification to include drug chart record keeping requirements and amended organisational structure	April 2014
3.0	Helen Clarke - Full review	June 2014
4.0	Su Ames – Full review	22nd October 2018

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1.0 Purpose

1.1 The purpose of this policy is to provide guidance to staff employed by Mid Essex Hospital Services Trust, hereafter referred to as the Trust, who contribute to paper and electronic health records.

1.2 The policy describes the basic record-keeping standards that all staff groups are required to adhere to when contributing to clinical records of patients under the care of the Trust. The standards set out in this policy do not replace standards set by professional organisations but are complementary to them.

1.3 In addition, implementation of the policy addresses the requirements of the NHS Digital Data Security and Protection Toolkit annual assessment.

2.0 Background

2.1 Clinical record keeping is an integral part of high quality treatment and care and all healthcare professionals have a responsibility to record accurate information about the care they are providing. The benefits of good record keeping include:

- Promoting high standards of clinical care by acting as a tool for assessment, treatment and care delivery;
- Providing a means of enhancing patient safety, minimising the likelihood of delays or inappropriate care;
- Providing an accurate account of treatment and care planning;
- Promoting effective communication that delivers continuity of care between members of the multidisciplinary health care team;
- Demonstrating that care follows evidence-based guidance or evidences variances including decisions not to treat; and
- Acting as a record of any problems that have arisen such as changes in the patient's condition and actions taken as a result.

2.2 Many professional disciplines produce guidelines for record keeping that should be read in conjunction with this policy. The standards stated within this policy are the minimum standards expected of practitioners within MEHT.

2.3 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 brought against NHS organisations.

2.4 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals

3.0 Scope

3.1 This policy applies to clinical records in use in all clinical areas of the Trust and to all individuals employed by the Trust including students, locum, bank and agency staff who contribute to the patient record.

3.2 This document applies to all contributions to paper and electronic records which are generated in the course of patient care and should be read in conjunction with guidelines on clinical record keeping issued by all relevant professional bodies, the NHS Record Keeping Code of Practice.

3.3 The policy does not describe the standard design of paper records. For further information refer to the Medical Records Policy

4.0 Definitions

Clinical records include:

- Notes made by doctors, nurses, midwives, allied healthcare professionals, social workers, technical and scientific staff and students;
- Operation notes, care plans, patient/parent held records, A&E cards, drug charts, prescriptions, transfer/referral records, maternity records, discharge summaries;
- Electronic records including but not limited to Metavision, PACS, eMED, Pathology System, Diamond, Lorenzo, printouts from monitoring and diagnostic equipment; etc
- All and any patient related correspondence.

5.0 Roles and Responsibilities

5.1 Managing Director

The Managing Director has overall responsibility for ensuring that the Trust has the necessary management systems in place to enable the effective implementation of this policy and overall responsibility for the health and safety of staff, patients and visitors.

5.2 Chief Medical Officer

The Chief Medical Officer is the designated Board Member for Patient Safety and has overall accountability for the management of health records.

5.3 Governance Performance Group

The Governance Performance group will receive the annual record keeping audit of compliance with the requirements of this policy and will be responsible for approving the report and associated organisational action plan.

5.4 **Business Information Group**

As specified in Information Governance Toolkit 404, the Business Information Group will receive the results of the annual clinical record audit undertaken.

5.5 **Corporate Nursing, Clinical Directors, Associate Directors of Nursing, Matrons, Chief Pharmacist**

- To promote high standards of clinical record keeping within their area of responsibility in accordance with this policy.

- To support participation in the annual documentation audit and ensure the audit report is disseminated within their area.

- To ensure action plans to address deficiencies in clinical record keeping identified by audit are reviewed at departmental meetings including Directorate Governance Meetings on a regular basis.

5.5 **Professionally Qualified Clinical Staff**

Each practitioner bears individual responsibility for:

- Their own clinical record keeping;

- Ensuring that where students or non-professionally qualified staff under their supervision complete clinical documentation, that meets the standards detailed in this policy.

5.6 **Ward and Department Managers**

- Ensure that clinical record keeping in their area is of the standard defined in this policy.

- Ensure participation in the annual audit and dissemination of findings to staff.

- Review audit reports and the relevant action plan addressing identified deficiencies.

- Ensure that any incidents that arise with regard to clinical record keeping are reported and managed in accordance with the Incident Policy.

- Maintain a regularly updated register of names and signatures

5.7 **All Trust staff**

Every member of staff who contributes to paper or electronic health records is responsible for:

- Correctly filing documents they have received in accordance with the rules printed on the inside back cover of all patients records;

- Ensuring any contribution to the clinical record meets the standards set in this policy;

- Reporting any near miss or incident relating to clinical record keeping that they witness or are involved in (in accordance with the Incidents Policy).

- All staff contributing to clinical record keeping must ensure that they comply with all legal and professional obligations with regards to the Data Protection Act 1998

5.8 **Risk Management Team**

The Risk Management Team are responsible for reporting incidents relating to clinical record keeping to the General Manager for Medical Records for investigation.

5.9 **Clinical Audit Department**

The Clinical Audit department is responsible for developing clinical audit pro formas for the audit of clinical record keeping in response to local and national drivers and for analysing audit data and disseminating the findings appropriately.

6.0 General Principles

6.1. The Trust is committed to managing the risks associated with clinical record keeping to facilitate the delivery of safe and effective care. Therefore all clinical records must be:

- Clear, accurate and legible
- Chronological and made contemporaneously
- Attributable
- Relevant
- Suitably frequent

6.2 An entry should be made in the hospital record whenever a patient is seen by a healthcare professional. There should be daily entries in acute care. If there is no entry, the next entry should explain why.

6.3 The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital.

6.4 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. For further guidance refer to the Consent Policy, the Adult Do Not Attempt Resuscitation Policy, Resuscitation Policy, Mental Capacity Act Policy

6.5 **Record keeping standards**

- Clinical records must be clear, factual, consistent, accurate and legible.

- Clinical records must be in black or dark blue suitable for photocopying. – the important factor is that it is not faint or “spidery”:

    - Operation notes may be made in red ink
    - Contributions from pharmacy staff may be made in green ink

- Clinical records must be dated and timed (24 hour clock).

- Clinical records must be signed with name and designation of the author printed to ensure that each entry can be attributed to an individual. Use of stamps issued by the Trust is acceptable.

- Every entry in the medical record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made.

- On each occasion the consultant responsible for the patient’s care changes, the name of the new responsible consultant and the date and time (24 hour clock) of the agreed transfer of care, should be recorded.

- Clinical records must be in chronological order within specialty.

- Retrospective information which needs to be added to the record should be entered as the next chronological entry using the current date and time (24 hour clock) and reference made to the date to which it relates.

- Clinical records must be written contemporaneously providing current information on the care and condition of the patient.

- Clinical record entries must not be erased. Justifiable alterations or additions may be made if dated, timed (24 hour clock) and signed and clearly attributable to a named person in an identifiable role in such a way that the original entry can be read clearly. Correction fluid must not be used.

- Clinical records must not include inappropriate abbreviations that would be out of context within the document.

- Clinical records should not include jargon, meaningless phrases, irrelevant speculation or subjective statements. Clinical Staff must bear in mind that patients have access to their records under the Data Protection Act.

- In nursing notes, the signatory sheet or first entries for each patient during a shift must be signed with name printed and designation recorded. All entries thereafter must be initialled.

- If record keeping is delegated to a student nurse then the record must be countersigned by a registered nurse. Signatures must be used not initials. Health professionals must clearly countersign the signature of any student who is being supervised in the administration of medicines.

- All users of care pathway documents must sign the sample signature sheet that is part of the documentation and each entry must show the date and time that the entry has been made.

6.6 Every page in the clinical record should include patient's name, NHS number and hospital number and location in the hospital. The patient identifiers must be the NHS and hospital number wherever these are known but may be the ED card number where the NHS or hospital number is not known.

6.7 The primary patient identifier is **always** the NHS/Hospital number and this must be recorded on every document created.

6.8 **Clinical information should include**

- A written diagnosis or differential diagnosis and reason for admission or referral
- An initial patient history including history of present condition, details of current medication, allergies, past medical history and social history
- A record of initial physical examination
- Assessments
- Plans of care including any concerns, and the details of any action you have taken; information you have shared and decisions you have made relating to those concerns
- Treatment and or interventions given
- Progress notes, observations and consultation reports
- Results of investigations (for example, pathology, imaging, photographs)
- Drug therapy records
- The appropriate completed consent form signed by the patient and health professional, where written consent is required
- Discharge arrangements.
- Details of instructions relating to 'do not resuscitate orders' and advanced directives.
- A note of all untoward and unexpected events and any actions taken including discussions with patients and / or carers (refer to Incident and Being Open Policies).

6.9 **All clinical records will:**

- Maintain the confidentiality of the information to be documented or recorded with no information on the outside of case notes other than name and NHS and

/ or Hospital number. An Alert sticker should be used to make staff aware of important information see 6.6.

- Use the NHS number as the national patient identifier in conjunction with the local hospital numbering system in accordance with NPSA/2008/SPN001. The NHS number should appear on every page. An A&E number may be used where the patient does not have an NHS or hospital number

- Ensure that any paper reports generated from the electronic systems are securely placed in the patients medical records in the designated sections and that printouts from monitoring and diagnostic equipment e.g. CTG, ECG are secured in accordance with the filing information printed on the inside back cover of the majority of patients casenotes.

6.10 **Electronic records**

Electronic records should comply with the requirements above and processes must be in place to ensure:

- All access to electronic clinical systems is as per the Information Security Policy
- That the Workstation Security Policy is complied with
- That the date and time of entries and identity of staff making the entry are recorded in the absence of a signature.

6.11 **Alerts**

6.11.1 All staff who become aware that there is a fact about a patient that must be made known to other staff involved in their care in the future must record an Alert by:

- Fixing a red Alert (see Inside front cover) sticker on the front cover of case notes
- Inputting the details of the alert on the inside front cover

6.11.2 Alerts may be required for any of the following purposes with details of any reactions documented if known - this list is not exhaustive:

- Drug allergies
- Drug sensitivities
- Difficulties with certain procedures eg bloods, airways
- Patient has previously undergone blood transfusion
- Latex or other substance allergy
- A sensory impairment
- Presence of an advance directive
- A “do not resuscitate” order
- A requirement for language interpretation
- One of a twins with the same initial
- Clinical trials

6.11.3 It is unacceptable for any alert information to be detailed on the front cover of the records and staff who find that this has occurred must complete a risk event form in

accordance with the Incident Policy and return the records to the Patients Records Library for replacement.

6.12 **Drug charts**

6.12.1 The following patient demographics should be recorded on the drug chart:

- Surname and first name
- Date of Birth
- Hospital Number
- NHS number
- Weight

6.12.2 Allergies must be recorded or 'nil known' documented.

6.12.3 Where a second chart is commenced, each should be labelled accordingly e.g. chart 1 of 2.

6.12.4 Drug names should be recorded in full in capitals, with frequency and strength noted.

6.12.5 If the drug is discontinued, the entry should be crossed through and if the dose is changed, the prescription should be crossed through and rewritten.

6.12.6 Each administration should be signed and dated.

6.12.7 Refer to the Prescription Chart Endorsement by Pharmacy Staff Policy for further information.

7.0 Staff Training

7.1 Staff should undertake training in accordance with the Trust Training Needs Analysis (Mandatory Training Policy).

8.0 Monitoring and Review

8.1 A Trust-wide clinical record keeping standards audit is undertaken annually. The clinical records of recently discharged patients from each clinical directorate will be audited using an appropriate audit tool.

8.2 Ward managers will ensure a minimum of 5 sets of notes per specialty/area are audited.

8.3 As a minimum the annual audit will review compliance for entries made by medical staff, nursing staff or allied health professionals during the last in-patient episode with the following criteria:

- Legibility of entries
- Use of dark, photocopy-appropriate ink
- Entries dated and timed
- Entries signed, with name printed and designation stated
- Compliance with standards regarding alterations
- History recorded

- Drug history / drug allergies recorded
- Social history recorded
- Observations recorded
- Diagnosis / differential diagnosis recorded
- Treatment plan recorded
- Discharge arrangements recorded
- Written consent present (if appropriate)
- Entries in appropriate chronological order
- Prescribed drug names are written in full with strength and frequency recorded

8.4 The findings of the audit will be reported to the Chief Medical Officer, Director of Nursing or their Deputy, Clinical Directors, Associate Directors of Nursing and Chief Pharmacist. In addition the audit findings will be reported to the Governance Performance Group.

8.5 Where indicated an organisational action plan will be developed by the clinical audit team in liaison with corporate nursing with progress monitored at subsequent Governance Performance Group meetings. Where performance is poor, more frequent audit may be indicated.

8.6 Clinical Directors and Associate Directors of Nursing will ensure that where any significant deficiencies are identified, a local action plan is developed by directorate to address these concerns. Progress with the implementation of any local action plans will be monitored at Directorate Governance Meetings.

8.7 Key learning points will be disseminated to all relevant staff via staff focus.

9.0 Communication and implementation

- This policy will be disseminated via the monthly Trust Staff Focus newsletter and will be available to staff on the trust intranet. It is the responsibility of all staff who contribute to health records to make sure they have read a copy.

- The policy will be distributed to Clinical Directors and Associate Directors of Nursing for dissemination.

10.0 Review

This policy will be reviewed after no more than three years, or at an earlier date as a result of national or local initiatives. Specialist audit tools may be developed independently without need to revise the policy.

11.0 References

General Medical Council (2014) Keeping Records,

Royal College of Physicians (2007) Generic medical record-keeping standards

Nursing Midwifery Council (2015) Record Keeping guidance covered by: The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives March

Data Security and Protection Toolkit - NHS Digital (April 2018)
https://digital.nhs.uk/data-security-protection-toolkit