Trust-wide Document

NHS
Great Western Hospitals
NHS Foundation Trust

Clinical Record-Keeping Policy

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Ratified by	Patient Records Committee	**Date Ratified**	11.12.18
Date implemented (made live for use)	18.12.18	**Next Review Date**	18.12.21
Status	LIVE		
Target Audience- who does the document apply to and who should be using it. - The target audience has the responsibility to ensure their compliance with this document by: • Ensuring any training required is attended and kept up to date. • Ensuring any competencies required are maintained. • Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.	All employees directly employed by the Trust whether permanent, part-time or temporary (including fixed-term contract). It applies equally to all others working for the Trust, including private-sector, voluntary-sector, bank, agency, locum, and secondees. For simplicity, they are referred to as 'employees' throughout this policy		
Special Cases	None		
Accountable Director	Medical Director		
Author/originator – Any Comments on this document should be addressed to the author	Health Records Manager		
Division and Department	Diagnostics & Outpatients, Health Records Department		
Implementation Lead	Health Records Manager		
If developed in partnership with another agency ratification details of the relevant agency	Not applicable		
Regulatory Position	• General medical record keeping standards (Royal Academy of Physicians) (Ref 1) • Standards for the structure and content of patient records (Academy of Medical Royal Colleges) (Ref 2) • Health and Social Care Act 2008 (Regulated Activities) Regulations: Regulation 17 (Ref 4) • Records Management Code of Practice for Health & Social Care (Ref 3)		
Review period. This document will be fully reviewed every three years in accordance with the Trust's agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.			

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1 Introduction & Purpose

1.1 Introduction and Purpose

The Trust has adopted the Generic Record Keeping Standards (Ref. 1) developed by the Royal College of Physicians and supported by the Academy of Medical Royal Colleges (Ref. 2). The standards contribute to patient safety, support professional best practice, and apply to clinical records in all formats.

Great Western Hospitals NHS Foundation Trust (the Trust) is committed to high quality record keeping and seeks to meet the national Generic Record Keeping Standards (Ref. 1) wherever possible, and to monitor and audit clinical records regularly to support patient care and minimise risk.

All clinical records must be clear, accurate and legible. They must be chronological and made contemporaneously, attributable, relevant and suitably frequent.

All healthcare professionals must **clearly date, sign and print their name** every time they write information in the clinical record.

Clinical records must include:

- Relevant clinical findings.
  The decisions made and actions agreed, and who is making the decisions and agreeing the actions.
- The information given to patients.
- Any drugs prescribed or other investigation or treatment.
- Who is making the record and when.

This document provides advice and guidance to healthcare professionals with regard to good standards of record keeping, ensuring all clinical records meet legal, national, and local requirements.

1.2 Glossary/Definitions

The following terms and acronyms are used within the document:

AMDs	Associate Medical Directors
CQC	Care Quality Commission
ED	Emergency Department
EDMS	Electronic Document Management System
EDS	Electronic Discharge Summary
EIA	Equality Impact Assessment
EPR	Electronic Patient Record
GMC	General Medical Council
GP	General Practitioner
ICU	Intensive Care Unit
IG	Information Governance
IT	Information Technology
Medical Record	The term medical record within this document refers to the health records maintained by all health professionals including doctors, nurse and AHP's.
NHS	National Health Service
NMC	Nursing & Midwifery Council
PAS	Patient Administration System

PCA	Provider Compliant Assessment
PQC	Patient Quality Committee
PRC	Patient Records Committee
RCP	Royal College of Physicians

2 Main Document Requirements

2.1 Generic Record Keeping Standards

Health professionals are required to comply with the 12 generic record keeping standards approved by the Academy of Medical Royal Colleges:

	Generic Record Keeping Standards
1	The patient's 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, hospital number (where applicable), and National Health Service (NHS) number.
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.
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 the 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 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.
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 days for acute medical care or seven 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.
12	Advance directives, consent and resuscitation status statements must be clearly recorded in the medical record.

2.2 Paper and Electronic Records

Health records within the Trust are held in both paper and electronic format. These include (but are not limited to) scanned records within the Electronic Document Management System (EDMS), clinical noting input directly into Medway, and community records held in SystmOne.

When reviewing the paper health records clinicians must be aware that electronic records may also exist.

It is not a legal requirement to keep manual duplicates of electronically held records, but the ability to produce a 'complete' record on request must be maintained.

2.3 Email or Text Messages

Information exchanged via email or text must be retained in the patient record if it is deemed clinically relevant. It can be stored electronically or within the paper records.

2.4 Diaries

Patient specific information recorded in diaries must be transferred to the main patient record as soon as possible.

2.5 In the Event of a Patient Death

The entry in the patient notes made when death is confirmed should contain the following:

- Date & Time of entry.
- Signature of certifying doctor, followed by full name in block capitals.
- Designation of certifying doctor.
- Bleep number of certifying doctor.
- Examination made establishing death.
- Time and date patient certified dead.

Certifying doctors must indicate when they are next on duty and will be available to sign the death certificate.

When the death certificate is completed, an entry must be made in the record stating:

Cause of death as appearing on the death certificate:

- Whether a cremation form has been completed.
- Whether and how the patients' relatives have been or will be informed.
- Whether and how the general practitioner (GP) has been or will be informed.

2.6 Alerts & Allergies

Alerts and allergies can be recorded on the paper record and/or the Electronic Patient Record (EPR), but **must** be on one or the other.

For recording on the paper record:

- Record the alert or allergy on the inside front cover of the case note folder, and include date, signature, and grade.
- Affix a red warning sticker to the front cover of the case note folder.

For recording on the EPR:

- Request (by telephone, email, or letter) the Health Records Manager, the Emergency Department (ED) Administration Manager, or the Information Technology (IT) Service Desk to record an Alert on the EPR.

- Alerts must be regularly reviewed, and if it is definitively agreed that an Alert is no longer appropriate, it should be removed.

For further information please refer to the Patient Administration System / Electronic Patient Record (PAS/EPR) Patient Alert Policy (Ref. 4) and the Medicine Control & Administration Policy (Ref. 11).

2.7 Security & Confidentiality

Healthcare professionals must ensure that their patients' personal information is protected against loss, damage, or unauthorised access, and kept confidential in accordance with the relevant legislation and guidance.

Please refer to the Code of Practice on Confidential Information (Ref. 10).

2.8 Filing within Clinical Records

All employees (including clinical employees) have a responsibility to maintain and file documents within the case note folder and the EPR in accordance with policies and procedures.

It is not a legal requirement to produce and file manual duplicates of electronically held records, but the ability to produce a 'complete' record on request must be maintained.

For further information please refer to the Health Records Department Operational Policy (Ref. 9).

2.9 Audit

Part of the multi-disciplinary care process should be to audit the quality of clinical information on which decisions about the care of the patient are made. Annual audit of clinical record-keeping is essential if the Trust is to achieve compliance with the standards required by the Care Quality Commission (CQC).

Audits are managed by the Clinical Audit & Effectiveness team and are conducted at regular intervals, at least annually. Audits are focussed on the advice contained in this guidance and in particular are aimed at establishing the existence of legible, attributable, and contemporaneous record entries.

3 Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

Measurable policy objectives	Monitoring or audit method	Monitoring responsibility (individual, group or committee)	Frequency of monitoring	Reporting arrangements (committee or group the monitoring results is presented to)	What action will be taken if gaps are identified
Record keeping is in accordance with the generic standards table within the policy	Trustwide Health Records Audit/ Monitoring –	Patient Records Committee (PRC)	Continuous	Clinical Audit Department to share monthly reports with the PRC and	Divisions are responsible for developing respective action plans

	facilitated by the Clinical Audit Department			Divisions for assessment of assurances and areas to develop	for areas of improvement. Action plans and progress reports will be reported to the PRC via the Clinical Audit Department for assessment and oversight. The PRC will escalate significant poor levels of compliance or concerns to the Patient Quality Committee (PQC).
CQC Regulations	Regulation 17	Health Records Manager	Annually	Patient Records Committee	Action will be taken to address any gaps in compliance

4 Duties and Responsibilities of Individuals and Groups

4.1 Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

4.2 Ward Managers, Matrons and Managers for Non Clinical Services

All Ward Managers, Matrons and Managers for Non Clinical Services must ensure that employees within their area are aware of this document; able to implement the document and that any superseded documents are destroyed.

4.3 Associate Medical Directors (AMDs)

AMDs have a duty to ensure the overall standard of clinical record keeping within their Divisions meets the requirements of this Policy. They are also responsible for implementing any action plans resulting from the annual audit and reporting progress to the Patient Quality Committee (PQC).

4.4 Clinical Audit & Effectiveness Team

The team is responsible for managing the annual audit of record keeping, maintaining appropriate and effective audit templates, and reporting audit results to the Patient Quality Committee and the Patient Records Committee. The relevant Clinical Audit & Effectiveness Co-ordinator will document and circulate the agreed action plan resulting from the audit to members of the PQC.

4.5 Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

4.6 Patient Records Committee

The Committee is responsible for promoting good practice with regard to record keeping, approving relevant policies and procedures, and monitoring record keeping standards.

5 Further Reading, Consultation and Glossary

5.1 References, Further Reading and Links to Other Policies

Ref. No.	Document Title	Document Location
1	General medical record keeping standards (Royal Academy of Physicians)	www.rcplondon.ac.uk
2	Standards for the structure and content of patient records (Academy of Medical Royal Colleges)	www.rcplondon.ac.uk
3	Records Management Code of Practice for Health and Social Care	https://digital.nhs.uk/
4	Health and Social Care Act 2008 (Regulated Activities) Regulations: Regulation 17	www.cqc.org.uk
5	GMC: Good Medical Practice	www.gmc-uk.org
6	The Code: Professional Standards & Behaviour for Nurses and Midwives	www.nmc.org.uk
7	PAS/EPR Patient Alert Policy	T:\Trust-wide Documents
8	Maternity Health Records Policy	T:\Trust-wide Documents
9	Health Records Department Operational Policy	T:\Trust-wide Documents
10	Code of Practice on Confidential Information	www.digital.nhs.uk
11	Medicine Control & Administration Policy	T:\Trust-wide Documents

5.2 Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

Job Title / Department	Date Consultee Agreed Document Contents
Clinical Audit & Effectiveness Manager	01/11/2018
Head of Clinical Coding	06/11/2018
Deputy Health Records Manager	26/10/2018

Job Title / Department	Date Consultee Agreed Document Contents
D&O Quality Governance Facilitator	21/11/2018

6 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this document and can be found at Appendix A

Appendix A - STAGE 1: Initial Screening For Equality Impact Assessment

At this stage, the following questions need to be considered:			
1	What is the name of the policy, strategy or project? **Clinical Record Keeping Policy**		
2.	Briefly describe the aim of the policy, strategy, and project. What needs or duty is it designed to meet? **This document provides advice and guidance to healthcare professionals with regard to good standards of record keeping, ensuring all clinical records meet legal, national, and local requirements**		
3.	Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics (as per Appendix A)?		**No**
4.	Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics have different needs and experiences that this policy is likely to assist i.e. there might be a *relative* adverse effect on other groups?		**No**
5.	Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?		**No**

Signed by the manager undertaking the assessment	Julie Taylor
Date completed	21st November 2018
Job Title	Health Records Manager

On completion of Stage 1 required if you have answered YES to one or more of questions 3, 4 and 5 above you need to complete a STAGE 2 - Full Equality Impact Assessment

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access & experience	Empowered engaged & included staff	Inclusive leadership at all levels

Our Vision

Working together with our partners in health and social care, we will deliver accessible, personalised and integrated services for local people whether at home, in the community or in hospital empowering people to lead independent and healthier lives.