Lancashire Care NHS
NHS Foundation Trust

CLINICAL RECORD KEEPING POLICY

POLICY REFERENCE NUMBER	CL027
DATE RATIFIED *(this version)*	March 2015
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APPROVED BY *(state group)*	Clinical Policy Council
ACCOUNTABLE DIRECTOR	Executive Directors - Director of Nursing, Medical Director
POLICY AUTHOR	Clinical Policy and Compliance Lead

Policy Statement/Key Objective:

Lancashire Care NHS Foundation Trust is committed to a philosophy of care which demands a positive attitude to record keeping. Good record keeping is an integral part of healthcare practice, and is essential to the provision of safe & effective care. It safeguards the interest of patients, carers, healthcare professionals and the organisation.

Executive Summary

Title of Policy:	Clinical Record Keeping
Subject:	The recording of clinical care. This policy describes what is expected from all healthcare staff when patient care is documented, it applies to both paper and electronic records.
Applicable to: *(state Network, Services and staff groups)*	All networks
Key Policy Issues:	This policy is about recording healthcare activity for purposes of patient care. It includes computerised or manual form or a mixture of both. It also includes such things as hand written clinical notes, letters to and from other health professionals, laboratory reports, X-rays, photographs, E mails, recordings and printouts from monitoring equipment.
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Dates Policy Reviewed: *(include all previous dates of review)*	August 2012, October 2014, Minor amendment May '15
Next Review Date:	March 2018 (extended until 1st October 2018)
Policy written by: *(state title only)*	Clinical Policy and Compliance Lead
Policy Lead: *(state title only)*	Executive Directors - Director of Nursing and the Medical Director
In Consultation with:	Clinical Policy Council Members, Professional Leads, Network Groups with responsibility for Policies and Procedures
Monitoring Arrangements:	See Section 7
Approved by: *(state group)*	Clinical Policy Council

Authorised by: *(state senior accountable person e.g. Network or Clinical Director)*	Director of Nursing, Medical Director
Related Procedural Documents:	All policies and procedures that relate to the provision of care will require a record to be kept about the clinical intervention. Several policies require in-depth recording and completion of specific forms some of these are listed below (this is not an exhaustive list) CL002 Consent to Examination and Treatment CL007 Enhanced Observation and Therapeutic Engagement Policy for Inpatient Mental Health Services CL012 Care Programme Approach Policy and Procedure CL026 26a Physical Health Care Policy and Procedure CL040 Policy for Sharing and Disclosure of Patient Related Information with External Agencies CL046 Policy for the Implementation of the Mental Capacity Act IMT004 Health Records Service Security and Confidentiality Policy IMT 009 Access to Health Records Policy IMT 014 Policy for Health Records Management IMT 015 Corporate Records Procedure
Links to CQC outcomes:	20, 6, 14, 21

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1.0 Introduction

Clinical records are the most basic of clinical tools and are involved in almost every consultation. They are there to give a clear and accurate account of the care and treatment of patients and to assist in making sure they receive the best possible clinical care.

They form a permanent record of individual considerations and the reasons for decisions. Clinical records help healthcare professionals[1] to communicate with other healthcare professionals and with themselves. They are essential to ensure that an individual's assessed needs are met comprehensively and in good time.

The clinical record is a healthcare professional's main defence if assessments or decisions are scrutinised. Any document which records any aspect of the care of a patient can be required as evidence before a coroner's court, a court of law or before the Professional Conduct Committee of the Nursing and Midwifery Council, or other similar regulatory bodies for health and social care professionals.

This policy describes the generic clinical record keeping standards that apply to all records made by medical, dental, nursing and allied health professionals. It reflects the principles that are contained in standards produced by several Medical Royal Colleges, General Dental Council, Specialist Societies, medical defence organisations, the NMC and professions supplementary to medicine.

As well as individual Professional Codes of Practice there are also national standards and regulations that must be met to ensure good clinical record keeping practice. These include:

Care Quality Commission – Essential standards for safety and quality. Outcome 21 details requirements for Record Keeping.

Information Governance Toolkit – Information Governance is to do with the way organisations 'process' or handle information and covers both personal and corporate information. The Information Governance Toolkit draws together the legal rules and central guidance and presents them in one place as a set of information governance requirements.

NHS Litigation Authority – Risk Management Standards - These are designed to address organisational, clinical, and non-clinical/health and safety risks.

In addition to this generic clinical record keeping policy for all staff, some specialist areas or services may have further requirements that are over and above these key standards. In these instances local record keeping protocols will be agreed and developed for specific staff groups/services. Protocols will be developed as appropriate and agreed in line with network governance processes.

[1] The term healthcare professional will denote any professional both health and social care who contribute to the clinical record.

2.0 Scope

This policy applies to recording healthcare activity for purposes of patient care. It applies to all healthcare professionals and healthcare support workers working for the Trust including students and bank staff.

All clinical records are covered by this policy: including any proforma for the collection of clinical information about certain conditions or patients, or separate records within departmental/ service systems e.g. Sexual Health Services.

It includes computerised or manual form or a mixture of both. It also includes such things as hand written clinical notes, letters to and from other health professionals, laboratory reports, photographs, emails, recordings and printouts from monitoring equipment.

3.0 Definitions

A Record comprises of recorded information in any format (e.g. digital, physical), of any type, in any location (e.g. central database server, stand-alone PC, filing cabinet, archive store), which is created, received, or maintained by Lancashire Care NHS Foundation Trust (LCFT) in the transaction of its activities or the conduct of its affairs, and kept as unique evidence of such activity.

A Health Record (also referred to as a clinical record) is defined in Section 68 of the Data Protection Act 1998 (2), and:

> "Consists of any information relating to the physical or mental health or condition of an individual"
> "Has been made by, or on behalf of, a health professional in connection with the care of that individual"

The Department of Health, Records Management: NHS Code of Practice 2006 defines a health record as "A single record with a unique identifier containing information relating to the physical or mental health of a given patient who can be identified from that information and which has been recorded by, or on behalf of a health professional in connection with the care of that patient.

Patient Throughout this policy the term patient shall be used to denote anyone who is in receipt healthcare and includes service user, young person, child or client**.**
Healthcare Assistant (HCA) for the purposes of this policy this term will encompass any member of staff who works as part of the multidisciplinary team in a role which supports delivery of healthcare to patients e.g. healthcare support worker, auxiliary nurse.

4.0 Duties

The Trust Board has a responsibility to ensure that the Trust complies with its duty under the Public Records Act 1958 to have procedures in place for the creation, use, safekeeping and eventual disposal of all types of NHS records.

Accountable Executive Directors

The Medical Director is the Caldicott Guardian for the Trust and is also responsible for ensuring the quality of record keeping by medical staff meets the standards within this policy.

The Director of Nursing is responsible for ensuring that the quality of record keeping by nurses and allied health professionals meets the standards within this policy.

Medical Consultants
Consultants are managers of the junior medical staff, and are responsible for providing on-going teaching and advice to junior doctors on documenting within the clinical record, and ensuring compliance with the standards set out in this policy.

Professional Leads are responsible for:

- Acting as champions for high quality record keeping within their professional group.
- Providing expert guidance in relation to the content of record keeping audits
- Providing advice to the education and training department about record keeping training.

Managers and Team Leaders
All Managers and Team Leaders are responsible for their staff and ensuring that local practices and procedures follow the principles set out in this policy. Their responsibilities include:

- Raising the profile of good record keeping practice
- Developing appropriate local induction/ training programmes
- Ensuring staff complete information governance mandatory training
- Monitoring the quality of record keeping, e.g. by peer review and sample audits
- Establishing adequate secure storage and tracking systems that allow prompt tracing and access to records held
- Ensuring compliance with relevant access legislation including; Data Protection and Freedom of Information
- Ensuring all staff are aware of their responsibility to maintain the confidentiality of patients and colleagues

Staff

All staff are responsible for:

- Any records that they create or use. This responsibility is incorporated into Professional Codes of Conduct e.g. Nursing and Midwifery Council (NMC) Record Keeping: Guidance for nurses and midwives 2009 ,General Medical Council (GMC) Good Medical Practice: guidance for doctors and Health and Care Professional Council (HCPC) Standards of Conduct, Performance and Ethics.
- Keeping up to date with relevant best practice guidelines, policies, procedures and codes of practice
- Reporting any record related incidents following guidance given in the LCFT incident reporting process.

The Clinical Records & Information Governance Group is responsible for:

- Providing guidance on the resolution of healthcare record issues including the format, storage media and quality of clinical records.
- Development, review and approval of policies, procedures and systems.
- Providing assurance of compliance with this policy to the IM&T Strategy Programme Board
- Resolving issues identified through the audit process.
- Development and monitoring of action plans to address issues of non-compliance with this policy.

5.0 The Policy

5.1The purpose of this policy is to define standards and principles for clinical record keeping to ensure:

- Health records created by the Trust provide accurate, timely and comprehensive recording about the history of each patient’s care including, biographical details, presenting symptoms, observations, risks, diagnosis assessment, treatment, care plans and consent.
- There is a clear description of responsibilities and duties for clinicians and healthcare support workers to maintain accurate and contemporaneous records
- There is compliance with legal requirements, NHS and professional codes of conduct and guidance.
- Risks associated with record keeping are minimised through ensuring that all staff follow acceptable standards of practice
- The wider purpose of teaching, research and clinical audit is supported and for healthcare services to learn from experience.
- Records provide information to address complaints or legal processes

5.2 Principles

There are a number of principles that underpin clinical record keeping:

- Record keeping is an integral part of professional practice and the process of care.

- The quality of the record of care is a direct reflection of the standard of clinical practice. Good record keeping practice is a mark of the skilled and safe practitioner, incomplete record keeping will create a poor representation of practice.
- Wherever possible the record of care should be an outcome of consultation and discussion that has taken place between the patient and respective members of the care team.
- Good record keeping assists practitioners in protecting the patient's welfare.
- Clinical records must be evaluated and recorded in response to the patient's needs.
- The value of collaborative working within the healthcare team can be enhanced through the use of shared records and the record of care is an invaluable method of communication both within the team and between practitioners and their patients.
- A record of care is an account of everything that the patient has been involved in.
- Clinical records must be treated as confidential and only shared as stated in policy CL 040.
- Clinical records must be stored securely especially when in transit.
- Where services provide patient held records, which are kept by the patient, these remain the property of the Trust.
- Patients must be offered and where they agree, receive copies of health professionals letters about them.

5.3 Process of Care

An essential fundamental aspect for the quality of record keeping is the involvement of the patient in the process of their care. This process will incorporate an assessment of the patient's needs, an analysis of information obtained from assessment and a collaborative approach to formulate a plan of care. The clinical record must indicate how the plan of care has been implemented and include an evaluation of care provided.

5.4 Key Standards

The following standards are required of all clinical records, whether held on paper or electronically.

5.4.1 Clear identification of patient[2]

Patient identification should be present on **every page** – including the reverse of a double sided sheet, and on pages bound together in a booklet.

The following patient identification must be recorded on every page:

Full name AND ID number/NHS Number

The NHS number is the only unique patient identifier across the NHS, and its use is mandatory on all patient documentation, as set out in the NPSA Safer Practice Notice NPSA/2009/SPN002.

[2] Sexual Health Services are an exception to the requirement for use of the NHS number.

In computer systems, the identity of the patient should be present on each screen, ideally at least the identifiers listed above for manual records. In all cases, clinical transactions and consequent records should be recorded against the correct patient, by undertaking checks against the patient identity before filing or inputting information.

The **record** must contain the following patient identification data:
Unique patient/client NHS number + name in full on every page and on charts e.g. Medicine, ECGs,
Title (if required)
Address and postcode
Date of Birth
General Practitioner’s name
General Practitioner’s address
Patient’s / user’s telephone number
Gender
Ethnic Group
First Language
Person to notify in an emergency and their telephone number

The following information should be included where relevant to the service/care provided
Occupation / School / Employment status
Source of referral (if required)
Admitting professional (if required)
Reason for admission (if required)

5.4.2 Chronological, accurate and complete records

Documentation within the clinical record should reflect the continuum of patient care and should be viewable in chronological order.
Records should be accurate and recorded in such a way that the meaning is clear, including being understandable by the patients. Records must not be falsified. Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation, coded expressions of sarcasm or humorous abbreviations to describe patients or carers. Opinions can be expressed, but should ideally be noted as such.
It is a matter of professional judgement to decide what is relevant and what should be recorded, but in general, clinical records should include the types of information described below. (GUM records will differ from these categories)

- An initial patient history with previous medical history, known allergies, the social context of the illness where appropriate
- Details of medication
- Details of any initial physical examination, including the patients weight and height (see CL026 Physical Health Care Policy and Procedures for more detail)
- History and examination findings clearly dated and signed
- Details of information given to the patient about care and treatment, including

health education/promotion provided to the patient or family e.g. instruction on care, medications, treatments, dietary requirements and referral information.

Electronic records:
Clinical records that are maintained electronically, an entry will be made at each clinical contact and will document the assessments, tests and treatments given, as set out in the computer system, which provides the structure as to what should be recorded. All fields relevant to the contact should be completed. Any free text entries must abide by the general principles concerning jargon and abbreviations detailed above.

5.4.3 Attribution of entries

Every entry in the clinical record should be:

- Dated
- Timed - it must be possible to distinguish between the time of the recording and the time that care was delivered
- Legible
- signed by the person making the entry
- the name and designation of the person making the entry should be legibly printed against their signature, or in the signature sheet filed in the record.

Entries made by students must be countersigned by a registered health professional until they are assessed a competent to undertake record keeping.

Deletions or alterations to the entries made should be crossed through with a single line, signed and dated in order to be auditable. Correction fluid must not be used. Sheets containing errors must not be rewritten or the originals removed from the clinical record.

For computer recorded entries, systems differ in whether it is a mandatory field to add the name of the user to an entry on screen, or when printed, and these records are not signed, but all systems contain audit trails which can attribute the user to an entry which is dated and timed in the background. These audit trails also record amendments to entries, which are also dated and timed. Staff are aware of the need to keep their own log in and password confidential as these are deemed to be equivalent to a signature.

5.4.4 Countersigning and delegation

There is no legal requirement for registered professionals to countersign clinical records made by a healthcare assistant (HCA), assistant practitioner (AP) or student.

The ability to delegate, assign tasks and supervise are essential competencies for all registered professionals working in all healthcare settings or sphere of practice. All decisions relating to delegation by registered professionals must be based on the fundamental principles of safety and public protection which are the underlying principles of regulation.

The act of record keeping attracts the same principles as any other delegated task in the healthcare setting, including the need for ongoing supervision as appropriate.

Record keeping is an integral part of every intervention and the HCA, AP or student **should be judged as competent** in the complete provision of care, which includes record keeping. ***Until they are deemed wholly competent in both the activity and its documentation this policy does require registered professionals, to perform countersigning.***

As a member of the wider healthcare team, HCA, AP or student takes personal accountability for good record keeping. They must keep clear, accurate and timely records of the care they provide to their patients to support communication continuity and decision making. This includes all forms of patient records, i.e. anything that is documented about a patient and their care and treatment.

The registered health professional retains professional accountability for the appropriateness of the delegation of the task, but the HCA, AP or student takes on personal accountability for the content and quality of the records.

This policy requires that supervision; management or clinical will include regular examination of the quality of record keeping standards. This supervision may be group or individual but the quality of record keeping standards expected and actual examination of entries made in records must be part of the content of supervision sessions.

5.4.5 Abbreviations

The record will only include standard and universally accepted clinical abbreviations, and these will be kept to an absolute minimum. These are published as an Appendix to this policy (Appendix 1) as a point of reference. Where others are used they must be written out in full the first time they are used within that particular episode of care. The abbreviation will follow this full use, in brackets. The exceptions to this are:

- on prescription charts where approved abbreviations articulated within the procedure for the prescribing of medication are permissible without the abbreviation having first being written in full.
- Local service line approved standard operating procedures (SoPs) or protocols can include additional lists of approved abbreviations for terms which are regularly used and relevant to that particular service.

5.4.6 Contemporaneous recording

All entries, including amendments, must be clearly dated and timed to reflect the date and time of the entry. All entries should be made contemporaneously or as soon as possible after the event, and before the relevant staff member goes off duty. If there is a valid reason that a record cannot be made prospectively, (e.g. in an emergency situation), ensure that the time of the event to which the note refers is also recorded i.e. enable the reader to distinguish between the time of the clinical intervention and the time of the entry.
All entries should record the contact type (face to face or telephone for example), venue where the contact took place and who was present at the contact.

5.4.7 Recording Consent
Where appropriate, consent to information sharing will be recorded and held within the relevant section of the record in line with policy CL040.

Consent to treatment statements must be recorded and filed in the appropriate section of the record. The seeking and giving of consent should not be a one-off event; it should be a continual process or communication between the patient and their healthcare professional.

Consent to treatment statements, advanced decisions to refuse treatment and cardio-pulmonary resuscitation decisions must be clearly recorded in the health record.

5.4.8 Copying Letters to Patients
Where patients agree, letters written by one health professional to another about a patient should be copied to the patient, or where appropriate parent or legal guardian. The general principle is that all letters which help to improve a patients understanding of their health and the care they are receiving, should be copied to them as of right.

Services need to develop local protocols to manage this process. Within a consultation the possibility of receipt of a letter should be raised so that patients are routinely asked whether they want a copy of any letter written as a result of that consultation and any related tests for interventions. There should be a clear process for recording the patient's view, similar to that for recording their consent to treatment. It is essential to check the correct postal address to reduce the potential of sensitive information being delivered inappropriately.

5.4.9 Information not to be filed in the Patient's clinical record

Any medico legal complaint or incident investigation documentation must not be stored in the patient's record. These documents must be filed separately.

6.0 Training

The training requirements of this policy are described in Trusts Mandatory Training Matrix available via the intranet e-HR portal.
The requirements include:

- Identification of relevant staff groups
- Frequency of training
- Attendance and follow up of non-attendance

Specific Training not covered by Mandatory Training
Bespoke training sessions based on an individual's training needs as defined within their annual appraisal or job description .In addition service specific training session will be arranged as appropriate.

7.0 Monitoring

Standard	Time frame/ format	How	Whom
Record keeping will comply with the standards described in this policy	All entries made in health records.	Review and examination of content of records on a regular basis during supervision Review and examination of a sample of 5 records for QSEEL process Poor quality record keeping may constitute professional misconduct and result in formal disciplinary proceedings	Managers and senior clinicians Team leaders
Supervision will include regular review and discussion of the quality of clinical records	Frequency and model as stated in service/ local protocol	During line management 1to1 sessions and /or clinical supervision check evidence of issues discussed i.e. must include record keeping	Team leader/ line manager
Staff receive record keeping training appropriate to their role and responsibilities	At induction to a new job role and refresher training Mandatory Training as per mandatory training matrix	Completion of appropriate induction forms checked during local induction process PDR meetings check record keeping training records	Line manager Line manager/ team leader
Entries by Students, HCAs, Support workers and APs will be countersigned by a registered professional until assessed to be competent	HCA, Student, support workers and AP will be supervised , records checked and countersigned at each entry until signed as competent	During the mentoring and supervision of unqualified staff who have been delegated duties as part of provision of healthcare appropriate to their role	The registered professional who is supervising and delegating healthcare
Record keeping audits will be	The audit reports will be received by	Networks will be responsible for developing and monitoring	Relevant network

undertaken as agreed and stated in networks' annual audit plans.	the relevant Network Governance Groups for their action.	appropriate action plans to address issues of non-compliance with this policy.	group with responsibility for Clinical Record Keeping

8.0 References

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Care Quality Commission, 2010, Essential Standards for Quality and Safety

Health Informatics Unit of the Royal College of Physicians 2009 RCP Approved Generic Medical Record Keeping Standards'

Lancashire Care NHS Foundation Trust Blue Light 41 record keeping and abbreviations

Lancashire Care NHS Foundation Trust Blue Light 74, Health records kept on LCFT premises.

NPSA Safer Practice Notice NPSA/2009/SPN002,
Nursing and Midwifery Council, 2009, Record keeping guidance for Nurses and Midwives **www.nmc-uk.org**

Royal College of Nursing, 2014, Delegating Record Keeping and Countersigning Records: Guidance for Nursing Staff.

Royal College of Physicians, 2010, The case and the vision for patient-focused records.

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Clinical record keeping and standards policy, 2013, Tameside Hospitals NHS Foundation Trust

Clinical record keeping policy, 2012, Newcastle upon Tyne Hospitals NHS Foundation Trust

Health records and clinical record keeping policy, 2012, University Hospital Manchester NHS Foundation Trust

Health records keeping standards policy, 2012, Northamptonshire Hospitals NHS Foundation Trust

Professional clinical record keeping policy, 2010, Lancashire Care NHS Foundation Trust

APPENDIX 1 List of agreed abbreviations

Appt: Appointment

ASAP: As soon as possible

AWOL: Absent Without Leave

BMI: Body Mass Index

BP: Blood Pressure

Ca: Cancer

CMHT: Community Mental Health Team

CPA: Care Programme Approach

CPN: Community Psychiatric Nurse

CPR: Cardiopulmonary Resuscitation

CT Computerised Tomography scan

DN: District Nurse

DNA: Did not attend

DoB: Date of Birth

DVT: Deep Vein Thrombosis

ECG: Electro Cardiogram

EEG Electroencephalogram

EWS: Early Warning Score

GP: General Practitioner

LCFT: Lancashire Care NHS Foundation Trust

MI: Myocardial Infarction

MRI Magnetic Resonance Imaging

NoK: Next of Kin

OT: Occupational therapy

PICU: Psychiatric Intensive Care Unit

RC: Responsible Clinician

TPR: Temperature, Pulse, Respiration

UTI: Urinary Tract Infection

VTE: Venous Thromboembolism