Record Keeping Policy

First Issued: July 2015
Review date: December 2023

DOCUMENT CONTROL SHEET

Name of Document:	Record Keeping Policy
Version:	3.2
File Location / Document Name:	Services/policy & guidelines/update policies
Date Of This Version:	November 2021
Produced By (Designation):	Record Keeping Task and Finish Group
Reviewed By:	Record Keeping Group
Synopsis and Outcomes of Consultation Undertaken:	
Synopsis and Outcomes of Equality and Diversity Impact Assessment:	No impact
Ratified By (Committee):-	Record Keeping Group
Date Ratified:	01/12/2021
Distribute To:	All staff responsible for record keeping
Date Due For Review:	December 2023
Enquiries To:	Executive Director of Quality
Approved by Appropriate Group/Committee	X Date: 01/12/2021

Version Control

Version Date	Version No.	Author/ Reviewer	Comments
06/09/2017	2	Jenny Harper	8.1.2 – removed inappropriate criteria and added AIS criteria. 15.3 – changed reporting to CARC 16.1 – training changed to 3 yearly
November 2018	3	Sam Leech	8.1 & 8.1.2 – added - Occupation/Employment Nutritional Screen
February 2020	3.1	Ali Jennings	8.2 – added instructions for system failure Transferred to the new policy format
November 2021	3.2	Ali Jennings & Hannah Lewis	Full review of policy completed including: • 16 - Updated training Information to annual • 17 - Updated list of related policies • 18 - Added References • 22 - Added Appendix • 1.4 – Updated toolkit reference to DSPT

EQUALITY AND DIVERSITY IMPACT ASSESSMENT

Impact Assessments must be conducted for:

- ❑ **All ECCH policies, procedures, protocols and guidelines (clinical and nonclinical)**
- ❑ **Service developments**
- ❑ **Estates and facilities developments**

Name of Policy / Procedure / Service	**CORPORATE**
Manager Leading the Assessment	**Deputy Director of Quality.**
Date of Assessment	**November 2021**

STAGE ONE – INITIAL ASSESSMENT

Q1. Is this a new or existing policy / procedure / service? **☐ New** **✓ Existing**
Q2. Who is the policy / procedure / service aimed at? **✓ Patients** **✓ Staff** **☐ Visitors**

Q3. Could the policy/procedure/service affect different groups (age, disability, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation) adversely?

☐ **Yes**

✓ **No**

If the answer to this question is NO please sign the form as the assessment is complete, if YES, proceed to Stage Two.

Analysis and Decision-Making

Using all of the information recorded above, please show below those groups for whom an adverse impact has been identified.

Adverse Impact Identified?

Age	No
Disability	No
Gender reassignment	No
Marriage and civil partnership,	No
Pregnancy and maternity	No
Race	No
Religion or Belief	No
Sex	No
Sexual Orientation	No

- Can this adverse impact be justified?
- Can the policy/procedure be changed to remove the adverse impact?

If your assessment is likely to have an adverse impact, is there an alternative way of achieving the organisation's aim, objective or outcome No
What changes, if any, need to be made in order to minimise unjustifiable adverse impact? N/A

Contents

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Assurance Statement

This policy relates to all clinical records, both electronic and paper based held by the organisation.

It is the policy of East Coast Community Healthcare CIC (ECCH) to ensure that there are comprehensive and effective procedures in place to address areas including the compilation, use, retrieval, storage and disposal of health care records, which should be monitored and reviewed on a regular basis.

This policy **MUST** be read by all employees of ECCH, both permanent and temporary (e.g., those on secondment and on honorary contracts). It also applies to anyone contracted to the organisation, who, in the course of their work is required to create and amend clinical records.

1. INTRODUCTION

1.1. Record keeping is an integral part of medical, nursing, social care and allied health professional's practice. It is an essential method of promoting communication within the health care team and between practitioners and service users. Records should be regarded as a fundamental resource in the delivery of safe patient care because of the information they contain. Staff should not underestimate the vital importance of good record keeping. A properly kept record will show the complete patient care history from beginning to end and will document all actions within the process. The information is only an asset if it is recorded correctly, updated as soon after care is delivered (ideally immediately but within 24 hours) and is easily accessible when required.

1.2. Healthcare professionals have a legal duty to keep up to date with, and adhere to, relevant legislation, case law and national and local policies and professional guidelines relating to information and record keeping.

1.3. The principles for manual (paper) records also apply to electronic records. Staff are accountable for all entries made and all electronic records must be uniquely identifiable ensuring it is clear who updates each record. As with manual records, staff must maintain the security of electronic records.

1.4. Good record keeping is an essential requirement of the National Health Service Litigation Authority (NHSLA) risk management standards, Data Security and Protection Toolkit and the Care Quality Commission fundamental standards of quality and safety. Clinical record keeping is subject to audit.

2. PURPOSE

2.1. This policy relates to record keeping standards for all healthcare records within ECCH, including paper and electronic. The purpose of this policy and procedure is to ensure that all staff, throughout the organisation, are aware of how to maintain good records so that the provision of clinical events in the delivery of patient care is fully recorded to give a complete account of all care given to patients.

- To ensure the organisation meets all its statutory requirements.

- To ensure that all staff are made aware of their record keeping responsibilities through specific training programmes.

3. SCOPE

3.1. This policy relates to all clinical and non-clinical staff who contributes to records held in any format by ECCH CIC. These include:

- all administrative records (e.g., personnel, estates, financial and accounting records, notes associated with complaints etc);

- all patient health records (for all specialties and including private patients, including x-ray and imaging reports, registers, telephone messages etc.)

4. DEFINITIONS

Health Record	Section 205 of the Data Protection Act 2018 (DPA18) defines a health record as a record which: *'Consists of data concerning health and has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates.'*
Data Protection Act (DPA)	The Data Protection Act 2018 controls how your personal information is used by organisations, businesses, or the government. The Data Protection Act 2018 is the UK's implementation of the General Data Protection Regulation (GDPR).
General Data Protection Regulation (GDPR)	The General Data Protection Regulation 2016/679 is a regulation in EU law on data protection and privacy in the European Union and the European Economic Area.
UK GDPR	The GDPR is retained in domestic law as the UK GDPR, but the UK has the independence to keep the framework under review. The 'UK GDPR' sits alongside an amended version of the DPA 2018. The key principles, rights and obligations remain the same. However, there are implications for the rules on transfers of personal data between the UK and the EEA.
Data Security & Protection Toolkit (DSPT)	The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.
Care Quality Commission	The independent regulator of health and social care in England
SystmOne	SystmOne provides clinicians and health professionals with a single shared Electronic Health Record (EHR) available in real time at the point of care.

5. RESPONSIBILITIES

5.1. The Chief Executive has the overall responsibility for the policy and for ensuring that the organisation complies with its statutory obligations and Department of Health directives.

5.2. All Directors and Deputy (Associate) Directors are responsible for the implementation of this policy into practice within their service areas and taking appropriate action should any breach of this policy occur.

5.3. All Locality Leads and Heads of Services have responsibility for providing evidence that this policy has been shared with staff (permanent, temporary or contracted), effectively implemented and that staff within their area have the appropriate knowledge, skills and support to adhere to this policy.

5.4. The SystmOne leads are responsible for the overall management and development of the healthcare records practices and services across the organisation, ensuring that services are of a high standard in order to comply with appropriate governance standards and delivery of high-quality patient care.

5.5. Each ward, department or team manager is responsible for monitoring that all staff undertakes appropriate training to ensure an adequate level of competency in the clinical record keeping functions used in their role creating and updating clinical records. Each ward, department or team manager is responsible for periodic review of staff competency in clinical record keeping

5.6. All staff are responsible for ensuring that accurate legible records are kept in accordance with policies and legal requirements via the annual healthcare records audit.

5.7. All staff whether permanent, temporary, or contracted **MUST** ensure that they keep appropriate records of their work in the organisation and have a duty of responsibility to manage and maintain all clinical records (electronic and / or paper) securely and in line with the standards and procedures as set out in this policy, Professional guidelines and with any other guidance subsequently produced.

5.8. All staff whether permanent, temporary, or contracted will make honest entries into to the record at all times. Knowingly making a false entry into the record is a breach of trust between the member of staff and their patient, and the member of staff and the organisation. Making a knowingly false entry into the record represents gross professional misconduct and will be dealt with accordingly via the organisation's Disciplinary Policy and Procedure.

Staff must:

- Adhere to this policy
- Ensure any training required is completed
- Ensure any competencies required are maintained and evidenced
- accordingly
- Co-operate with the development and implementation of policies as part of their normal duties and responsibilities
- Identify the need for a change in policy, as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly

- Identify any training needs in respect of policies and escalate these to their manager

6. PROCEDURE

6.1. A record is a structured document that contains information, in any media, including electronic, which has been collated or created as part of the work of any employee delivering care.

6.2. Electronic format has been identified as the primary form of health records used by ECCH

7. WHAT IS A RECORD?

7.1. A record is a structured document that contains information, in any media, including both paper, electronic or a combination of both, which has been collated or created as part of the work of a range of healthcare professionals in one organisation. The primary aim of keeping patient records is to enable the healthcare team to provide the best possible patient care. The clinical record may include:

- Handwritten notes by any healthcare professional
- Computer printouts from monitoring equipment
- Laboratory reports
- Photographs
- Videos
- Tape recordings & the recording of telephone calls
- X-Rays
- Letters and correspondence about clinical care – including handwritten or other transfer and referral letters

7.2. A health record, as defined in the Data Protection Act, consists of information relating to the physical or mental health or condition of an individual and has been made by or on behalf of a health professional in connection with the care of that individual.

8. PURPOSE OF HEALTHCARE RECORDS

8.1. To ensure all healthcare interventions are recorded and makes clear all information required for:

- Supporting patient care, continuity of care and evidence informed clinical practice
- To provide a baseline record against which improvement or deterioration may be judged
- Accurate and comprehensive assessments
- Use of rationale, evidence informed interventions
- Avoiding interventions recorded as harmful or useless
- Using interventions recorded as effective and acceptable

8.2. To ensure that the service user's experience is improved by:

- Reducing the need for the service user to repeatedly give their history
- Establishing the accuracy of information held about the service user

8.3. To ensure accountability by providing a record for scrutiny for:

- The service user and/or their representative

- Legal processes - 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 a Professional Conduct Committee (e.g. Nursing and Midwifery Council, Health Professions Council), or other similar regulatory bodies for health and social care professionals. The legal approach to record keeping is "if it is not recorded it has not been done". This is particularly relevant where the patient/client condition is stable and no record is made of care delivered.
- Support complaints / incident investigation
- Research, clinical audit and statutory information returns
- To support day to day interventions which underpins the delivery of care
- To support sound administration and managerial decision making

9. RECORD KEEPING STANDARDS

9.1. For Generic Record Keeping Standards

It is essential to record demographic information for each patient. This information is required in order to contact the service user effectively, as part of National Data Set returns and is used in measuring performance against key indicators. Both internally and externally ECCH are required to monitor service uptake for various different groups.

Mandatory service user identification data:

- NHS Number
- Family / Given name - Full name of the service user
- Usual address
- Postcode
- Date of birth - DD/MM/YYYY format
- Telephone numbers (Home / Mobile)
- Occupation/Employment
- GP address/surgery name
- Name and designation of any professional
- Nutritional Screen
- Gender - In the case of trans-gender service users, the gender that is stated on the service user's birth certificate at the current time should be entered. Do not record "Not Specified / Unknown".
- Religion
- Ethnicity - this should be recorded using the National ethnicity codes and should be stated by the Service User. Do not record "not known (not requested)".
- Is interpreter required - Preferred communication language used at home.
- Has the AIS template been completed

9.2. For Service user clinical record information Records must be:

- Started at initial contact with the service user
- Clear, unambiguous, honest and legible.
- Accurate, complete and concise. The clinical notes should contain clinically relevant information only (who, what, when, where, why) and should not include clinically irrelevant information such as financial information, complaints or legal

correspondence. Information of this nature will be stored corporately within the relevant department(s).

- Provide evidence of the assessment, identified risks, care planned, risk management plans, decisions made, reasons for decisions taken, care delivered, patient response and evaluation of care.
- State reasons for any diagnostic tests ordered or undertaken (e.g., blood tests).
- Contain written details / summary of any verbal instructions / advice given to service users or their carer's.
- Notes should be in chronological order.
- The record must be grammatically correct, and spell checked where this is available
- Records should be written in terms that the patient will be able to understand.
- Records should be service user identifiable.
- Entries MUST be made within 24 hours of the events to which they relate, providing current information on the care and condition of the service user.
- Entries should be made in such a manner that the text cannot be erased with any space being left between the entries so that entries can be made at a later date.
- All entries MUST be signed, dated and timed (using the 24-hour clock) indicating the name and designation of the member of staff that the entry relates to. It is the responsibility of the member of staff undertaking the contact / consultation to ensure that an accurate record of the contact / attempted contact is recorded within the clinical notes. Do not rely on support staff to record findings from consultations and examinations.
- Where information is entered by one staff member on behalf of another staff member, this MUST be clearly stated in the entry.
- Any alterations must be made by scoring out with a single line, signed, dated and timed (or electronic equivalent).
- Clinical notes must be written for every appointment, consultations or contact (including non-attendances and cancellations) and to identify that significant documents have been uploaded / inserted into the record (e.g., reports / referrals / letters received and sent). These documents must be filed / uploaded to the correct section of the record
- Records MUST not include any unqualified abbreviations, jargon, offensive, judgemental or subjective statements. All abbreviations qualified in brackets at the first time of use and visible at all times.

9.3. For Electronic Record Keeping Standards

- Staff must ensure that electronic records are validated / saved as soon as the entries are complete.
- When prompted, records must be synchronised with the national spine to ensure that they contain the latest demographic information about the patient. All staff has a responsibility to ensure the accuracy of the entry is checked whenever appropriate with the patient at every opportunity and that any necessary corrections are made.
- Clinical notes must be timed and dated to match the time of the patient contact. Where clinical notes are entered retrospectively, the date and time of the entry should be made in real time with the date and time of the retrospective intervention / contact clearly shown

- All safeguarding issues must be recorded according to the appropriate system-specific guidance.
- Any risks / alerts must be recorded according to the appropriate system specific guidance.
- Team leads should verify with leavers that all clinical records and contacts have been updated and validated / saved prior to the staff member leaving.
- If there is a system failure the staff member is to input the patient's notes onto a Word document until access to the system is resumed, whereby the notes must be transferred directly onto SystmOne and subsequently deleted from their desktop.

9.4. For Paper record keeping standards

Electronic records are the primary patient record for ECCH patients. If paper records must be used these must be compiled correctly, ensuring the record is legible and that the following procedures must be followed:

Front cover

- Patient identifier and service username must be legible, this is the minimum information required on a front cover
- The cover must be in good condition
- If more than one volume exists for any patient, the volume number must be recorded clearly on the cover
- Date volume opened and closed

Within the record

- All documents MUST be filed into the correct section, should be secured and in chronological order, poly pockets must not be used to store documents within the record.
- When the staff member is writing in the patient's record for the first time they will print their name and designation under their signature.
- The NHS number MUST be recorded on both sides of each page of the paper clinical record.
- Any alterations MUST be made by scoring out with a single line, signed, dated and timed. Correction fluid MUST NEVER be used. Do not try to conceal the alteration. Any pages containing errors must not be removed from the record.

9.5. Scanned records

Where scanners are available, paper records will be scanned into the electronic patient record.

All information contained within the documents should be easily readable. No information should be obscured or have to be inferred. Documents should be examined prior to the scanning process, to ensure their suitability. Such factors as their physical state (thin paper, creased, stapled, etc.) and the attributes of the information (black and white, colour, tonal range, etc.) should be noted, especially where the original document is to be destroyed.

10. PATIENT LETTERS

10.1. Letters or documentation relating to the service user PATIENT must include the NHS Number (or unique identifier) as standard. This can be facilitated by "editable letter" or “mail merge” functions within electronic clinical record systems. If envelopes with windows are used patient identifiable information such as date of birth (DOB) and NHS number or clinical aspects of their care or the name of the clinic MUST NOT be visible through the window of the envelope.

10.2. It is standard practice as detailed within the “The NHS Plan (Paragraph 10.3)” that patients or, where appropriate, parent or legal guardians should receive copies of clinicians’ letters about them as of right.

11. PATIENT HELD RECORDS

11.1. Patient-held records may be used in certain areas which contain details of the ongoing treatment and care.

11.2. Patient-held records comprise part of the patient’s health records and remain ECCH property. It is essential that they are retrieved and retained at the conclusion of treatment as they are the sole record of much of the care given.

11.3. It is the responsibility of the department from where the records originated to ensure the safe return of the patient held records and compilation into the primary electronic health records.

12. TEST RESULTS

12.1. Any test results must be read, signed/electronically validated and dated by clinicians to indicate that they have been seen prior to being filed in the record or scanned. If there are no signatures on the result report, it must be assumed that they have not been read or seen by a clinician.

12.2. Alerts, allergies and serious physical conditions.

12.3. Medication allergies should always be noted in the correct section within the paper-based health care record. Allergies to environmental allergens, food etc. should also be noted as they can affect patient behaviour.

12.4. Other alerts including Do Not Resuscitate status, access needs and general alerts must also be recorded in the appropriate section.

13. MEDICATION

13.1. Medication details should be recorded within the agreed area of the clinical record / system. Medication names must not be abbreviated. Spell out drug names and dosages completely when recorded within clinical notes. Where electronic prescribing systems are used they will have their own system-specific guidance.

14. DOCUMENT NAMING CONVENTIONS

14.1. Paper documents must be scanned and uploaded into the appropriate electronic clinical record ensuring full legibility of the uploaded document.

15. MONITORING AND AUDIT OF RECORDS

15.1. Audit forms part of the ECCH's overall planned approach to continued improvement in clinical information and healthcare records standards for both electronic and paper records. It is also vital in ensuring that quality of care is maintained and delivered. The aim of auditing is to assess the standard of the record and identify areas requiring improvement and staff training. Audit also highlights where non-conformance to procedures is occurring and will suggest a tightening of controls and adjustments to related procedures. Audit can also be used to identify non-compliance with this policy and this information can, where appropriate, be used as part of an investigation.

15.2. Monitoring of compliance with this Policy is principally achieved through the annual ECCH- wide healthcare records audit. This audit will cover records generated by all ECCH services either electronic or paper records. Records are audited against a generic questionnaire which is reviewed and updated as necessary each year.

15.3. The results of the annual ECCH-wide healthcare records audits will be reported to the CARC and cascaded via reporting lines to the Integrated Governance Committee. The Integrated Governance Committee will be responsible for monitoring and ensuring improvements are made against specific action plans with clinical services.

16. TRANING

15.4. ECCH is responsible to provide training and guidance on legal and ethical responsibilities and operational good practice for all staff involved in records management.

15.5. Training for record keeping is mandatory for staff delivering clinical care on an annual basis.

15.6. Training and guidance enables employees to understand and implement policies, be reminded of their accountability and responsibility in relation to record keeping in line with professional regulation and facilitates the efficient implementation of good record keeping. Where relevant, all employees must receive training in local record keeping and management processes and procedures.

15.7. Any shortfall in compliance with the policy will be:

- Highlighted and addressed in staff yearly appraisals.
- Have action plans drawn up and implemented.
- Require evidence of change.

15.8. Assistant Directors and Service Managers are responsible for ensuring their staff have training related to record keeping and record management in their specific areas.

17. ASSOCIATED POLICIES & PROCEDURES (To include but not limited to)

- Standard Operating Procedures (SOP) for; Using SystmOne Effectively for Record Keeping
- Information Governance Handbook
- Information Governance Policy
- Data Protection and Personal Information Handling Policy
- Confidentiality Policy
- Records Management Policy
- Access to Health Records / Subject Access Request (SAR) Policy and Procedure Guidance
- Policy for Information Governance in SystmOne and summary care record

18. REFERENCES

- CQC Fundamental Standards
  - https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards
- Professional Codes of Conduct (HPC & NMC) –
  - https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/
  - https://www.nmc.org.uk/standards/code/

19. REFERENCES

None noted

20. AUTHOR

Ali Jennings, Deputy Director of Quality
Hannah Lewis Risk & Information Governance Team Lead – DPO
November 2021, East Coast Community Healthcare

21. APPENDICES

Appendix 1 - Record Keeping Workbook

east coast community healthcare

Appendix 1

East Coast Community Healthcare Record Keeping & Consent Workbook

Contents

What is a healthcare record?

Section 205 of the Data Protection Act 2018 (DPA18) defines a health record as a record which**:**

'Consists of data concerning health, and has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom the data relates.'

Healthcare records include anything that makes reference to the care of the patient and any record can be called as evidence as part of:

1. Coroners' inquests or claims.
2. Nursing & Midwifery Council's, Allied Health Professionals & other registration authorities Fitness to Practice Committee.
3. Incident Investigations.
4. NHS Professionals' disciplinary investigations.

A health record may include:

- Digital records such as SystmOne entries or paper records.
- Equipment order forms.
- Laboratory reports and results.
- Photographs of wounds.
- Radiology reports and images.
- Letters, referrals, discharge summaries and other correspondence about clinical care.
- Datix Incident Report.

✓ What is the purpose of healthcare records?

To compile a complete record of the patient's/client's journey through all health services.

To enable the continuity of care for the patient/client, both within and between all health services.

To be the primary source of evidence of effective ongoing care to your patients and to account for your actions, decisions and relevant omissions.

Healthcare records must:

Be Contemporaneous

- ✓ Records must be written immediately or as soon as possible after the event and definitely within 24hours.

Consider Partnership

- ✓ Records must detail how the patient/client is contributing to his or her care.
- ✓ Records should be recorded where possible with patient/client, carer/relative/advocate involvement.
- ✓ Records must be written in a way that allows information to be readily extracted by anyone who needs to do so. *(e.g. Other staff, other providers, the patient or their family)*

Be Accurate and Attributed

- ✓ Records must be factual, consistent, and accurate; they should focus on facts, not speculation.
- ✓ Records should not include unnecessary abbreviations, jargon or judgement/bias.
- ✓ Records shouldn't include inappropriate remarks or vague comments.
- ✓ Records shouldn't include illegible or blurred photocopies, photos or scans.

Communicate Clearly

- ✓ Records must record events accurately and clearly – remember that the patient/client may wish to see the record at some point, so make sure you write in language that he or she will understand.

Entered for the Correct Patient

- ✓ Double-check that you are saving notes or scanning referrals into the correct patient record, especially when they have a common surname.

Distinguishing fact from opinion

☺ The term fact can refer to, depending on context, a detail concerning circumstances past or present, a claim corresponding to objective reality, or a probably true concept.

☹ An opinion is a belief that cannot be proved with evidence. It is a subjective feeling and may be the result of an emotion or an interpretation of facts; people may draw opposing opinions from the same facts.

✓ Keep the Patient at the Centre of the Record

Patient Centred Care

Being person-centred is about focusing care on the needs of individual. Ensuring that people's preferences, needs and values guide clinical decisions, and providing care that is respectful of and responsive to them.

- Develop care and support plans with the patient.
- Involve the patient in decisions about them.
- Focus on their goals and aspirations; ask them about their wishes and feelings.
- When care planning explore potential for change, opportunities to develop their capacity and ability.
- Ensure the patient feels supported to express how they would like their care and support to be delivered.
- Ensure the patient understands any risks they may be taking but respect their rights to take the risk when fully informed.
- Try to ensure care planning conversations takes place at a time when the person is most or more likely to have capacity.

Record the patient's involvement in their care

It is essential to provide person-centred care, however it is not enough to just involve them in their care you should also ensure this is recorded within their record.

- When possible, the patient should be involved in the record keeping & should be able to understand what the records say.
- Document discussions you have with the patient include their worries, concerns, wishes and feelings.
- Record any goals and aspirations the patient has and any conversations around these.
- Conversations with the patient relating to care planning and decision making should me recorded within the record.
- Document your explanations of any risks and that you have checked the patient's understanding.
- Document that you have assessed the patient's capacity and that you continue to assess this throughout their care.

"Evidence tells us that supporting patients to be actively involved in their own care, treatment and support can improve outcomes and experience for patients, and potentially yield efficiency savings for the system through more personalised commissioning and supporting people to stay well and manage their own conditions better."
NHS England
https://www.england.nhs.uk/ourwork/patient-participation/

"The good physician treats the disease; the great physician treats the patient who has the disease"
William Osler (1849 – 1919)

✓ Why is good record keeping essential?

- Good record keeping is an integral part of professional practice and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow.
- Records may be viewed by a range of others. For example, to support a claim, manage a complaint, investigate a serious incident, transfer care to another provider or if access is requested by a patient. It is, therefore, essential that they are written in a way that allows information to be readily extracted by anyone who needs to do so.
- By documenting all relevant clinical information you are recording this information for future reference. **Remember, if you did not write it down, it did not happen.**

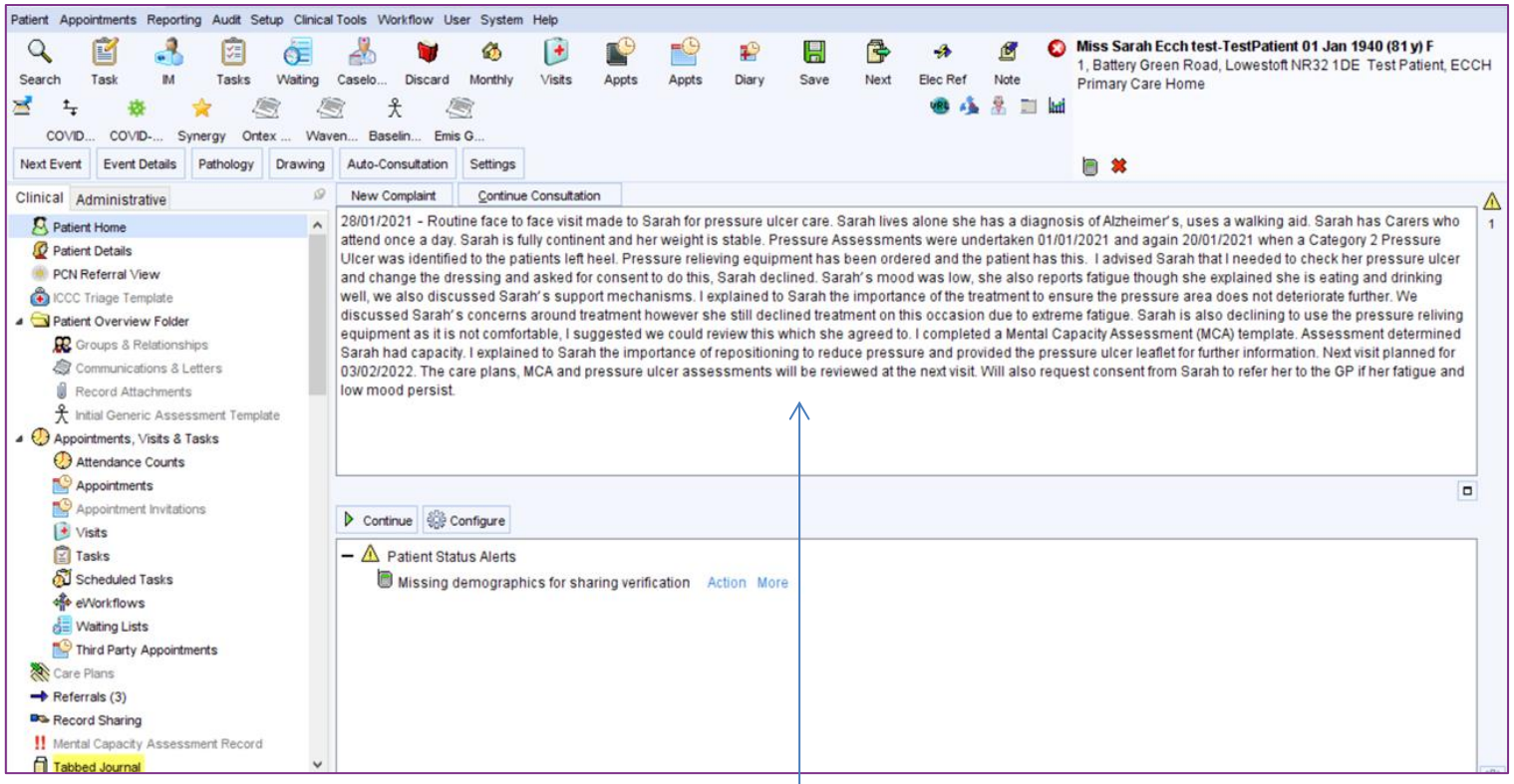
"It's about a change in thinking - records are as important as the care we're providing to the person. We also see record keeping consistently in the top three reasons why people appear before Fitness and Practice panels..."
NMC professional advisor Martine Tune, NMC 2009

✓ What should be recorded within the record?

- Patient demographics *(Data such as - age, gender, race and ethnicity)*
- Reasons for the current visit
- Patient consent
- The scope of examination / visit
- Positive exam findings
- Pertinent negative exam findings
- Key abnormal test findings
- Diagnosis or impression
- Clear management plan and agreed actions *(Think - Health Coaching)*
- Treatment details and future treatment recommendations
- Medication administered, prescribed or renewed and any drug allergies
- Written (or oral) instructions and/or educational information given to the patient
- Documentation of communications with patient and family/friends (level of awareness of the situation and acceptance of the plans)
- Recommended return visit date
- Telephone contact / assessments

✓ Example of a good record

Documented SystmOne Visit Example



'28/01/2021 – Routine face to face visit made to Sarah for pressure ulcer care. Sarah lives alone she has a diagnosis of Alzheimer's, uses a walking aid. Sarah has Carers who attend once a day. Sarah is fully continent, and her weight is stable. Pressure Assessments were undertaken 01/01/2021 and again 20/01/2021 when a Category 2 Pressure Ulcer was identified to the patients left heel. Pressure relieving equipment has been ordered and the patient has this. I advised Sarah that I needed to check her pressure ulcer and change the dressing and asked for consent to do this, Sarah declined. Sarah's mood was low, she also reports fatigue though she explained she is eating and drinking well, we also discussed Sarah's support mechanisms. I explained to Sarah the importance of the treatment to ensure the pressure area does not deteriorate further. We discussed Sarah's concerns around treatment however she still declined treatment on this occasion due to extreme fatigue. Sarah is also declining to use the pressure reliving equipment as it is not comfortable, I suggested we could review this which she agreed to. I completed a Mental Capacity Assessment (MCA) template. Assessment determined Sarah had capacity. I explained to Sarah the importance of repositioning to reduce pressure and provided the pressure ulcer leaflet for further information. Next visit planned for 03/02/2022. The care plans, MCA and pressure ulcer assessments will be reviewed

Common record keeping errors and omissions

- Absence of clarity e.g. the meaning of 'Had a good day' and ‘slept well’ is not clear.
- Delay in completing the record.
- Inaccuracies of the patient information including NHS number, name, date of birth and address.
- Documents for the wrong patient attached to the record.
- Unprofessional terminology, e.g. ’dull as a doorstep’.
- Meaningless phrases , e.g. ‘lovely child’ ‘appears’ ‘Slept well’ ‘Encouraged’.
- Failure to record action taken when a problem is identified.
- Missing information, e.g. administration of a drug not documented.
- Spelling mistakes.
- Inaccurate records.
- Failure to document; conversations, care given, special needs.
- Failure to record telephone calls including communication between healthcare professionals.
- Opinion mixed with facts.
- Reliance on information from others without identifying the source.
- Subjective not objective comments, e.g. ’normal development.

What to do if you identify a record keeping error

- Report the error to your line manager.
- Report a Datix incident.
- Log it with System Support Team for action if required.

What is Consent?

Consent is an individual's valid agreement for a health professional to provide care.
Seeking consent should always be a process of joint decision-making that reflects the recognition of people's dignity and autonomy.
Written information should be made available where possible to support decision making.

Remember - Consent should always be documented in the patient's healthcare record.

Agreement/Consent may be provided in different ways …

Non-Verbal Consent

Verbal Consent

Written Consent

Remember - Consent can also be refused / declined, this must also be documented within the record.

Simple Consent

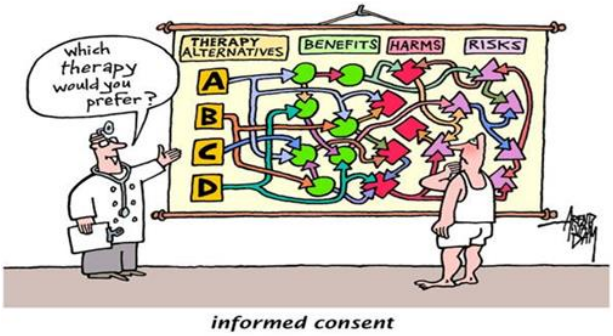
- All medical procedures and interventions require patient agreement.
- Simple consent implies the patient has had opportunity to discuss.
- It applies even when there is a clear course of action.
- May require high level discussion.

Implied Consent

- An example of implied consent would be where a person, after receiving appropriate information holds their arm out to have their blood pressure taken or opens their mouth to have their teeth examined.
- The Practitioners must still communicate what they are going to do and document it within the record.

What is Informed Consent?

- Informed consent is the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention.
- The patient must be competent to make a voluntary decision about whether to undergo the procedure or intervention.
- Information required for all types of consent.
- Records patient's explicit authorisation.
- Affects liability in the event of any untoward complications.
- Applies whether it is one or many actions / options to choose from.
- NB when related to safeguarding, information can sometimes be shared without consent, when, for example, there is a public interest justification, or the person may be placed at additional risk. Please seek advice from the Safeguarding team if needed.



informed consent

Capacity

Means the ability to use and understand information to make a decision, and communicate any decision made. A person lacks capacity if their mind is impaired or disturbed in some way, which means they're unable to make a decision at that time. Remember lack of capacity can be permanent, temporary or fluctuating and is time and context dependent.

- mental health conditions – such as schizophrenia or bipolar disorder
- dementia
- severe learning disabilities
- brain damage – for example, from a stroke or other brain injury
- physical or mental conditions that cause confusion, drowsiness or a loss of consciousness
- intoxication caused by drugs or alcohol misuse

Mental Capacity Act

The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

🗁 **Remember - If the person has been assessed as not having capacity meaning they are unable to make a decision at the time this must be clearly documented within the healthcare record.**

Children & Consent

- Children 16 or over are entitled to consent to their own treatment. This can only be overridden in exceptional circumstances.
- Like adults, children aged 16 or 17, are presumed to have sufficient capacity to decide on their own treatment unless there is significant evidence to suggest otherwise.
- Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent.
- If a young person refuses treatment, which may lead to their death or a severe permanent injury, their decision can be overruled by the Court of Protection.

When a Child is Not Able to Give Consent

When a child cannot give consent, somebody with parental responsibility can give consent for them.
This could be:

- The child's mother or father (if he has parental responsibility).
- Another adult with a Parental Responsibility Agreement or Parental Responsibility Order.
- The child's legally appointed guardian.
- A person with a residence order concerning the child.
- A local authority designated to care for the child.
- A local authority or person with an emergency protection order for the child.

Parental Responsibility

- A person with parental responsibility must have the capacity to give consent.
- If someone with PR refuses to give consent to a particular treatment, this decision can be overruled by the courts if treatment is thought to be in the best interests of the child.
- By law, healthcare professionals only need 1 person with PR to give consent for them to provide treatment.
- In cases where 1 parent disagrees with the treatment, doctors are often unwilling to go against their wishes and will try to gain agreement.

- If agreement about a particular treatment or what's in the child's best interests cannot be reached, the courts can make a decision.
- In an emergency, where treatment is vital and waiting for parental consent would place the child at risk, treatment can proceed without consent.

National standards, legislation and regulations for record keeping

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

- Care Quality Commission: Regulation 17, Good Governance https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance
- Data Security and Protection Toolkit https://www.dsptoolkit.nhs.uk/
- General Data Protection Regulation 2016 https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/
- Accessible Information Standard 2016 https://www.england.nhs.uk/ourwork/accessibleinfo/
- NMC & HCPC https://www.nmc.org.uk/ https://www.hcpc-uk.org/

Legal Aspects of Record Keeping

Health departments in the UK make two things clear about the legal aspects of record-keeping in health services:

- Individuals who work for health care organisations are responsible for what they write.
- Anything an individual writes in relation to their work as a health care employee becomes a public record.

Relevant Record Keeping Policies/Procedures & User Guides

- ECCH SystmOne User Guides
  - ECCHO – SystmOne/RA - SystmOne Quick Guides

- ECCH Policies & Procedures
  - Record Keeping Policy
  - Records Management Policy and Procedure
  - Access to Health Records Policy
  - IG Handbook
  - Accessible Information Standards (AIS) Policy
  - Consent to Examination or Treatment Policy
  - Mental Capacity Act Policy

Helpful References

- The Royal College of Nursing Record Keeping Guidance: *https://rcni.com/hosted-content/rcn/first-steps/record-keeping*
- The Chartered Society of Physiotherapy Record Keeping Guidance: *https://www.csp.org.uk/publications/record-keeping-guidance*
  - https://www.norfolksafeguardingadultsboard.info/assets/documents/NSAB-SN-H-Practitioners-Guide-JUNE2018FINAL02.pdf
- NHS Consent to Treatment & MCA
  https://www.nhs.uk/conditions/consent-to-treatment/capacity/
  https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/

Useful Contacts

System Support	*systemsupport@ecchcic.nhs.uk*
Data Protection Officer	*hannah.lewis@ecchcic.nhs.uk*
Safeguarding	*safeguarding@ecchcic.nhs.uk*

Version Control

Version Date	Version No.	Author/ Reviewer	Comments
16/12/2020	V2	Risk & IG Team Lead (DPO) & Named Nurse Safeguarding Adults/ Children	*Complete review and update of the workbook as part of the record keeping workshop.*
07/05/2021	V3	Risk & IG Team Lead (DPO) & Named Nurse Safeguarding Adults/ Children	*Further updates to record keeping to add more information about person centred record keeping and add examples. Added further information on consent.*
06/07/2021	V3.1	Risk & IG Team Lead (DPO) & Named Nurse Safeguarding Adults/ Children	*Minor changes added.*
04/10/2021	V3.2	Named Nurse for Safeguarding	Minor changes to questions and information about consent and safeguarding

Activity sheet

1. What you think constitutes a healthcare record?

Please type your answer here

2. Type as many reasons as you can for keeping good records in the below.

Please type your answer here

3. Following a visit to a patient's house that is extremely cluttered you read this sentence in the previous record entry. *"Mr Smith's lounge was dirty, unkempt and smelly."* Please re word this sentence to make it less judgemental, more descriptive and address possible risks (you may want to make use of the policy…..)

Re word the statement here

4. From your experience and observations, what do you think are the most common errors in record keeping?

Please type your answer here

5. Accurate records are essential to support what?

Please type your answer here

6. Below are some examples of poor record keeping. Please explain in detail what is wrong with each of these records.

a. *'Fell 2/52. Hx of LBP for 6/7. s/b GP - NSAI Px with adequate effect. Now pain ↑in R leg. Rx with physio. Pt rude and dirty. Smells of urine. Refused to do exercises despite being told to. Does not appear to have pain! Persistent cough, Smoker, known to SS, son in prison!! (In error)'*

Please type your answer here

b. *'Ax by SaLT , Wt over 1/12. Has very poor diet. Very overweight'*

Please type your answer here

c. *'Told to do exercises, doubt they will. See again 6/52 for review'*

Please type your answer here

7. What is good about the below record?

'28/01/2021 – Routine face to face visit made to Sarah for pressure ulcer care. Sarah lives alone she has a diagnosis of Alzheimer's, uses a walking aid. Sarah has Carers who attend once a day. Sarah is fully continent and her weight is stable. Pressure Assessments were undertaken 01/01/2021 and again 20/01/2021 when a Category 2 Pressure Ulcer was identified to the patients left heel. Pressure relieving equipment has been ordered and the patient has this. I advised Sarah that I needed to check her pressure ulcer and change the dressing and asked for consent to do this, Sarah declined. Sarah's mood was low, she also reports fatigue though she explained she is eating and drinking well, we also discussed Sarah's support mechanisms. I explained to Sarah the importance of the treatment to ensure the pressure area does not deteriorate further. We discussed Sarah's concerns

around treatment however she still declined treatment on this occasion due to extreme fatigue. Sarah is also declining to use the pressure reliving equipment as it is not comfortable, I suggested we could review this which she agreed to. I completed a Mental Capacity Assessment (MCA) template. Assessment determined Sarah had capacity. I explained to Sarah the importance of repositioning to reduce pressure and provided the pressure ulcer leaflet for further information. Next visit planned for 03/02/2022. The care plans, MCA and pressure ulcer assessments will be reviewed at the next visit. Will also request consent from Sarah to refer her to the GP if her fatigue and low mood persist.'
Please type your answer here

8. List some of the questions you would need answered before you gave consent to a medical procedure or treatment for yourself.

Please list your answers here

9. Which of the following require consent?

- Entering a patient's home. Yes ☐ No ☐ Maybe ☐ select the box
- Making a safeguarding referral Yes ☐ No ☐ Maybe ☐ select the box
- Redressing a wound Yes ☐ No ☐ Maybe ☐ select the box
- Photographing a pressure ulcer Yes ☐ No ☐ Maybe ☐ select the box
- Liaising with an outside agency Yes ☐ No ☐ Maybe ☐ select the box
- Making an onward referral Yes ☐ No ☐ Maybe ☐ select the box

10. Who below are competent to give consent? ***(please tick and comment)***

Patients who are drunk / intoxicated? Yes ☐ No ☐ Maybe ☐
Comments:

Patients with severe mental health disorders Yes ☐ No ☐ Maybe ☐
Comments:

Patients with a communication disability Yes ☐ No ☐ Maybe ☐
Comments:

Patients with a learning disability Yes ☐ No ☐ Maybe ☐
Comments:

11. Patient arrives unconscious in A&E. His leg is severely damaged and the vascular surgeon's decision is to amputate immediately due to un-controllable bleeding. Can you as the clinician make that decision/consent for the patient?

Yes ☐ or No ☐
select the box and comment
Comments:

12. Rob is a four year old boy. He has been admitted to hospital with cellulitis and antibiotic therapy is indicated. His mother suffered an unpleasant reaction to antibiotics as a teenager and refuses to allow Rob to have this treatment. Rob's father thinks

the medical advice to treat with antibiotics should be accepted. Would you treat this child without his mother's permission?

Yes ☐ or No ☐

select the box and comment

Comments:

Once you have read and completed this workbook please return it to:

roxy.king@ecchcic.nhs.uk