Healthcare Record Keeping Policy

Version No. 4: September 2024

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Contents

*(For quick access to a specific heading - **press CTRL and click your mouse** to follow the link for the below options)*

1. INTRODUCTION

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 and is easily accessible when required.

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.

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.

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

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

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

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

- all patient health records on SystmOne or in any additional formats (including x-ray and imaging reports, registers, telephone messages)

4. DEFINITIONS

The following definitions are intended to provide a brief explanation of the various terms used within this policy.

Term	Definition
Policy	A policy is a formal written statement detailing an enforceable set of principles or rules. Policies set the boundaries within which we operate. They also reflect the philosophy of our organisation.
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.
Care Quality Commission (CQC)	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

ECCH Employees – All staff are responsible for ensuring that accurate legible records are kept in accordance with policies and legal requirements.

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.

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 and any associated procedures
- Ensure any training required is completed and up to date.
- 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.

- **Chief Executive of ECCH** – has the overall responsibility for the policy and for ensuring that the organisation complies with its statutory obligations and Department of Health directives.

- **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.

- **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.

- **Systems Team** 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.

- **All 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 team manager is responsible for periodic review of staff competency in clinical record keeping.

- **The Clinical Audit Team** is responsible for ensuring an annual clinical records audit is undertaken looking at SystmOne records.

6. POLICY STATEMENT

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 creation, compilation and use of health care records, which should be monitored and reviewed on a regular basis.

This policy **MUST** be read by all patient facing 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.

7. PROCEDURE

7.1 WHAT IS A RECORD?

Record

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 staff in an organisation.

Healthcare Record

A health care record is a summary of an individual's health and medical history. It includes information from various sources, such as data entered by the individual as allergies, medications, and family history etc.

7.2 PURPOSE OF HEALTHCARE RECORDS

Healthcare records are used for several key purposes:

- **Patient care:** Healthcare records provide the documented basis for planning patient care and treatment. To support day to day interventions which underpins the delivery of care. To support sound administration and managerial decision making.
- **Communication:** Healthcare records are used to communicate information between healthcare providers.
- **Legal processes:** Healthcare records are used as legal documentation in case of medical claims, 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.

- **Research and Quality Management:** Healthcare records are used to measure and analyse trends in healthcare use, patient characteristics, and quality of care.
- **Service User Experience:** Reducing the need for the service user to repeatedly give their history. Establishing the accuracy of information held about the service user.
- **Governance:** Support any investigations that are required for incidents, complaints etc. Enable Research, clinical audit and statutory information returns**.**
- **Subject Access Requests:** Enable the service user and/or their representative to obtain copies of records.

7.3 RECORD KEEPING STANDARDS

Demographic Information
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 to include in all records (paper or electronic) :

- **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**
- **Gender**
- **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 **Accessible Information Standards (AIS)** template been completed

Healthcare Record Standards for Records held in any Format.

For service users the healthcare record must be:

- Entries should be made at the point of contact (visit/assessment/call etc) or as close to real-time as possible. This improves accuracy and timeliness and reflects professional guidance. (Records MUST be made within your shift)
- Entries should provide current information on the care and condition of the service user.

- Started at initial contact with the service user
- Clear, unambiguous, honest and legible.
- Accurate, complete and concise. The 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.
- Decisions made on behalf of a person who lacks capacity must be recorded and provide evidence that these have been taken in line with the requirements of the Mental Capacity Act 2005.
- Notes should be in chronological order.
- The record must be grammatically correct with appropriate use of capital letters and punctuation and spell checked. (SystmOne has a function available to spell check.)
- Records should be written in terms that the patient will be able to understand.
- Records should be service user identifiable.
- 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).
- Notes must be written for every appointment, consultations or contact (including non-attendances, cancellations, telephone calls etc) 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. Abbreviations should only be used if qualified in brackets at the first time of use and visible at all times.

Electronic Record Keeping Standards

High-quality electronic records should contain all the information needed about a patient's health to provide good care to that person. This information can be relied upon to make clinical decisions with confidence when it:

- is accurate
- is appropriately and correctly coded
- has the correct context

- contains no inaccurate or data not related to the patient
- is curated to allow all this information to be accessible

Missing, inaccurate, or non-standard information can, however, lead to Inconsistent care, or risk the quality, and safety, of care delivered.

Staff must ensure that:

- electronic records are checked 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 have 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.

Paper Record Keeping Standards

Electronic records are the primary patient record for ECCH patients. If paper records must be used this must be authorised and risk assessed. These must then 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.

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.

7.4 PATIENT LETTERS

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.

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.

7.5 PATIENT HELD RECORDS

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

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.

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.

7.6 TEST RESULTS

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.

Alerts, allergies and serious physical conditions.

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.

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

7.7 MEDICATION

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.

7.8 DOCUMENT NAMING CONVENTIONS

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

7.9 MONITORING AND AUDIT OF RECORDS

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.

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.

The results of the annual ECCH-wide healthcare records audits will be reported to the Clinical Audit & Risk Champions Group (CARC) and cascaded via reporting lines to the Quality Committee & Audit & Risk Committee. The CARC will be responsible for monitoring and ensuring improvements are made against specific action plans with clinical services.

7.10 TRAINING

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

Training for record keeping is mandatory for patient facing staff. Training is face to face at induction and then online after this. SystmOne training is also provided at induction for anyone writing records in SystmOne.

Training and guidance enable 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.

Any shortfall in compliance with the policy will be, identified via record keeping audits or as part of operational accessing of records for patient care and then:

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

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

8. MONITORING AND REVIEW

This document will be reviewed by the **Clinical Quality Group, every 3 years** or sooner if changes in legislation occur or new best practice evidence becomes available.

9. REFERENCES

- CQC Regulation - Regulation 17: Good governance - Care Quality Commission (cqc.org.uk)
- Professional Codes of Conduct (HPC & NMC) –
  - https://www.hcpc-uk.org/standards/standards-of-conduct-performance-andethics/
  - https://www.nmc.org.uk/standards/code/
- NHS Gender Recording -
  - Gender identity - NHS England Digital

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

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

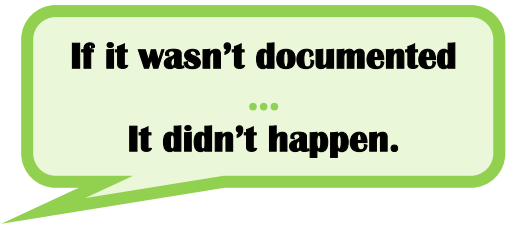
- Safety Event Reporting Policy
- Wound Photography SOP
- Mental Capacity Act Policy

11. AUTHOR

Head of Corporate Governance Risk Management & Data Protection Officer & Named Nurse Safeguarding Adults/Children and Freedom to Speak Up Guardian

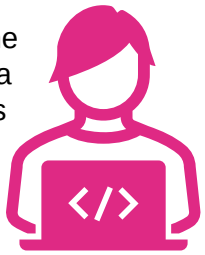
12. APPENDICES

Appendix 1 – Top Tips for Good Record Keeping for Staff



Good record keeping is a vital part of effective communication within our services and the wider system, it is integral to promoting safety and continuity of care for patients and clients.

It is essential to use your ECCH provided mobile working devices (laptops/phones) to keep patient records including photos safe. Use of notebooks, paper and diaries for personal identifiable record keeping is not permitted. Using your laptop to access the SystmOne record at the point of contact phone call/appointment/assessment or visit will ensure you correctly identify the patient, are able to access most recent care information and allow you to update the record in a timely way making it available to other clinicians who may be visiting, additionally it also reduces the likelihood of adding it to the wrong record for forgetting information.



Missing, inaccurate, or non-standard information can, however, lead to Inconsistent care, or risk the quality, and safety, of care delivered.

All records should be:

Be Contemporaneous & Safe

- Entries should be made at the point of contact (visit/assessment/call etc) or as close to real-time as possible. This improves accuracy and timeliness and reflects professional guidance. (Records MUST be made within your shift)
- Written directly into SystmOne using your laptop, record keeping should not be done in notebooks or on paper.

Consider Partnership

- Records must detail how the patient/client is contributing to their care.
- Records should be recorded where possible with patient/client, carer/relative/advocate involvement.
- When possible, the person in your care should be involved in the record keeping and should be able to understand what the records say.
- Records must be written in a way that allows information to be readily understood by any other health professional who may need to access them to provide care.
- Records should capture the patients voice, including their thoughts wishes and feelings.
- Decisions made on behalf of a person who lacks capacity must be recorded and provide evidence that these have been taken in line with the requirements of the Mental Capacity Act.

Be Accurate and Attributed

- Records must be completed accurately and without any falsification and provide detailed information about the care given as well as arrangements for future and ongoing care.
- Records should not include abbreviations, inappropriate remarks, or vague comments.
- Records and photos should be readable when scanned/uploaded onto the record.
- The record should capture all the information relating to the contact.

Communicate Clearly

- Explain things clearly in a way anyone can understand, and any speculation and judgement should be avoided.
- Remember that the patient/client may wish to see the record at some point, so make sure you write in language that they will understand.

Entered for the Correct Patient

- Double-check that you are saving notes, uploading photos or scans the correct patient record, especially when the patient has a common surname or address is similar.

To Avoid Errors in Record Keeping:

- Try to complete the record at the point of contact and work with one record open at a time when entering or adding any information and do a final check before saving the record.
- If you identify any record keeping incident or near miss report an incident onto QUEST.

Appendix 2 – Nursing & Midwifery Council (NMC) CODE - Record Keeping

Keep clear and accurate records relevant to your practice.

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:

- complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event.
- identify any risks or problems that have arisen, and the steps taken to deal with them, so that colleagues who use the records have all the information they need
- complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.
- attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.
- take all steps to make sure that records are kept securely.
- collect, treat and store all data and research findings appropriately.

Appendix 3 - Health and Care Professions Council (HCPC) Record Keeping Standards

Full, clear and accurate record keeping is vital to the delivery of safe and effective healthcare.

Once you are registered with us, you have a professional responsibility to keep full, clear and accurate records for everyone you care for, treat or provide other services to. This is to:

- safeguard continuity of care by providing information to colleagues involved in care and treatment.
- ensure service users receive appropriate treatment that is in their best interests.
- meet legal requirements or respond to Freedom of Information or Subject Access Requests; and
- evidence your decision-making processes if later queried or investigated.
- What records you need to keep, in what format and for how long, varies depending on the setting you are working in and the subject matter of those records.
- Completing records promptly
- Records need to be completed promptly to ensure continuity of care. You should make sure that the records can be shared with colleagues as soon as possible after care and treatment. We know that prompt record keeping can be challenging, especially for our registrants working in busy front-line services. Often you might be facing time constraints or targets, meaning you struggle to find time to keep records promptly.

Appendix 4 – Care Quality Commission (CQC) Regulation

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17

Regulation 17 – Good Governance

17(2)(c) maintain securely an accurate, complete, and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided

Guidance on 17(2)(c)

- Records relating to the care and treatment of each person using the service must be kept and be fit for purpose. Fit for purpose means they must:
    - Be complete, legible, indelible, accurate and up to date, with no undue delays in adding and filing information, as far as is reasonable. This includes results of diagnostic tests, correspondence, and changes to care plans following medical advice.
    - Include an accurate record of all decisions taken in relation to care and treatment and make reference to discussions with people who use the service, their carers and those lawfully acting on their behalf. This includes consent records and advance decisions to refuse treatment. Consent records include when consent changes, why the person changed consent and alternatives offered.
    - Be accessible to authorised people as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe. This applies both internally and externally to other organisations.
    - Be created, amended, stored, and destroyed in line with current legislation and nationally recognised guidance.
    - Be kept secure at all times and only accessed, amended, or securely destroyed by authorised people.
- Both paper and electronic records can be held securely providing they meet the requirements of the Data Protection Act 2018.
- Decisions made on behalf of a person who lacks capacity must be recorded and provide evidence that these have been taken in line with the requirements of the Mental Capacity Act 2005 or, where relevant, the Mental Health Act 1983, and their associated Codes of Practice.

- Information in all formats must be managed in line with current legislation and guidance.
- Systems and processes must support the confidentiality of people using the service and not contravene the Data Protection Act 2018.

13. EQUALITY & DIVERSITY IMPACT ASSESSMENT

In reviewing this policy, the Policy Group considered, as a minimum, the following questions:
- Are the aims of this policy clear?
- Are responsibilities clearly identified?
- Has the policy been reviewed to ascertain any potential discrimination?
- Are there any specific groups impacted upon?
- Is this impact positive or negative?
- Could any impact constitute unlawful discrimination?
- Are communication proposals adequate?
- Does training need to be given? If so, is this planned?

Adverse impact has been considered for age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.

14. DOCUMENT CONTROL

Version Date	Version No.	Author/ Reviewer	Comments
Sept 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
Nov 2018	3	Sam Leech	8.1 & 8.1.2 added – Occupation/employment Nutritional Screen
Feb 2020	3.1	Ali Jennings	8.2 – added instructions for system failure. Transferred to the new policy format
Nov 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
Sept 2024	4	DPO	Full review of policy completed including • Changes to layout to make it clearer • Enhancement to content but no significant change to content. • Removed record keeping workbook as this has been replaced by online training. • Added section on capacity decision making / MCA recording. • Changed the section on updating in 24hours to make this more specific about as near to real time as possible/within shift. • Added a new appendix to be used for Staff Top Tips • Added CQC/HCPC/NMC standards as appendices. • Updated gender recording

DOCUMENT CONTROL SHEET

Name of Document:	Record Keeping Policy
Version:	4
File Location / Document Name:	ECCHO Services/policy & guidelines/update policies
Date Of This Version:	September 2024
Produced By (Designation):	Quality Team
Reviewed By:	Clinical Quality 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:	10/10/2024
Distribute To:	All staff responsible for record keeping
Date Due for Review:	September 2027
Enquiries To:	Quality Team
Approved by Appropriate Group/Committee	☐ Date: 10/10/2024