Record Keeping Policy

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DOCUMENT CONTROL SHEET

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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

EQUALITY AND DIVERSITY IMPACT ASSESSMENT

Impact Assessments must be conducted for:

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

Name of Policy / Procedure / Service	**CORPORATE**
Manager Leading the Assessment	**Deputy Director of Quality.**
Date of Assessment	**February 2020**

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

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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 professionals 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 under estimate 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, Connecting for Health Information Governance Toolkit (IGT) 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:

2.1 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.

2.2 To ensure the organisation meets all its statutory requirements.

2.3 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

Not relevant

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 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 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.

5.7.1 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.

5.7.2 All staff whether permanent, temporary or contracted will at all times make honest entries into to the record. 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 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. WHAT IS A RECORD?

6.1 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 print-outs 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

6.2 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.

7. PURPOSE OF HEALTHCARE RECORDS

7.1 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

7.2 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

7.3 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

8. RECORD KEEPING STANDARDS

8.1 For Generic Record Keeping Standards

8.1.1 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.

8.1.2 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

8.1.3 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.

8.2 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.

8.3 For Paper record keeping standards

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

8.3.1.1 Front cover

- Patient identifier and service user name 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

8.3.1.2 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.

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

8.4.1 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.

9. PATIENT LETTERS

9.1 Letters or documentation relating to the service user PATIWNT 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.

9.2 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.

10. PATIENT HELD RECORDS

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

10.2 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.

10.3 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.

11. TEST RESULTS

11.1 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.

11.2 Alerts, allergies and serious physical conditions

11.3 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.

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

12. MEDICATION

12.1 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.

13. DOCUMENT NAMING CONVENTIONS

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

14. MONITORING AND AUDIT OF RECORDS

14.1 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.

14.2 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.

14.3 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.

15. TRANING

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

15.1 Training for record keeping is mandatory for staff delivering clinical care on a three yearly basis.

15.2 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.

15.3 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.

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

16. OTHER POLICIES OF RELEVANCE

16.1 The following policies need to read in conjunction with the policy:

- Data Protection Act
- Confidentiality Code of Conduct
- Caldicott and Safe Haven Procedures
- Records Management Policy
- Professional regulations relating to Record Keeping

17. PROCEDURE

17.1 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.

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

18. MONITORING AND REVIEW

If there are any questions or queries about this policy or procedure, contact the Executive Director of Quality for advice.

19. REFERENCES

None noted

20. AUTHOR

Ali Jennings, Deputy Director of Quality,
February 2020, East Coast Community Healthcare

APPENDICES
None