RECORD KEEPING IN HEALTHCARE RECORDS POLICY

Version 6.0

Key Points

- The Policy provides a framework for the quality of the clinical record facilitates high quality, safe patient care and that subsequently the healthcare record can justify any clinical decision if required.
- All Healthcare Professionals must **clearly sign and print** their name every time they write information in the medical record.
- An entry should be made in the medical record whenever a patient is seen by a health professional. This should be done as soon as possible after the patient is seen or the procedure is complete.
- Allergy status must be recorded where appropriate

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Meta Data

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Superseded documents	Record Keeping in Healthcare Records Policy - 2006
Relevant External Standards/ Legislation	Generic Medical Record Keeping Standards (RCP 2007) NMC Record Keeping Standards 2007 NHS Records Management Code of Practice NHS IM&T Security Manual *Health Service Circular 1998/153* Data Protection Act 1998 Computer Misuse Act 1990 NHS Connecting for Health Information Governance Toolkit NHSLA Risk Management Standards Care Quality Commission
Key Words	Record, Standards, Electronic, Manual, Legible

Revision History

Version	Status	Date	Consultee	Comments	Action from Comment
4		01/6/08	Medical records Manager et al	Various comments for inclusion	Amendments made
4.1		01/8/08	Healthcare Gov	Confirmation of Committee responsibility	Confirmed
4.1		01/8/08	Electronic records manager	Confirmation of electronic audit content	Confirmed
4.2		01/10/08	Healthcare Gov	Change to reporting structures addition of electronic audit report template	Amendments made
4.3		01/12/08	Healthcare Gov	Change to Key points, written and electronic standards. Addition of the Audit Programme in Appendix A	Amendments made
5.0	Final	01/12/08			
5.1	Draft	29/04/09	ICT Gov Mgr	Changes to reflect introduction of Message Alerts to iCare system	Amendments made MRC to approve
6.0	Final	05/05/09	Medical Records Committee		Approved
6.0	Final	13/05/09	Info Gov Comttee		Approved
6.0	Final	29/06/2010	Director of Safety and Governance	Minor changes to reflect changes to Trust structure	Approved

Table of Contents

1 Circulation

This Policy applies to all staff and applies equally to staff in a permanent, temporary, voluntary or contractor role acting for or on behalf of Heart of England NHS Foundation Trust.

2 Scope

This policy covers standards of recording keeping in paper and electronic healthcare records.

3 Definitions

For the purposes of this policy the *patient record*, *healthcare record*, *medical record* is the operational record of multidisciplinary and clinical information that accompanies a patient when they attend or are admitted to hospital.

4 Reason for development

Heart of England NHS Foundation Trust is committed to improving the quality of care to patients and the safety of staff and members of the public.

The Trust recognises the importance of maintaining robust and accurate patient information. It acknowledges that the medical records should provide a detailed account of patient care from the time they enter the hospital until the time of discharge.

In order to ensure that staff provide a contemporaneous and complete record of care; the Trust has adopted basic record keeping standards that apply to all healthcare records in accordance with local and national recognised standards.

The Trust is committed to the adoption of these standards for all multi-disciplinary groups throughout the organisation. The Trust will monitor compliance with these standards via audits on an annual basis to measure and act upon compliance with this policy.

5 Aims and Objectives

- To provide a policy framework in order to ensure that Healthcare professionals record and communicate patient information in a consistent way at all times;
- To ensure that all authors in the clinical records are identifiable;
- To maximise patient safety and quality of care;
- To achieve compliance with Information Governance and NHSLA risk management standards.

6 Standards for Record Keeping

6.1 Basic record keeping standards for all healthcare records

While the standards required in record keeping may vary from profession to profession, some standards apply to all healthcare professionals. The following standards are a basic requirement for all healthcare records:

a) Each entry must clearly identify the author.
b) Each entry must be legible.
c) Each entry must include the time the entry is made.
d) Each entry must include the date the entry is made.
e) Each page of the record must clearly identify the patient by recording the name, location and PID.

f) Any change to the record (deletion or amendment) should clearly identify the person making the change and the date the change was made. No entry should be permanently erased.
g) Documentation within the medical record should reflect the continuum of patient care and should be recorded, stored and accessible in chronological order.
h) An entry should be made in the medical record each time a patient is seen by a health professional. This should be done as soon as possible after the patient is seen or the procedure is complete.
i) Only facts and clinical opinions should be recorded.
j) Abbreviations should be avoided and if used, should be only those in widespread use within the profession.
k) Allergy status should be recorded as appropriate.

Compliance with standards a) to g) will be monitored through the Trust's annual documentation audit.

6.2 Supplementary standards for record keeping in written records

In addition to the standards detailed in section 6.1, there are a number of standards that should be observed when completing written (as opposed to electronic) healthcare records; they are as follows:

a) In order that the author may be properly identified the designation of the person making the entry should be written against their signature.
b) Entries should be made in black ink unless a specific requirement to use other colours (such as green ink for pharmacy charts) exists.
c) If diagrams are used they must be clear and appropriately labelled
d) For outpatients, a record should be made in the notes at the time of each visit (although this can be supplemented at a later date with dictated notes).

6.3 Supplementary standards for record keeping in electronic records

The principles for manual records also apply to electronic records; however in addition, some specific standards apply and are listed below.

a) The user ID of the person making the entry will automatically be recorded with the date and time.
b) Message Alerts, giving information about, for example advance directives or specific long term and/or rare conditions should be entered on the iCare system. The clinician responsible for the patient's care should check all existing alerts before adding additional alerts.
c) When a clinician is presented with a warning that a patient healthcare record has been merged the major PID must be used in all subsequent recording keeping.
d) Where a clinician is warned about a possible misfiled document they are responsible for deciding if the record should remain on the patient's file.
e) Electronic Patient handover is to be updated as a minimum once each shift
f) Access codes must not be shared at any time.
g) Passwords must never be displayed on the computer screen, on any audit trails, on any printed reports or in back up media.
h) As with manual records, staff must maintain the security of electronic records.

7 Responsibilities

This section sets out the roles and responsibilities of key individuals in ensuring compliance and monitoring of this policy.

7.1 Individual Responsibilities

7.1.1 Chief Executive

The Chief Executive retains overall responsibility for standards of records management.

7.1.2 Director of Safety and Governance

Operational responsibility is delegated to The Director of Safety and Governance.

7.1.3 Executive Directors

The Executive Directors are responsible for ensuring adherence to record standards as outlined in the policy in areas of their responsibilities.

7.1.4 All Staff Who Make Entries in Medical Records

- All staff that make entries in medical records are responsible for the quality, content of those records and adherence to this policy.
- All staff who supervise unqualified staff/staff in training are responsible for the content and quality of the medical notes written by the junior staff under their supervision.
- All staff must ensure that they comply with this policy and must report any related incidents involving breaches of confidentiality (including data loss) using the Trust risk management procedures.

7.1.5 Department/Ward Manager (or designated deputy)

To ensure that all staff are familiar with this policy and comply with it at all times. This includes temporary, locum and contract staff.

7.1.6 Clinical Directors

To ensure that all clinical staff, qualified and in training, within their team understand and adhere to this policy. This includes temporary, locum and contract staff.

7.1.7 Consultants

To ensure that all medical staff, qualified and in training, within their team understand and adhere to this policy. This includes temporary, locum and contract staff. The quality of record keeping by junior medical staff is ultimately the responsibility of the supervising consultant.

7.1.8 Clinical Audit Leads

To discuss audit findings and recommendations with all stakeholders within their directorate and for ensuring that an action plan is developed to address any recommendations.

7.1.9 Safety and Governance Directorate

- To ensure that there is an annual programme of audit of record keeping standards supported by action plans. The results of the audit will be fed back to the directorates and reported to the relevant Board/Committee.
- To ensure that this policy is reviewed annually to incorporate changes in legislation, guidance or evidence from audit.
- To review the Audit tool on an annual basis.

7.2 Board and Committee Responsibilities

7.2.1 Clinical Standards Committee

Responsible for approving the policy, managing the monitoring arrangements for the policy and to address barriers to implementation of the policy. The Clinical Standards Committee is responsible for making recommendations to improve and maintain performance based on audit findings.

7.2.2 Governance and Risk Committee

The Governance and Risk Committee is responsible for ratifying this Policy and receives quarterly reports from Clinical Standards Committee for information and assurance purposes.

7.2.3 Group Quality and Safety Committees

A bi-annually summary of the report is provided to ensure that, where areas of concern exist regarding compliance, remedial action is taken at local level.

8 Training Requirements

All Trust staff are made aware of their responsibilities for record keeping and record management through generic and specific training programmes and guidance.

It is the responsibility of directorates to identify and support the training needs of all staff that make an entry in the medical records. This includes:

- General Corporate Induction Programme
- Junior Doctor web based induction programme
- Local Induction programmes
- Individual support where identified to be required

9 Monitoring and Compliance

Compliance with this Policy is monitored through an annual rolling programme of audit of standards in recording keeping in written and electronic healthcare records. Results are compared year on year to ensure effective monitoring of the Policy and increasing adherence to the standards contained within.

The auditable basic record keeping standards within this policy will be monitored through an annual rolling programme of audit in written and electronic healthcare records. Results will be collated by the Safety and Governance team and reported to Clinical Standards Committee.

Standard	Monitoring	Responsible	Committee
Author identified	**Paper Records** Annual review of sample of healthcare records for each directorate from each site.	All directorates with supervision by the Governance team.* *Maternity, Pharmacy, Pathology, Theatres and Anaesthetics undertake independent audits.	Clinical Standards Committee
Entries legible			
Entries timed			
Entries dated			
Patient identified on each page.			
Changes (amendment or deletion) to record appropriately made			
Records in chronological order			

10 References

Record Keeping Policy (2007)- Central and North West London Mental Health NHS Trust

Filing Procedures and General Use of Medical Records Folders (2006) – Heart of England NHS Foundation Trust

Generic Medical record Keeping Standards (2007) - Royal College of Physicians

Record Keeping (July 2007) - Nursing & Midwifery Council

Using Electronic Records in Hospitals: Legal Requirements and Good Practice
Health Service Circular HSC 1998/153

Medicines Management Policy (2008) Heart of England NHS Foundation Trust

Attachment 1 Equality and Diversity - Policy Screening Checklist

Policy Title: Record Keeping in Healthcare Records Policy	Directorate: Healthcare Governance
Name of person/s auditing/developing/authoring a policy: Information Governance Manager/ Governance Manager	

Policy Content:

- For each of the following check the policy/service is sensitive to people of different age, ethnicity, gender, disability, religion or belief, and sexual orientation?
- The checklists below will help you to see any strengths and/or highlight improvements required to ensure that the policy/service is compliant with equality legislation.

1. Check for DIRECT discrimination against any group of SERVICE USERS:

Question: Does your policy/service contain any statements/functions which may exclude people from using the services who otherwise meet the criteria under the grounds of:		Response		Action required		Resource implication	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
1.1	Age?		X				
1.2	Gender (Male, Female and Transsexual)?		X				
1.3	Disability?		X				
1.4	Race or Ethnicity?		X				
1.5	Religious, Spiritual belief (including other belief)?		X				
1.6	Sexual Orientation?		X				

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

2. Check for DIRECT discrimination against any group relating to EMPLOYEES:

Question: Does your policy/service contain any statements/functions which may exclude employees from operating the under the grounds of:		Response		Action required		Resource implication	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
2.1	Age?		X				
2.2	Gender (Male, Female and Transsexual)?		X				
2.3	Disability?		X				
2.4	Race or Ethnicity?		X				
2.5	Religious, Spiritual belief (including other belief)?		X				
2.6	Sexual Orientation?		X				

If yes is answered to any of the above items the policy/service may be considered discriminatory and

requires review and further work to ensure compliance with legislation.
TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING DIRECT DISCRIMINATION = 0

3. Check for INDIRECT discrimination against any group of SERVICE USERS:							
Question: Does your policy/service contain any conditions or requirements which are applied equally to everyone, but disadvantage particular persons' because they cannot comply due to:		Response		**Action required**		Resource implication	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
3.1	Age?		X				
3.2	Gender (Male, Female and Transsexual)?		X				
3.3	Disability?		X				
3.4	Race or Ethnicity?		X				
3.5	Religious, Spiritual belief (including other belief)?		X				
3.6	Sexual Orientation?		X				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
4. Check for INDIRECT discrimination against any group relating to EMPLOYEES:							
Question: Does your policy/service contain any statements which may exclude employees from operating the under the grounds of:		Response		**Action required**		Resource implication	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
4.1	Age?		X				
4.2	Gender (Male, Female and Transsexual)?		X				
4.3	Disability?	X		X			
4.4	Race or Ethnicity?		X				
4.5	Religious, Spiritual belief (including other belief)?		X				
4.6	Sexual Orientation?		X				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING INDIRECT DISCRIMINATION = 1							

Signatures of authors / auditors: **Date of signing:**

FOR ADVICE UPON THIS DIVERSITY IMPACT ASSESSMENT PLEASE CONTACT YOUR LOCAL DIVERSITY ADVISOR OR THE TRUST HEAD OF DIVERSITY

Equality and Diversity – Review Plan

Directorate: Healthcare Governance

Responsible Manager: Director of Healthcare Governance

Information Governance Manager

The second part of the impact assessment is to complete this review plan. This should be used to identify when the review will take place and who should be involved. The plan will form part of the quarterly Governance Performance Reviews.

Service/Policy:	Consultation Group:	Completed by:
Not applicable (included in Policy re. Large Print available)		Completed with launch

When completed please return this assessment and review plan to our Trust Equality and Diversity Lead; Pamela Chandler or Jane Turvey.

Signed by Responsible Manager:	Bridget Francis	Date:	13 May 09

Equality Action Plan/Report

Directorate: Medical Records/Information Governance

Policy: Record Keeping in Healthcare Records Policy

Responsible Manager: Information Governance Manager/ Governance Manager

Name of Person Developing the Action Plan: Information Governance Manager

Consultation Group(s):

Review Date: November 2011 or before that date should there be any material change

The above service/policy has been reviewed and the following actions identified and prioritised. All identified actions must be completed by: _____

Action*:	Lead:	Timescale:
Rewriting policies or procedures – paragraph added with regard to disability (visual impairment) (7.2.3)	Information Governance Manager	Immediate
Stopping or introducing a new policy or service		
Improve /increased consultation		
A different approach to how that service is managed or delivered		
Increase in partnership working		
Monitoring		
Training/Awareness Raising/Learning		
Positive action		
Reviewing supplier profiles/procurement Arrangements		
A rethink as to how things are publicised		

* Actions may include – addition to the risk register or completion of an incident form.

When completed please return this action plan to the Trust Equality and Diversity Lead; Pamela Chandler or Jane Turvey. The plan will form part of the quarterly Governance Performance Reviews.

Signed by Responsible Manager:	Bridget Francis	Date:	13 May 09