Aneurin Bevan University Health Board

Clinical Record Keeping Policy

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Contents

1 Aim

The aim of this document is to outline the policy and standards for the recording of information within health records by all health professionals, non-registered staff and includes student nurses and bank staff. The audience includes staff within the acute hospital services including Scheduled Care, Unscheduled Care, Family & Therapies, Mental Health, Child and Adolescent Mental Health Services Learning Disability Services, Child Health including Health Visiting and School Nursing records, community and primary care services.

2 Executive Summary

Clinical record keeping is an integral part of professional practice, designed to inform all aspects of the care process. Health care records enable health professionals to maintain a record of diagnoses made, treatment planned and given and the service user's progress.

Aggregated, they form a permanent account of an individual's considerations and the reasons for decisions. The use of this information is a key element in supporting the everyday aspects of the delivery of high quality, evidence based health care. Good record keeping also improves accountability, can provide a medicolegal record of the care provided and is fundamental to good risk management practice. It is therefore essential that all records are correctly, accurately and legibly recorded, up to date and easily accessible to those who need to use them.

Record keeping standards are the minimal requirements for all staff to adhere to in the achievement of effective safe record keeping and documentation of clinical care. The standards set out in this policy do not replace standards set by professional organisations but are complementary to them.

The benefits of good record keeping include:

- Promoting high standards of clinical care by acting as a tool for assessment, treatment and care delivery
- Providing a means of enhancing patient safety, minimising the likelihood of delays or inappropriate care
- Providing an accurate account of treatment and care planning
- Promoting effective communication that delivers continuity of care between members of the multidisciplinary health care team
- Demonstrating that care follows evidence-based guidance or evidences variances including decisions not to treat
- Acting as a record of any problems that have arisen such as changes in the service user's condition and actions taken as a result

The transition from a paper based health record to a digitised format and electronic environment needs to be addressed and managed on many different and complex levels: administratively, financially, culturally and institutionally.

The content of the health record can enhance the Health Board's and individuals' liability against:

- negligence claims, including indemnity for damages and costs;
- Local Health Board enquiries;
- disciplinary proceedings relating to professional misconduct or incompetence;
- inquests;
- complaints;
- criminal matters arising from professional practice

3 Purpose

The aim of this policy is to provide direction and guidance to staff on how to meet the standards required for the recording of information within the heath care record. The implementation of the Welsh Standards Regulations 2017 provides patients and staff with legal rights to receive Welsh language services from our Health Board. It should therefore be noted that if a consultation is conducted in Welsh and recorded in Welsh it must be translated and the professional is responsible for ensuring that the context is accurate so that there is no possible misinterpretation of the event.

4 Scope of the Policy

Health Records within Aneurin Bevan University Health Board are currently a hybrid with a variety of formats in use: paper, digitised (i.e. scanned images) or born digital documents such as those created in Med Secs application.

Records created within specialty specific digital systems currently and to be implemented in future has contributed to more elements of the records being held digitally and displayed within Clinical Workstation as the portal which also links to the digitised (scanned) record. It is recognised there are a number of local systems, apps used and digital systems downloaded; the use of these should still adhere to the standards and principles laid out in those policy.

Health records created in the health board are now contributing towards the national patient record in databases such as the Welsh Care Records Service which currently displays records in the Welsh Clinical Portal. Therefore the ability to be able link records through the correct identification of patients (outside the context of CWS / WPAS) is vital to support safe care.

This policy aims to set out best practice and guidance for the hybrid model of records that currently exist with the service and to ensure that digitised records meet the required standards of:

- Authenticity, integrity, security and maximum evidential weight of scanned, stored and migrated information
- Improve the reliability of and confidence in health record information and digitised documents
- Provide confidence to external inspectors (e.g. auditors) that the Health Board's information and business practices in relation to the health record digitisation are robust and reliable

Out of scope are records held by GP and independent primary care providers and practitioners.

5 The Purpose of Records

- It is a legal requirement to keep records.
- To facilitate clinical communication concerning an individual patient to all those involved in the longitudinal care of the patient regardless of the service providing that care.
- To provide accurate, current, comprehensive and concise information concerning the condition and care of the patient and associated observations.
- To provide a record of any problems that arise and the action taken in to rectify them
- To provide evidence of care planned, the decisions made and reviewed, the care delivered and the information shared.
- Providing evidence of actions agreed with the service user (including consent to treatment and/ or consent to share)
- To include a record of any factors (physical, psychological or social), that appear to affect the patient.
- Including relevant disclosures by the service user – pertinent to understanding cause or effecting cure/ treatment
- Identifying clear escalations of concerns when service user's needs are not being met – i.e. safeguarding
- Providing evidence of multi professional working
- Details of all professional, voluntary, independent and others involved in service user's care
- To provide an uninterrupted record of events and the reasons for the decisions made.

- To support standard setting, quality assessment and audit.
- To provide a baseline record against which improvement or deterioration may be judged.
- To provide a framework for care planning and assist in communication amongst professionals.
- To enable the patient to receive effective continuing care.
- To enable the patient to be identified without risk or error.
- To facilitate the collection of data for research/education and audit with the patient's consent.
- The information can be used for legal proceedings and complaints having obtained the patient's consent.
- To document the patient's consent to treatment
- To enable the Medical Examiners process to review the records of each death in hospital.

6 Standards of Record Keeping:

Generic health record keeping standards define good practice for health records and address the broad requirements that apply to all clinical note keeping.

Standard No.	**Description of Professional Standards**
1.	The patient's complete health record should be available at all times during their stay in hospital.
2.	Every page in the health record should include the patient's name, date of birth, identification number (NHS number) and location in the hospital.
3.	The contents of the health record should have a standardised structure and layout.
4.	Documentation within the health record should reflect the continuum of patient care and should be viewable in chronological order.
5.	Data recorded or communicated on admission, handover and discharge should be recorded using a standardised proforma
6.	Every entry in the health record should be dated, timed (24 hour clock), legible and signed by the person making the entry. The name and designation of the person making the entry should be legibly printed against their signature and GMC number**. Deletions and alterations** should be countersigned, dated and timed. ***Errors should not be obliterated e.g.with Tippex. They should be crossed through with a single line and a reason for the error noted e.g. wrong patient notes. Do not erase, obscure or scribble out errors.***
7	Entries to the health record should be made as soon as possible after the event to be documented (e.g. change in clinical state, ward round,

	investigation) and before the relevant staff member goes off duty. If there is a delay, the time of the event and the delay should be recorded
8.	Entries must be made in **indelible black ink** in order to ensure that it can be captured by the scanners. The only exception to this is Pharmacists who are permitted to use green ink.
9.	Every entry in the health record should identify the most senior healthcare professional present (who is responsible for decision making) at the time the entry is made.
10.	On each occasion the clinician responsible for the patient's care changes, the name of the new responsible clinician and the date and time of the agreed transfer of care, should be recorded.
11.	An entry should be made in the health record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four (4) days for acute medical care or seven (7) days for long-stay continuing care, the next entry should explain why. *The maximum interval between entries in the record would in normal circumstances be one (1) day or less. The maximum interval that would cover a bank holiday weekend for instance, should be four (4) days.*
12.	There must be no gaps between entries. If an entry has finished part way along a page cross through the remaining page if this is the last entry that will be made for the episode of care.
13.	The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital.
14.	Advance Decisions to Refuse Treatment, Consent, Do Not Attempt Resuscitation decisions must be clearly recorded in the health record. In circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney.
15.	The full name (first and last name), position and profession of any other health care worker involved in the care must be clearly recorded (never record first names only) All non-registered clinical staff making independent clinical entries in electronic case notes or paper clinical records must be competent to do so. Only staff who are competent in clinical record keeping may make entries in the clinical record; thus removing the need for countersignature. However countersignatures in paper records and verification of entries in electronic records are required in certain situations.
Additional ABUHB Clinical Standards	
16.	Dictated and typed notes should be signed by their author. It is quite appropriate for students to sign records however they must be countersigned by the registered health professional to whom they are responsible. Alternatively, the manager of the service may wish to hold a record of the signatures, initials, and forwarding address of staff (including assistants, students, and locum staff) in order to be able to facilitate the interpretation of records, should the need arise, in later years.
17.	If additions to an entry are required, these must be documented as a separate entry, signed, dated and timed.

18.	Demographic data i.e. name, address, GP, next of kin etc must be documented immediately on admission or in the event of an emergency as soon as possible thereafter e.g. unconscious patient into Resus will be issued with a Unknown Patient Identifier but as soon as information becomes available this will be merged into any existing patient record or a new registration and record created.
19.	Jargon and meaningless phrases should not be used. However, areas may have an agreed list of abbreviations, but agreement should be reached within that Directorate/Department and the list held centrally within the Directorate/Department to provide future clarity should it be required. Clinicians may use abbreviations as listed in the back of the British National Formulary.
21.	Particular care must be exercised and regular record entries made where patients present with complex problems, show deviation from the norm e.g. change in clinical state, require more intensive care than normal, are confused and disorientated or in other ways give cause for concern. Professional judgment must be used, (if necessary with other members of the health care team), to determine where these circumstances exist and the frequency of documentation e.g. 15 minute/hourly observations
22.	In an emergency, whenever possible a member of the team should be delegated to ensure the immediate record keeping of events. If a **retrospective record** is made it should be clear when the record was made, the actual time of the event as far as possible and the reason for the delay in writing up the record. The documentation whether in the patients' clinical notes or on a consent form must record the decision-making process.
23.	It is recommended that in situations where the condition of the patient is apparently unchanging, the clinicians overall assessment may be recorded as 'no change'. There should be an entry in the record at least once every 24 hour for acute medical care, and at least twice a week for rehabilitative care. An entry should be made in the record whenever a patient is seen by a doctor. When there is no entry in the record for more than four days for acute medical care or seven days for long-stay continuing care the next entry should explain the reason why.
24.	Records must include the name, date of birth and address of the patient, and the referring general practitioner should be identified. The hospital number should be clear. The hospital and responsible clinician must also be recorded.
25.	Information on allergies and major medical problems must be recorded on WPAS (Clinical Alerts) in order to pull through into CWS. If a paper record exists this must also be recorded on the Alerts page at the front of the record with the source of the information, dated and signed.
ABUHB Nursing Specific Standards	
Nursing Assessment documentation will vary according to the health care setting: day care, outpatient, inpatient, short or long stay, peri-operative, critical care or rehabilitation care, acute or chronic illness, and primary care setting.	

26	The first written assessment and the identification of the patient's immediate needs must begin within 4 hours of admission. This must include any allergies or infection risks of the patient and the contact details of the next of kin.
27.	A full assessment must be completed within a maximum of 24 hours from the time of admission and include: • completion of nutritional, oral, and manual handling risk assessments • other relevant assessment tools, e.g. pain and wound assessment • a record of all the current nursing needs and an initial discharge plan
28.	Pressure Ulcer documentation must be completed **within 6 hours of admission**
29.	Care plans should be written wherever possible with the involvement of the patient, in terms that they can understand, and include: • patient-focused, measurable, realistic and achievable goals • nursing interventions reflecting best practice • relevant core care plans which are individualised, signed, dated and timed.
30.	The care plan must be referred to at shift handover so it must be kept up to date and evaluated every shift. The written evaluation must correlate with the care plan and identify whether the patient's condition is stable, has deteriorated or has improved.
31.	Every page in the record must include the patient's full name and unique identifier (including typed notes). Patient Identification labels in the case record should be utilised for this purpose. In addition, the date and time of any consultation should be recorded on each page and where a set of records is to be scanned the information should be on the reverse of the page as well.
32.	If student nurses, student allied health professionals have been trained to appropriate standards, are competent to produce records as part of the overall provision of care and it is in the service user's best interests for recording of care (as well as care provision) to be delegated there will be no requirement for the registered nurse to countersign the notes. Until staff are deemed wholly competent, countersigning should be performed. If registered nurses are required to countersign they should only do this if they have witnessed the activity or can validate that it took place. Students must ensure that the records are countersigned before they leave the shift. The registered nurse retains professional accountability for the appropriateness of the delegation of the task, but the student takes on personal accountability for the content and quality of the records.
33.	If clinical staff use digital aids such as apps to assess a patient's condition e.g. risk score this must be documented in the patient's record.

34.	Where templated assessment documents are completed by more than one nurse (student, Associate Practitioner) then the author of each entry needs to be clearly identified to the standards outlined above. CWS linear forms will be traceable and auditable back to the person whose Nadex ID is assigned at the time of the recording on the form.
ABUHB Discharge Standards	
35.	The discharge record/discharge summary should be commenced at the time a patient is admitted to hospital.
36.	A clinical communication must be provided for all doctors in the form of an SBAR and inter-site transfer documentation involved in the care of the patient when care is transferred out of the hospital i.e. the GP and any secondary/tertiary care consultant who has regular care for the patient or that the patient has been referred to for ongoing care.
ABUHB General Standards	
35.	**All patient attendance, non-attendance, and refusal of treatment and/or advice must be noted**. It is advisable to record when telephone contacts are made. It is imperative that the Health Professional dealing with a particular patient on a specific day can be identified; the patient's attendance is dated and signed either in the records or on a register, or both.
36..	Clinical trial documentation should be held separately from the general health record. An alert indicating that the patient is on a clinical trial should be placed on the Alerts Notification Card within the Health Record together with the contact details of the person(s) responsible for the trial.
37.	Diaries are also part of the clinical record; staff should be aware of their responsibilities in maintaining their diary. • Entries must be work related. Personal information that staff don't want shared should not be written in the diary • Entries should be legible and in black ink. Tippex should not be used, errors or changes should be scored through with a single line • Diaries can be used to record, appointments, visits, mileage (optional), relevant occurrences and contacts • Entries related to a specific service user should be transferred to the service user clinical record as soon as is practicable and within the standards defined in this policy • Diary entries can relate to telephone and face to face • Care of the diary is important, e.g. general appearance, keep binding intact, kept in confidential place • Diaries to be made available for checking (e.g. by line manager or for audit purposes) • Diaries to be kept at the end of the year; diaries should be archived and retained for a minimum of 2 year (after the last date in the diary). They can then be • Lost diaries should be reported on an incident form.

	Where an electronic system such as CWS is used for recording health record entries the user is responsible for ensuring that they are logged into the system using their own Nadex ID. The system audit log will assign the record that user id and the user will be held responsible for the entry.
	If clinical staff are using digital aids such as apps to assess a patient's condition e.g. risk scoring, this must be documented in the patients notes.
Incident Handling:	
38.	The first step in the process is to identify the incident. Examples of incidents that you might report include: • unexpected deaths • delayed or missed diagnoses • medication errors • communication failures. • report any circumstance where you believe something has gone wrong even when the patient has not come to harm as it might still be an opportunity to learn lessons and reduce risk. • Wrong documentation in a patient's record, missing documentation on handover and loose documentation on wards should be datixed as a routine.
39.	There are some clinical scenarios such as reference ranges / screening services where the birth sex of a patient is important; therefore for transgender patients this information will be required as well as the gender the patient identifies with or has transitioned to. It is the clinician's responsibility to ensure in specific circumstances this information is available in the health record.
40.	It would be considered unacceptable for clinicians to record health records on any medium not designed to record information e.g. assessments written on paper towels

All health professionals have specific guidelines that are issued by their own professional body. This policy is designed to provide general guidance but does not overwrite any further professional standards that may be in existence and these should be referred to and adhered to by each professional group.

The approach to record keeping which courts of law adopt tends to be that '**if it is not recorded, it has not been done'**. Professional judgment must be used to decide what is relevant and what should be recorded. When working with clients who are subject to mental health legislation, it must be ensured that staff have a thorough working knowledge of the statutory powers that can be applied and reference should be made to the Mental Capacity Act. When making entries in records for these clients, they must comply as appropriate with the guidance given by the Mental Health Act Commission for England and Wales.

7 Audit

Good Record keeping is necessary to promote quality of records within the organisation and reflects the quality of care delivered. Audits should be undertaken on specialty audit days and results reported to the Divisional Director with a copy sent to the Head of Health Records. The results of independent clinical audit will be shared with the Quality and Patient Safety Committee following presentation at the Clinical Council to inform of results.

Electronic audits will also be undertaken of digital system to ensure timeliness of entries meet the standards set out by this policy.

Tracking and trending of incidents will also inform quality improvement initiatives and highlight the need for a refinement of the standards outlined above.

8 Training

The organisation will ensure that staff employed across the organisation with responsibility for patient care and recordkeeping will undertake training on the Clinical Record Keeping Policy through:

- The Corporate Induction Programme(s).
- The Training and Development Programme for Health Records Staff.
- Junior Doctors Induction slots
- Ensuring the Policy is available to staff on the Intranet
- Action plans arising from Audits of patients notes.
- Health Record Awareness Sessions for staff.
-

9 Conclusion

This policy will provide a planned approach to ensure the Health Board can demonstrate recognised standards of compliance for recordkeeping in both paper and digital systems. This document will also work in tandem with any existing Record Keeping Policies that departments have developed. Further information and advice on Record Keeping is available from the Head of Health Records.

'Remember – The Record is the Patient'
NO RECORD = NO DEFENCE

10 References

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https://www.bing.com/search?q=royal+colleges+clinical+record+keeping+standards&src=IE-SearchBox&FORM=IESR3S&PC=UF03

https://www.rcseng.ac.uk/standards-and-research/gsp/domain-1/1-3-record-your-work-clearly-accurately-and-legibly/

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https://publishing.rcseng.ac.uk/doi/10.1308/003588409X359367

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https://nwis.nhs.wales/ig/information-governance/information-governance-fundamentals/caldicott-guardian-skills-and-understanding/caldicott-principles/

https://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-and-the-law/mental-health-act/

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https://www.legislation.gov.uk/ukpga/Eliz2/6-7/51/contents

Taking_Responsibility_Accountable_Clinicians_0614.pdf (aomrc.org.uk)

11 Appendices

Appendix 1 **FORM 1**

Aneurin Bevan University Health Board

Equality Impact Assessment (EqIA)

Form 1

Part A: Preparation and Assessment of Relevance & Priority

Step1: Preparation

Title of Policy – Clinical Record Keeping Policy

1 What are you equality impact assessing?

Ensuring everyone is aware of the policy with regard to Clinical Record Keeping Standards within the organisation

2. Policy Aims and Brief Description - What are its aims, give brief description.

The purpose of this policy is to ensure all staff are aware of their personal responsibility for Clinical Record Keeping and is an update to the existing policy.

3. Who Owns the Policy? - Who is responsible for the policy/work?

Owner: Medical Director **Dept**:: Executive Board

4. Who is involved in undertaking this EqIA? - Who are the key contributors to the EqIA and what are their roles in the process?

Policy working group members including:
Clinical Council
CCIO and CNIO for Informatics

5. Other Policies- Describe where this policy/work fits in a wider context.

This policy should be read in conjunction with the following policies and Guidelines:
ABHB Health Records Management Policy
ABHB Records Management Code of Practice 2020

6. Stakeholders – Who is involved with or affected by this policy?

All ABHB staff who handle, record or utilise the health record

7. What factors may contribute to the outcomes of the policy? What factors may detract from the outcomes? These could be internal or external factors.

External Factors that may detract from the outcomes of the policy:-
.
Internal Factors
Evidence of good practice from all staff groups, from the top down should encourage awareness. Poor adherence and commitment to uphold the practice will detract from the message

Next Steps

For the next stage of the EqIA process please see form: Part A, Step 2 - Evidence Gathering.

FORM 2

Appendix 2

Aneurin Bevan University Health Board
Equality Impact Assessment: Part a Step 2 Evidence Gathering
. Clinical Record Keeping Policy

Equality Strand	Evidence Gathered	Does the evidence apply to the following with regard to this policy/work? Tick as appropriate													
Race	None noted	Harassment		Promoting Equality of Opportunity		Promoting Good Relations and Positive Attitudes		Encouraging Participation in Public Life		Taking account of difference even if it involves treating some individuals more favourably*					
Disability	None noted														
Gender	None noted														
Sexual Orientation	None noted														
Age	None noted														
Religion/ Belief	None noted														
Welsh Language	None noted														
Human Rights	None noted														

*This column relates only to disability due to the DDA 2005 specific duty

Appendix 3

Aneurin Bevan University Health Board
Equality Impact Assessment Action Plan

FORM 3

Name of Policy: Clinical Record Keeping Policy

Recommendation	Expected Outcome	Response	Responsible person	Progress to date
No actions identified or needed	Adoption of Policy			

Appendix 4

Aneurin Bevan University Health Board: Equality Impact Assessment
Assessment of Relevance and Priority – Scoring Chart

FORM 4

Clinical Record Keeping Policy

Equality Strand	Evidence: Existing evidence to suggest some groups affected gathered from Part A Step 2.	Potential Impact: Nature, profile, scale, cost, numbers affected, significance.	Decision: Multiply 'Evidence' score by 'Potential Impact' score.
Race	0	0	0
Disability	0	0	0
Gender	0	0	0
Sexual Orientation	0	0	0
Age	0	0	0
Religion/ Belief	0	0	0
Welsh Language	0	0	0
Human Rights	0	0	0

Evidence Available		Potential Impact		Impact Decision	
3	Existing data/research	**-3**	High negative	**-6 to -9**	High Impact (H)

2	Anecdotal/awareness data only	**-2**	Medium negative	**-3 to -5**	Medium Impact (M)
1	No evidence or suggestion	**-1**	Low negative	**-1 to -2**	Low Impact (L)
		0	No impact	**0**	No Impact (N)
		+1	Low positive	**1 to 9**	Positive Impact (P)
		+2	Medium positive		
		+3	High positive		

Appendix 5

Aneurin Bevan University Health Board

FORM 5

Equality Impact Assessment (EqIA) Outcome Report

Policy Title	Clinical Record Keeping Policy
Organisation	Aneurin Bevan University Health Board
Name of policy Assessors:	Robin Rice, CCIO Informatics and Orthopaedic Surgeon Peggy Edwards. CNIO, Informatics
Division/ Department	Informatics
Proceed to Full EqIA:	
Summary of the EqIA process and key points to be actioned	
Responsibility for validation of the EqIA	
Date:	
Monitoring Arrangements:	
Policy expiry date:	**This policy will be reviewed in April 2021 and will expire April 2023**

This information is available on request in a range of accessible formats, Welsh and other community languages as required.
For more information please contact: Aneurin Bevan University Health Board Policy Coordinator