University Hospitals of Leicester NHS
NHS Trust

Patient Health Records - Documenting UHL Policy

*previously called 'clinical records'

Policy review date extended for 3 months as Policy is still fit for purpose, as agreed by PGC Chairman 16/04/21

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Approved By:	**Policy and Guideline Committee**
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First Review, February 2011:
This policy underwent a full review and re-write, all references to the maintenance of medical records removed and references to the separate documents which cover this topic included in Section Three.

1 INTRODUCTION

1.1 Patients' health records are a tool of professional practice and are fundamental to the patient care process. Legible, accurate and timely entries within patients' health records are essential for the protection and welfare of patients and clients.

1.2 Poor documentation poses a significant risk to the Trust in terms of patient safety and litigation. Accurate and clear documentation is also an essential requirement of clinical and information governance.

1.3 Guidelines and best practice principles have been published by a number of professional bodies, including the General Medical Council (GMC), Nursing and Midwifery Council (NMC) and Chartered Society of Physiotherapy (CSP) (see section 13 for the full list).

1.4 Patients' health records have historically been paper based, however there is an increasing move towards electronic based (full or partial) health records being used in the Trust. Examples include Euroking (Maternity); ORMIS (Theatres); Proton (Renal); EDIS (Emergency Department); Eclipse (Diabetes) and Clinical Workstation (Medicine).

1.5 A patient's health record can therefore involve more than one source, both paper and electronic.

2 POLICY AIMS / STATEMENT OF INTENT

2.1 The key aim of this policy is that patients receive safe and appropriate care by ensuring that all aspects of the patients' management throughout the patient episode is documented accurately and All entries should be made as soon as possible after the event and in chronological order.

2.2 The policy also aims to provide clear guidance for staff on their roles and responsibilities in respect of documentation.

3 POLICY SCOPE

3.1 This policy sets out the standards that are expected of all staff who make any entries within either paper or electronic patients' records.

3.2 The policy applies to all forms of paper and electronic health records and to all documents held within the health record e.g. test results, prescription charts, nursing care plans etc. Where there is a need for additional speciality specific standards (eg Maternity for CNST; printing of ORMIS records for inclusion in paper health records) these should be outlined in a separate speciality specific document to be read in conjunction with this policy.

3.3 This policy does not cover the management of health records, please refer to the UHL Patient Records Maintenance Procedure (INsite Ref 57706) for further information

4 DEFINITIONS

4.1 A **health record** is the document that describes aspects of a patient's health care episode.

4.2 A **paper health record** is commonly referred to as 'case notes' and is currently where most patients' care and treatment is documented. This includes nursing notes which may be kept at the patients' bedside during their stay and will then be filed as part of the case notes on discharge.

4.3 An **electronic health record** for the purpose of this policy refers to where clinical staff enter information regarding a patient's care or treatment

5 ROLES AND RESPONSIBILITIES

5.1 Executive Responsibilities

5.1.1 **The Medical Director** is Executive Lead for the NHSLA Standard (1.:2) relating to the quality of written and electronic patient health records and as such is the Executive Lead for this Policy.

The Medical Director will in addition be responsible for overseeing the level of compliance by medical staff with the standards in this Policy and for referring any areas of concern to the relevant Divisional Director for action.

5.1.2 **The Chief Nurse**, supported by the Director of Nursing, is responsible for overseeing the level of compliance by nursing staff with the standards in this Policy and for referring any areas of concern to the relevant Divisional Heads of Nursing for action

5.2 Divisional Managers, Directors and Heads of Nursing responsibilities:

5.2.1 Ensuring the standards within this Policy are disseminated to their CBUs

5.2.2 Reviewing results of the documentation audit for their Division

5.3 CBU Medical and Nursing Leads responsibilities:

5.3.1 Supporting the Divisional Directors, Managers and Lead Nurses with the dissemination of these policy standards to all staff with their CBU

5.3.2 Identifying a documentation audit lead for the CBU

5.3.3 Overseeing the development and monitoring of action plans where not fully compliant

5.4 CBU Documentation Audit Leads responsibilities

5.4.1 Co-ordinating, in collaboration with the CASE team, the annual audit of this policy within their CBU

5.4.2 Co-ordinating the review, reporting and dissemination of audit results

5.5 All Staff responsibilities

5.5.1 Ensuring all health record entries are made in line with the standards set out in this policy

5.5.2 Comply with the UHL Patient Records Maintenance Procedure INsite Ref 57706

5.5.3 Identifying any training needs with their line manager

5.6 In addition, Consultants, Ward Sisters/Charge Nurses and other Senior Clinical Staff (e.g. directorate lead pharmacists and senior AHP's / therapists) are responsible for:

5.6.1 **Setting Standards and Challenging Poor Practice to include:**

a) Setting a good example with their own documentation

b) Making staff in their clinical area aware of the importance of good documentation

c) Providing access to training opportunities as identified through the appraisal process and staff's Personal Development Plans

d) Taking action where staff's practice does not meet the standards set in this policy.

e) Ensuring objectives to improve record keeping are written into annual appraisal personal development plan and monitored accordingly

5.6.2 **Audit** – Ensuring audit of documentation takes place within their clinical area

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 The skills required for implementing most aspects of this policy are considered to be core skills of the various individuals to whom this policy applies.

6.2 Information Governance and Health Record Keeping Standards form part of the UHL Statutory and Mandatory training programme and relevant staff must attend training in line with the UHL Training Needs Analysis (see Policy for Statutory and Mandatory Training, Trust reference B21/2005)

7 POLICY STATEMENTS AND PROCEDURES

7.1 General Documentation Standards for both electronic and paper clinical records

7.1.1 Legibility and Readability

a) All entries must be legible

b) All entries must be in black ink.

- Red ink can be used for operation/procedure notes and for emergency operations/procedures recorded in the theatre register
- Pharmacists can use green ink on prescription charts

c) All entries must be concise and easy to understand

d) All errors must be scored out with a single line and signed and dated with an explanation for their deletion

e) Any retrospective additions or amendments must be signed and dated with an explanation for their late inclusion

f) Any retrospective alteration to electronic health records should be identifiable and reason for alteration explained.

g) Correction fluid must not be used in paper case notes/theatre registers

h) Abbreviations should be avoided wherever possible and should only be used where an 'approved abbreviation list' exists within specialties. Inappropriate abbreviations must not be used.

Further guidance on amendments, deletions, and additions to patient notes can be found in the 'Amendments to Healthcare Records' Legal Affairs Briefing Note (30) (DMS No 33988).

7.1.2 Identification Data (patient and staff)

a) The patient's full name and unique identifier number must be on every page (if electronic record: will need to be on each page when printed).

b) Staff entries must be clearly identifiable

- Identification is by using their signature and printed name.
- Staff designation must also be stated.
- Best practice also recommends using a unique identifier such as a Professional Body number (e.g.GMC / NMC) adjacent to each entry or in a signature sheet.

c) Student entries must be countersigned by a registered practitioner within the same shift period that the entry in made.

d) All entries must be dated and timed using the 24 hour clock, (Outpatient clinic entries - date only required)

e) Where an Alert sticker is used, details of the alert must be clearly recorded on front inside cover of notes or on the Alert Notification sheet

7.2 Clinical Content

All entries should be made as soon as possible after the event and in chronological order.

The patient's health record will provide clear evidence of assessment; care planned, decisions made, care delivered and the information shared in respect of the following:

7.2.1 Assessment (on admission/referral by relevant members of the clinical team

a) To include use of appropriate assessment proformas (VTE, Falls, Nutrition, Pressure Ulcers, Physio, OT, SALT, Dietetics etc)

b) Symptoms causing admission / Working Diagnosis

c) Investigations requested and reviewed

d) Estimated Discharge Date (EDD) and discussion of date with patient and carers

7.2.2 Plan of Care

a) Review and confirmation of diagnosis and plan

b) Treatment options and investigations agreed

c) Nursing Care Plans / Therapy Goals Agreed and consent obtained (see UHL Consent Policy for further information and advice Trust Reference A16/2002)

7.2.3 Delivery of Care

a) Medicines prescribed and administered (see Leicestershire Medicine Code on LMST website)

b) Operations and/or interventions carried out

c) Anaesthesia given, where applicable

d) Care delivered by all members of the multidisciplinary team

7.2.4 Review

a) Review of investigation results

b) Evaluation of care and response to treatment

c) Further care plan drawn up, where applicable

d) Review of EDD and discharge plans as applicable

7.2.5 Delegated Documentation

a) The most senior clinician present at patient review, making decisions or involved in patient/carer discussions must be identified.

b) Formal Multi Disciplinary Team (MDT) discussions must identify all team members present by name and designation.

7.2.6 Nursing Documentation

a) All patient observation and risk assessment documentation will provide details of ward, patient name, date of birth and S number in line with the Nursing Metrics' standards.

b) Day case patients and those who will have a stay of less than 36 hours should use the "Green for Go Documentation". The admitting Registered Nurse will make the decision on the appropriate documentation to be used.

c) In the event of a day case patient requiring a stay greater than 36 hours, then the Registered Nurse is responsible for ensuring the standardised nursing documentation is completed.

d) Patient not on 'Green for Go Documentation will have the following standardised nursing documentation done as a minimum on admission:

Document Title	Timescale / Standard
Patient History	On Admission and then reviewed on transfer to base Ward / Unit / Department and as required
Patient Assessment, Core Care Plans, Evaluation and Communication Sheet	On Admission and then reviewed on transfer to base Ward / Unit / Department and as required
Early Warning Scores (EWS) (Medical and Surgical)	On admission and then twice a day or as indicated by EWS score
Pressure Ulcer and Waterlow Risk Assessment / Paediatric Pressure Area Care Assessment	Within 6 hours of admission and then reviewed on transfer to base Ward / Unit / Department and weekly unless there is a change in patients condition and on discharge or transfer
Falls Risk Assessment	On Admission, on transfer to base Ward / Unit / Department and reviewed weekly unless there is a change in patients condition or further falls
Malnutrition Universal Screening Tool (MUST)	On Admission, on transfer to base Ward / Unit / Department and reviewed weekly unless there is a change in patients condition and on discharge or transfer
Risk Assessment for Prevention of Deep Vein Thrombosis (DVT)	On Admission and then reviewed on transfer to base Ward / Unit / Department, every 72 hours during the patients stay and on discharge (as per NICE recommendations) (Patients under the age of 18 are excluded)
Discharge Planning template and Discharge Information Checklist	On Admission and updated as required through the patients' stay

e) Exceptions are Maternity and Neonatal Services which are covered by CNST requirements) and those patient groups where patient care pathways have been agreed. The admitting Registered Nurse will make the decision on the appropriate documentation to be used.

7.3 Communication between staff and patients

The patient's health records will accurately record details of any communication between professionals and patients or between professionals and carers involved in the patient's care, this can either be 'face to face' or on the telephone; to include:

a) Between members of the multidisciplinary team

b) With the patient

c) With the patient's carers/family, as applicable

d) 'Patient Information' given – both verbal and written

7.4 Transfer of Care / Discharge

The patients' health records will provide clear and accurate documentation regarding transfer or discharge requirements and arrangements as per the UHL Discharge Policy (Trust reference B3/2003). This will include:

a) Discharge Planning template

b) Medical Discharge Letter

c) Follow up arrangements

d) Completion of discharge checklist for all patients on the day of discharge

e) District Nurse Referral Letter (where appropriate)

f) Transfer of Care Letter – within UHL and externally (where appropriate)

7.5 Continuing Healthcare Needs (in Adult Patients)

a) All patients with ongoing healthcare needs following discharge should have a Continuing Health Care Checklist completed

b) All patients with a positive Continuing Health Care Checklist will need full consideration for eligibility for NHS funded Continuing Healthcare by completing a Decision support tool

c) Patients who are rapidly deteriorating or in the end stage of a terminal illness will need completion of a 'Fast Track' form for Continuing Health Care

8 EQUALITY IMPACT ASSESSMENT

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 PROCESS FOR MONITORING COMPLIANCE

9.1 Audit Frequency

Auditing compliance with this policy is undertaken on an annual basis as a minimum, using the UHL 'Documentation Audit Criteria and methodology' (available on INsite http://insite.xuhl-tr.nhs.uk/homepage/clinical/audit-and-effectiveness/clinical-audit/trustwideaudits/documentation-audit) developed and reviewed for each annual audit

Nursing Documentation is also audited monthly through the Nursing Metrics

9.2 Key audit standards

The following audit standards will be included as a minimum in the annual Documentation Audit for all staff groups, any additional audit criteria will be included on request

a) All entries must be in black ink

b) All entries must be concise and easy to understand

c) All errors must be scored out with a single line and signed and dated with an explanation for their deletion

d) Any retrospective additions or amendments must be signed and dated with an explanation for their late inclusion

e) Any retrospective alterations to electronic health records should be identifiable and reason for alteration explained

f) Correction fluid must not be used

g) Abbreviations should be avoided wherever possible and should only be used where an "approved abbreviation list" exists within specialties.

h) The patient's full name and unique identifier number must be on every page

i) Staff entries must be clearly identifiable

- Identification is by using their signature and printed name
- Staff designation must also be stated

j) All entries must be dated and timed using the 24 hour clock

9.3 Audit Leads

The Medical Director has executive responsibility for overseeing the monitoring arrangements of this policy.

As detailed in section 5.3 each CBU Medical and Nursing Lead is responsible for identifying a CBU documentation audit lead.

9.4 Audit Reports

Audit reports need to meet the minimum requirements as detailed in the UHL 'Documentation Audit Criteria and methodology' and must include details of actions undertaken to improve compliance where indicated.

Audit results and action plans must be presented to Divisional Quality Boards and the UHL Clinical Audit Committee who will refer on to the Clinical Effectiveness Committee if areas of concern are highlighted.

9.5 Audit Actions

CBU Medical and Nursing Leads are responsible for ensuring an action plan is developed that addresses any areas of non compliance.

9.6 Process and timescales for monitoring compliance

The annual Documentation audit takes place in June, results available for Divisions /CBU's in August, action plans must be completed by the end of September, and are subsequently monitored quarterly through the Divisonal Quality Boards (see 9.4)

10 DEVELOPMENT AND CONSULTATION PROCESS

This policy has been reviewed and revised with input from nursing, medical, AHP / Therapies and administrative staff.

It has been circulated to all CBU medical, nursing and AHP / Therapies leads for comments.

11 DOCUMENT CONTROL, ARCHIVING AND REVIEW OF THE DOCUMENT

This policy will be stored and archived through UHL INsite Documents

This policy will be reviewed every three years or sooner in response to clinical need

12 LEGAL LIABILITY

The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their Directorate to undertake the activity.
- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable - such decision to be fully recorded in the patient's notes.

It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies.

13. EVIDENCE BASE AND RELATED POLICIES

Sources used to Inform the Documentation Policy

Health Service Circular HSC 1999/053 – For the Record (issued 19th March 1999) http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/HealthServiceCircularsArticle/fs/en?CONTENT_ID=4003513&chk=Y%2BiufR

Audit Commission – Setting the Record Straight; a Review of Progress in Health Records Services (November 1999)
Audit Commission - Setting the Record Straight: A Review of Progress in Health Records Services

Healthcare Commission Standards for Better Health, July 2003, Updated April 2006, Third Domain – Governance, Core Standard 9 p12
http://www.dh.gov.uk/assetRoot/04/13/29/91/04132991.pdf

THE VICTORIA CLIMBIÉ INQUIRY by Lord Laming – January 2003, Recommendation 12
http://www.nationalarchives.gov.uk/ERO/records/vc/1/1/finreport/summary-report.pdf

Essence of Care Patient Focused Benchmarks for Clinical Governance, April 2003 "Record Keeping' Benchmark"
http://www.modern.nhs.uk/home/key/docs/Essence%20of%20Care.pdf

NHSLA Risk Management Standards for Acute Trusts 2006 (derived from the former CNST and RPST standards). Standard 4.3
http://www.nhsla.com/NR/rdonlyres/E46B5722-2E6A-484C-B9D1-213241A148E2/0/NHSLAAcuteStandardsApril2006pilot.doc

Royal College of Physicians **Clinicians guides to medical record standards, October 2008** "Clinicians guide part 2 - Standards for the structure and content of medical records on patient admission"

http://www.rcplondon.ac.uk/resources/clinical-resources/standards-medical-record-keeping/structure-and-content-medical-notes/de

Nursing and Midwifery Council – Guidelines for Records and Record Keeping (revised edition April 2002)
http://www.nmc-uk.org/(rge0fy3v5jaszk2jkzcbsr55)/aDisplayDocument.aspx?DocumentID=516

General Medical Council – Good Medical Practice (May 2001) Recommendation 3
http://www.gmc-uk.org/guidance/library/GMP.pdf

Royal College of Surgeons of England – Guidelines for Clinicians on Medical Records and Notes (revised edition 1994)
Guidelines for Clinicians on Medical Records and Notes — The Royal College of Surgeons of England

British Dietetic Association – Joint BDA/Dietitians Board Guidance on Standards for Records and Record Keeping (second edition January 2001)
http://www.bda.uk.com/Downloads/safe%20caseload%20management.pdf

College of Occupational Therapists – Standards for Practice, Core Standard; Occupational Therapy Record Keeping (July 2000)
http://www.cot.org.uk/members/publications/ethics/pdf/code0605.pdf
(see section 3.3 in online version)

Chartered Society of Physiotherapists – Core Standards of Physiotherapy Practice (2000) pages 14-15
http://www.csp.org.uk/uploads/documents/csp_core_standards_2005.pdf (see pages 36-40 in online version)

BAPO British Association of Prosthetics and Orthotists
http://www.bapo.com/site/

Royal College of Speech and Language Therapists
http://www.rcslt.org/

HPC Health Professionals Council
http://www.hpc-uk.org/

British Psychological Society – Clinical Psychology and Case Notes: Guidance on Good Practice
http://www.bps.org.uk/downloadfile.cfm?file_uuid=A7A2B860-1143-DFD0-7E2B-2AFD97CF13C9&ext=pdf&restricted=true

The Leicestershire Medicines Code (LMST website)
http://www.lmsg.nhs.uk/LMSGDocs%5CLMC%5CLMC01_Introduction_200806.pdf

The UHL Discharge Policy for Adults Leaving Hospital (INsite Ref: 11826)

UHL Consent Policy (INsite Ref 11772)

UHL Patient Records Maintenance Procedure (INsite Ref: 57706)

UHL ‘Amendments to Healthcare Records’ Legal Affairs Briefing Note (30) (INsite Ref: 33988)