Clinical record keeping and records management Policy

Department / Service:	Corporate
Originator:	Associate Medical Director of Patient Safety
Accountable Director:	Chief Medical Officer
Approved by:	Clinical Governance Group
Date of Approval:	5TH February 2019
Extension Approved:	9th May 2022
Review Date: **This is the most current document and should be used until a revised version is in place**	25th December 2024
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All
Target staff categories	All health care professionals and clinical administration staff

Purpose of this document:

The purpose of this document is to ensure that all Trust staff are provided with a policy and procedure with regards to maintaining clear, accurate and contemporaneous clinical records and managing the risks associated with them. In addition

Key amendments to this Document:

Date	Amendment	By:
July 2012	Removed paper case notes related processes	Booking Services and Health Records Manager
July 2012	Updated clinical record keeping audits	Booking Services and Health Records Manager
June 2013	Monitoring Section format/style changed into a monitoring table	Booking Services and Health Records Manager
June 2013	Minor amendments made to wording but not content of policy	Booking Services and Health Records Manager

Aug 2016	Amendments to take account of legal admissibility standards, CQC feedback and Trust moving to mainly electronic record keeping and data capture. Combining with clinical records management policy.	ICT Business Change and Records Lead
Jan 2018	Amendments to take account of new approach to auditing policy compliance and standards. Changes to health records committee (HRC) name and management of electronic communications	Chief Medical Officer
February 2021	Document extended for 6 months, as per Trust agreement 11/02/2021.	
July 2021	Document review date amended as per the Key Documents policy 3 year approval update.	Trust policy
May 2022	Document extended for 6 months whilst document is updated and reviewed.	Matthew Thurland
25th June 2024	Document extended for 6 months whilst document is reviewed	Matthew Thurland

Contents page:

Background and Summary of Policy

1.1 Record keeping is an integral part of patient care, and serves to protect patients by promoting communication between health care professionals. Accurate and comprehensive record keeping is an essential part of patient care. This policy sets out the standards for both written and electronic patient records and should be adhered to by all health care professionals and administration staff throughout the Trust.

1.2 Records Management is essential for the Trust to operate effectively and to ensure patient records are authentic, maintained, managed and controlled effectively commensurate with legal, operational and information needs. Through proper control of the content, storage, transfer and use of records, the risk of legal challenge and poor quality care will be reduced (refer to full information in Corporate Records Management Policy WAHT-CG-127 and ICT policy (WAHT-TWI-007)

1.3 Confidentiality of patient records is essential. Refer to Information Governance Policies, in particular the code of conduct for employees (WAHT – IG – 001)

1.4 This policy is designed to provide all professionals working within the Trust with information on the principles of safe records management and record keeping.

1.5 All clinical records should be accurate and accessible and produced and referred to in a way as to ensure that the patient's care is not inappropriate or delayed due to unclear, incomplete or unavailable clinical records.

1.6 The Worcestershire Acute Hospitals NHS Trust uses a digital multi-professional, integrated unified Patient Record *(clinical portal).* The full unified patient record can be viewed through the Trust's Electronic Patient Record Information system (Clinical Portal). Multiple applications make up the patients clinical record. It is however recognised that some records are not currently electronic, integrated or multi-professional and the policy will therefore need to be interpreted flexibly until integration of all records can be achieved.

1.7 All hand written record keeping standards outlined within this policy must apply to event notes and any other hand written notes, to ensure a contemporaneous episode of care is completed. Where electronic data capture replaces handwritten notes, the design of the electronic documents will ensure national record keeping standards are adhered to.

2. Scope of the Policy

2.1 This policy applies to all employees working within the Worcestershire Acute Trust when writing in patient's health records and capturing clinical information electronically.

2.2 All health care professionals must adhere to the standards set out in the **Clinical Record Keeping principles and guidelines** – see appendix 1,

2.3 Electronic patient records are created and maintained in the same way as paper based records and management of them is treated accordingly.

2.4 Electronic information will be managed in accordance with theICT policy WAHT-TWI-007) and Corporate Records Management Policy (WAHT – CG – 127)

3. Policy Statement

Record keeping

All handwritten records *must* be:
Legible
Accurate
Signed, with designation stated and the author identifiable
Dated
Timed
Contemporaneous (written at or near the time of the event)
Able to prove a chronology of events

In **black ink (exception: pharmacist may use green ink)**
Contain only limited abbreviations agreed and published by each department and issued to staff on commencement.

Refer to other policies regarding legal and human rights implications
Deprivation of Liberties Safeguards policy WAHT – KD-026
Use of the Mental Health Act in an Acute Hospital Setting WAHT – KD – 026
See appendix 1 for details of clinical record keeping principles.

Clinical Information Users

3.1 All records must be accessed in line with confidentiality and data protection guidelines (see Corporate Records Management Policy WAHT – CG – 127 and Information Governance Policies).

3.2 Information users will capture and use information at a proper time, using proper systems and processes.

3.3 Information users will ensure the accuracy and completeness of the information they use or create

3.4 Information users will report inaccuracies, inconsistencies and completeness of the clinical information, the information systems and information processes they use. (Refer to Health Records business processes on ICT website)
http://nww.worcsacute.nhs.uk/departments-a-to-z/health-records/

3.5 Managers must ensure that staff have correct access rights to appropriate clinical systems and are adequately trained to use those systems. Managers and users must ensure they are competent to make effective use of paper and electronic records in order to support clinical and non-clinical patient care. Further advice about training is available via the ICT and Health Records website.
http://nww.worcsacute.nhs.uk/departments-a-to-z/acute-ict/it-training/

3.6 To ensure that it is possible to identify who completed or viewed electronic clinical records, passwords should never be shared. If employees suspect that somebody has access to their passwords, users are responsible for taking steps to change the password immediately and alerting their line manager

3.7 Audit trails will track all use of electronic clinical information. Audit data will be retained in line with destruction standards

Availability of medical records

3.8 The patient's recent medical records will be available at all times during their stay in hospital

3.9 Where clinically required and on request, the patient's older historical records will be made available

Storage, transfer and security of clinical records

3.10 All paper and electronic records managed by the Trust (and Third Party Records Provider) will be stored in a way that maintains patient confidentiality at all times and secure from unauthorised and inadvertent alteration and erasure.

3.11 Access and disclosure will be properly controlled.

3.12 Where clinical information remains in paper folders, those holding the paper information will ensure no risk of unauthorised sight or access. Departments, offices and trolleys etc. must be secure. Access by authorised personnel must be possible 24/7 if the clinical information is likely to be needed.

3.13 Implied patient consent allows daily care notes to be stored at the bed side.

3.14 Records transported around the sites must be safeguarded from theft, damage, destruction, loss and access by unauthorised individuals. Records must not be left unattended.

3.15 Patient information must not be displayed on the outside of envelopes or boxes used for transportation. If records are sent externally, they must be sent recorded delivery.

3.16 The Trust will only use copies of clinical records to share with external NHS organisations for the purpose of clinical care. Originals must remain within the Trust. An exception to this is when patients are discharged to Community Hospitals, as the original event paperwork may follow the patient if a copy is not available. Community Hospitals will return the original event notes within 48 hours.

3.17 The storage and transfer of electronic clinical information must adhere to the principles Trust's ICT policy WAHT-TWI-007

3.18 To ensure the authenticity and integrity of scanned notes, the Trust (and Third Party Records Provider) will comply with the British Standard (BS10008: 14 for evidential weight and legal admissibility of electronic information). http://www.bsigroup.com/en-GB/bs-10008-electronic-information-management/ Where scanning of critical clinical information is undertaken by a Third Party Provider, the Trust will ensure good quality scanning through effective contract agreements and audits. Copies of mental health act detention originals will be retained before being sent for scanning.

3.19 The Trust has a responsibility to ensure storage areas managed by Third Parties meet storage and security requirements.

3.20 Paper notes that move between areas / departments will be raised and tracked using the Trust's PAS. Exceptions have been agreed and include outpatient paperwork, day case event notes that are sent to scanning on the same or following working day or event notes that are on the ward where the patient is a current inpatient.

3.21 The whereabouts of clinical records will be known at all times in order to ensure their quick and efficient location. Staff sending clinical notes must ensure the tracking location is up to date in the agreed tracking system. The receiver must also check this on receipt of the notes.

3.22 All staff receiving tracked clinical notes must ensure that they have an up to date tracking location, which is routinely checked and updated. If notes are unable to be located at the recorded tracking location, the sender and receiver must carry out a missing notes search and agree if the notes are to be tracked as missing. Note: no physical historical notes volumes exist on the hospital sites, so any notes still tracked to hospital site locations are presumed to be tracking errors and can be referred to the Third Party Records Officer for advice.

3.23 Records will be stored and maintained to ensure they are readable for as long as records are required. Refer to appendix 3 for Trust retention schedule.

Capturing and preparing clinical information for electronic storage

3.24 Documentation captured electronically should reflect the continuum of patient care and should be viewable in chronological order

3.25 Clinical staff will select and write on (or type into) the correct bar coded (or electronic) forms / charts. This will ensure that clinical information is automatically scanned (or ingested/saved) into the correct section of the notes, titled correctly, is searchable and accessible by the appropriate users.

3.26 The contents of the electronic record should have a standardised structure and layout.

3.27 Mapping of individual forms to a defined location within the agreed case notes structure will be the responsibility of each specific form owner, supported by the ICT clinical applications team.

3.28 Some forms, once scanned or ingested, will have restricted user access (for example safeguarding documents). Users are responsible for ensuring the right documentation is used for safeguarding notes.

3.29 Users are responsible for ensuring they know how to correctly utilise any electronic data capture forms.

3.30 Where bar coded form templates are not available, preparation for scan processes will ensure documents of significant clinical interest are appropriately identified and bar coded header sheets are used.

3.31 Clinical and non-clinical staff will be competent to print bar coded forms correctly to ensure the correct information is contained within the bar code.

3.32 Clinical and non-clinical staff will prepare event paperwork in accordance with agreed processes.

3.33 Clinical documents received electronically (and of agreed types, such as PDFs) may be added directly into the patient's case notes by system users, ensuring that the correct naming configuration, event details and location in the case notes is selected.

3.34 All e-mails exchanged between clinicians relating to a patients care must be included in the named patient's medical record, either via electronic upload or printed for scan.

3.35 Clinical staff will use section dividers where specific clinical information must be kept separate e.g. safeguarding divider

3.36 To reduce risks associated with scanning, photocopies of clinical forms and clinical information must be avoided.

3.37 All documentation and electronic forms intended for inclusion within the patient's record must adhere to agreed design principles and be approved via the Health Records Clinical working group.

Third Party Records Service

3.38 Third Party Health Records Service Providers will adhere to agreed service levels documented within the contract and will be monitored via regular Service Review Meetings. This includes scanning historical and event documents within agreed timescales (see appendix 4)

Retention and destruction of electronic and paper notes

3.39 Paper and electronic records which are no longer required should be considered for archiving or disposal. If resources allow, retention and destruction of records must be carried out in accordance with the Trusts clinical record management destruction schedules and processes (refer to Corporate Records Management Policy WAHT – CG – 127) and NHS Code of Practice (refer to appendix 3 for retention schedule). http://systems.digital.nhs.uk/infogov/iga/resources/rmcop/index_html Exceptions to this include electronic information in clinical systems which do not yet have the functionality to effectively archive, or are unable to effectively identify an anticipated disposal date. In this circumstance, electronic notes and the audit information exceeding the agreed retention period will not be disposed of.

3.40 Where clinical records must be preserved or retained for longer than the agreed retention period (due to litigation or external requirement), the agreed legal holds process must be followed. All requests for legal holds will come from the Medico-legal department

3.41 Paper originals of scanned notes will be destroyed within 90 days of scanning.

Requests for copies, or details, of patient clinical records

3.42 Where patients want access to or a copy of their records then any request, whether in writing or via telephone, should be referred to the Legal Services department.

3.43 There may be occasions when a patient, generally when they are in clinic or on the ward, will ask the clinician for a copy documents such as the clinic letter or a result. As the patient is actually present at the time the information is requested and therefore the clinician knows the identity of the patient then, if it is practical for them to do so, the clinician can simply print off the specific document at that time. However, if the patient wants more extensive records then they should be referred to legal services for the formal process to be undertaken.

3.44 All written and telephone requests for copies of patient's confidential information (other than those from clinical professionals regarding the named patient's clinical care) must be referred to the medico-legal department at Alexandra Hospital (refer to Subject Access Request Policy WAHT – CG – 764). This includes requests from patients, relatives, police, courts, outside companies such as insurance agents or solicitors.

3.45 Written clinical information may be shown to the patient themselves whilst attending the hospital, under the supervision of an appropriate member of the clinical team. The patient can look at their notes at the time, with a clinician present to be able to explain (decipher) any entries. The patient should not be left alone with the records.

3.46 Requests for copies of clinical information from clinical staff or their representatives outside of the Trust, for purposes of patient care only, do not require patient consent. Information can be shared where it is necessary to do so in order for other clinical staff to provide the named patient with care. No explicit consent is needed, the assumption being that it is the patient's best interests, although the patient can of course withhold their consent.

3.47 In a situation where the information that is requested does not directly relate to the provision of care, then written consent from the patient is always required.

3.48 Any copies of clinical information (or exported electronic clinical information) provided to the patient (or the NHS organisation caring for them) must be accurate and users must ensure that the most recent information is included.

3.49 Information must be sent securely (e.g. using NHS mail, encrypted disc, recorded delivery, safe haven fax). Where removal storage media is used, it is encrypted and handled in accordance with the manufacturer's recommendations. Refer to the Trust Internet and email policy (ICT policy WAHT-TWI-007).

3.50 Any requests for clinical information on members of staff should be directed to the Human Resources team

3.51 If any members of staff receive a telephone request, confirmation of any patient information is prohibited – this includes confirming or denying that the Trust has records for the patient. Transfer the request to the medico-legal department.

3.52 Power of Attorney documents received by the Trust will be managed in accordance with the policy for assessing mental health (refer to WAHT – KD – 026). Where requested, the legal department will approve for legal documents to be filed into the case notes. http://nww.worcsacute.nhs.uk/document-finder/

Preparing and scanning paper notes

3.53 Documents will be scanned in time for the next episode of care and therefore staff must be aware of the scan turnaround times (see appendix 4). Clinical and non-clinical staff will identify patient notes requiring priority scan and ensure they follow the agreed priority scan health records processes. In the event that the case notes cannot be scanned prior to an episode of care, the physical paper notes will be raised, tracked and made available to the clinician taking appointment.

3.54 By default, the most recent Trust historical note only will be scanned before the start of an episode of care. Exceptions to this are short notice appointments (less than one working scan day) and emergency attendances, which are scanned during the next

working day. Older historical volumes may be requested for scan, if deemed clinically important.

3.55 Old pregnancy notes will only be scanned for patients attending for a limited number of specialty appointments.

3.56 Out of hours, in an emergency, the consultant in charge of the patients care can request for un-scanned paper notes to be extracted from the off-site paper case note library and delivered to the hospital site.

3.57 Documents requiring scanning will be prepared according to agreed practice. Documents not suitable for scanning (unscannables) will be retained in unscannable format and tracked to the central storage location.

3.58 Patient owned documents (such as living wills, DNACPR, cards, red books) will be returned to the patient (or relatives) and not sent for scanning.

3.59 DNACPR forms that are for whatever reason not returned to a living patient must be scored through, marked 'no longer valid' and scanned.

3.60 Only authorised personnel (as documented in each system access rights guide) will be permitted to make changes to saved electronic information. This includes records retained beyond the agreed retention period.

3.61 If corrections are to be made to scanned notes using the annotations process, the user must specify the justification for the correction, what needs to be corrected and the when the correction was made, so there is a clear audit trail should there be a challenge.

3.62 Historical notes and event notes will be stored in paper format until scanned.

3.63 Historical case notes (usually the most recent volume) will be scanned into the Trust's case notes viewer (Evolve™) system when an episode of care is added to the Patient Administration System (PAS) or when manually requested. Event notes will be scanned into the same system after discharge (admissions) or after clinical attendance (OPD). Notes will be prepared and sent for scanning within 2 working days of the physical discharge, unless priority scan is required.

3.64 Clinical information for the unified digital record will be captured both electronically and in paper. Bar coded documents are used to ensure clinical information is scanned into the correct patient's notes, the correct section of the notes, with the correct event date and specialty.

3.65 Some documents are ingested from one clinical application to the Trust's case notes viewer (Evolve). Configuration decisions regarding ingestion will be approved at the Clinical and Non-clinical Health Records working group.

3.66 Users will upload or print directly into the Evolve case notes viewer to reduce the level of scanning. Users will ensure that documents are virus free and assigned the correct patient, event date, specialty, title and location of the notes

3.67 Where necessary, users may refer to any agreed naming conventions guidance when setting up letter templates, uploading documents into the case notes viewer and printing documents direct to the case notes viewer.

3.68 Missing or temporarily unavailable notes are monitored by the non-clinical Health Records working group. Missing notes are recorded on the Trust's PAS tracking system.

General

3.69 Risks associated with clinical record keeping and records management will be known, documented, monitored and mitigated.

3.70 Clinical record keeping and record management practices will be continuously reviewed and improved.

3.71 The Trust will continually improve the information management systems supporting electronic clinical records.

3.72 All records must be indexed in a way that ensures that patients' records are easily identifiable and retrievable, including patients who hold multiple patient numbers or case notes.

3.73 The NHS number is the primary patient identifier. All pages must clearly identify the patient using three identifiers (usually name, DOB, NHS number). The exception to this is approved clinical booklets.

3.74 All system configurations that pertain to clinical health records must be reviewed and approved by the clinical or non-clinical health records working group

4. Processes

Clinical Record Keeping Principles and Guidelines – appendix 1

5. Responsibility and Duties

5.1 All Worcestershire Acute Hospitals Staff are responsible for clinical record keeping. All staff creating, writing in, filing or handling a patients' clinical record, must follow the processes and principles set out in this policy.

5.2 The Departmental managers and Clinical leads within each Division have joint responsibility for clinical record keeping. It is their responsibility to ensure that all staff within their directorate are aware of this policy and, through regular audits, monitor adherence to standards and take action to improve compliance where necessary.

5.3 Annual Record keeping audits will be undertaken. It is the responsibility of the Divisions to monitor the high level results arising from the Clinical Record Keeping Audits and to ensure continuous improvement. The Divisional Boards will review results and progress against improvement plans. Divisions will assure the Health Records Clinical working group that actions are being taken to address issues.

5.4 Therapies Managers have responsibility to ensure separate annual documentation audit takes place.

5.5 Divisional clinical leads and therapy leads will alert the Health Records Clinical working group if Trust wide changes to health records policies, procedures or system configurations are required

5.6 It is the responsibility of every member of staff who creates, adds to, files within or handles a patients' clinical record to ensure that the principles, processes and standards set out in this policy are adhered to.

5.7 It is the duty of all staff to identify risks that are associated with patients' clinical records and follow the correct process for managing that risk. (Refer to Clinical Incident and reporting process (WAHT – CG - 008)

6. Implications of Non Adherence

6.1 It is a clinical risk to patient care if clinical record keeping does not follow the standards set out in this policy, therefore, both written and electronic records must be of a high standard of record keeping.

6.2 A lack of care when creating, writing, filing, storing or handling patient records could lead to a delay in patient care or inappropriate care being given.

6.3 All incidents will be investigated as outlined in the clinical incident policy and in extreme cases may result in disciplinary action in line with Trust policy (reference WAHT – HR – 017).

7. Standards

7.1 Written Record Keeping: 95% of written clinical records should adhere to the basic record keeping standards of date, time, name set out in appendix 1.

7.2 Electronic Record Keeping: Any records that are kept electronically should follow the

same standards as records in any other media and have good data quality. Data Quality is defined as the maintenance of demonstrably accurate, consistent, electronic patient activity data conformant with national guidelines.

7.3 The Trust will, where possible, comply will BS1008,

7.4 99% of active paper notes will be raised and tracked according to policy before transfer.

7.5 100% of notes will be accessible 24/7 by authorised users

7.6 98% of notes will be available before due date and time

8. Monitoring

Monitoring will be carried out as described in the table below:

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for ensuring the check is carried out:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
Appendix 1	Clinical record keeping forms an integral part of the communication process between health care professionals in the care of patients. Accurate and comprehensive record keeping is an essential part of patient care. All record keeping standards for both written and electronic patient records should be adhered to by all health care professionals and administration staff throughout the trust.	Audit of the essential record keeping standards to be agreed by Divisional Leads each year.	Annual	Chief Medical Officer	Divisional Medical Directors	At least annual
Page 10 - standards	Non-clinical business processes affect the ability of clinical staff to carryout patient care	SLA standards within third party contract Annual spot checks of adherence to business processes	Monthly Annual	Trust Health Records Lead	Non-clinical Health Records working group	At least annual

9. Exceptions

There are no exceptions to clear, accurate, comprehensive and accessible clinical records.

10. Consultation

This policy has been updated by the Associate Medical Director - Patient Safety. Expert advice was sought from both the Health Records clinical working group, IG team, Legal Department, Safeguarding team, therapies management team.
Consultation has taken place with Divisional Clinical leads.

11. Approval process

11.1.1 The clinical record keeping elements of this policy has been reviewed by the clinical representatives.

11.1.2 The Associate Medical Director for Patient Safety has ensured that any government directives have been incorporated.

11.1.3 This policy has been approved by the Trust Health Records lead and Health Records Clinical working group and a review date agreed.

12. Implementation arrangements

12.1.1 It is intended that this be the only reference document for Clinical Record Keeping within the Trust and replaces all previous policies.

12.1.2 Chief Medical Officer and Chief Nurse must ensure that their staff have access to this policy and are implementing the requirements within it.

12.1.3 It is strongly advised that all staff are made aware of the monitoring and audits resulting from this policy.

13. Dissemination Process

13.1.1 This policy will be displayed on the Trust Intranet and a link will be sent by the Chief Nursing Officer to all nursing leads for dissemination and by the Chief Medical Officer to all clinical leads and heads of Departments for dissemination.

13.1.2 Junior doctors are provided with a crib sheet for written clinical record keeping (see appendix 2) as well as a section in their handbooks being devoted to it.

13.1.3 Materials explaining the basics of written clinical record keeping are available for department managers to use.

14. Training and Awareness

Training may be provided as part of induction and / or via e-learning tool for record keeping
Video training and class room will be available for non-clinical staff handling case notes. Ad hoc class room sessions are available on request
Support for staff regarding health records practices is available from the Trust Health Records Lead, as required and via the health records webpage.

15. Development of the Policy

15.1.1 The clinical part of this policy will be reviewed by the HRC (Health Records Clinical Working Group) Chair and the Deputy Chief Nurse along with any other relevant clinical staff.

15.1.2 Any amendments that are recommended will be submitted to the HRC for approval.

15.1.3 The HRC must review all amendments and agree them prior to an updated version of this policy being circulated/displayed to staff.

16. Freedom of Information, Data Protection and Caldicott Guidelines

16.1 As soon as a record is created, whether paper or electronic it becomes subject to Data Protection and Freedom of Information. Staff should make every effort to ensure that patient confidentiality is maintained at all times and be aware of their responsibilities pertaining to patients records. In the case of a complaint the patients' record may be used as a legal document and MUST follow this policy to ensure that data quality is good.

16.2 See appendix 2 for an information sheet showing basic principles for Data Protection, Freedom of Information, Caldicott Principles, Confidentiality, misuse of Computer act and computer password guidance.

16.3 Links to the National Websites for Information Governance are shown in section 17

17. Useful National Guidelines Web Links

Freedom of Information Act 2000
Data Protection Act 1998
Information on Caldicott Guardians
Patient Confidentiality

18. Appendices:

Appendix 1: Clinical Record Keeping Principles
Appendix 2: Crib Sheet - poster for Clinical Record Keeping
Appendix 3: Retention schedule
Appendix 4: Scan turnaround times

Appendix 1
Clinical Record Keeping Principles

Section 1 –The Clinical Record

These principles apply for all patients requiring the intervention of a health care practitioner within the Worcestershire Acute Hospitals NHS Trust, including in-patients, day patients, out patients, people undergoing assessment in Accident and Emergency Departments, Medical Assessment Units or Minor Injuries Units and women receiving care from maternity services, including in-patients, ante-natal clinics, community midwife services and the Day Assessment Unit.

- The clinical record is any record which 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.
- All clinical documentation should accurately reflect the past, current and future care treatment and support of a patient including verbal communications
- Practitioners are responsible for any records they create or use. This responsibility is established at, and defined by, the law
- Documentation within the clinical record should reflect the continuum of patient care and should be viewable in chronological order. Entries to the medical record should be made as soon as possible after the event to be documented and before the relevant staff member goes off duty. If there is a delay, the time of the event should be recorded.
- Any records created by employees of the National Health Service are public records
- Any new document template (or a current document which is being modified) which is intended to be part of the patient record must have been approved for use as such by the Health Records Clinical working group and tested for suitability to scan.
- Documents intended for use in the patient record will not have been produced by individuals, or wards, or departments, in isolation; nor will such documents be produced by “Desk Top Publishing” methods and/ or photocopying (refer to WAHT forms creation process) http://nww.worcsacute.nhs.uk/departments-a-to-z/health-records/

Section 2– General Principles and Style of Records

- All entries to the written and digital clinical record will be dated and timed
- All entries to the clinical record will be signed in full, without the use of initials. (or the author's details captured automatically through the electronic data capture systems).
- Passwords must not be shared.
- Each time a health professional writes in the paper record, he or she will print his or her name and either bleep, pager or contact number and state designation. If a stamp is used, this is in addition to signature as a stamp is only for making the signatories identity clear.
- The name of the most senior healthcare professional responsible for decision-making at the time the entry must be clearly recorded.
- All written entries will be legible and clear and written in black ink.
- All pharmacist written endorsements must be made in green ink, although these are scanned in black and white.
- All entries to the record will be precise and objective observations avoiding subjective remarks or opinions.
- All entries to the record will be factual, accurate and maintain the dignity and confidentiality of all aspects of patient care.
- Entries will be recorded as soon as possible after the event to which they refer.
- If there is no entry in the health record for a significant period the next entry must explain why.
- An entry should be made in the medical record whenever a patient is seen by a doctor. When there is no entry in the hospital record for more than four days for acute medical care or seven days for long-stay continuing care, the next entry should explain why
- Abbreviations will be avoided, and those that are used will be well-recognised by the professional body.
- All entries will be up to date.
- On every occasion when the responsibility for the patient's care changes, the name of the new responsible consultant must be recorded.
- Relevant information (where practicable) will be shared with other professionals rather than copied, to reduce risks to confidentiality. Refer to Information Sharing policy (WAHT - CG - 777)
- The process of record keeping will involve the patient concerned. Carers are involved at the request of the patient or if the patient is unable to communicate or participate in planning or negotiating their own care. They, or others acting on their behalf, and relevant staff, can access and where appropriate, contribute to the record.
- Blank spaces or empty lines should not be left between entries; remove any blank spaces by drawing neat lines through them
- Wherever possible, entries to the clinical record will be in terms the patient can understand or reference.
- Advanced Decisions to Refuse Treatment, Consent, Cardio-Pulmonary Resuscitation decision must be clearly recorded in the medical record. In the circumstances where the patient is not the decision maker, that person should be identified e.g. Lasting Power of Attorney.

Section 3 –Content of Clinical Records

Multi-professional communication

- The source of patient referral will be recorded
- There will be a written or electronic record of all referrals made to other health care professionals
- The findings of each health care professional will be accessible to others directly involved in the patient's clinical care
- Any conversations or shared information with outside organisations (e.g. Social Services, police) must be recorded
- The record will record patient care related conversations that are held with the patient and relatives
- The record will detail restraint techniques used.
- The record will include evidence of clinical staff commenting on electronic documents, such as referrals
- There will be an electronic record of all email communications related to patient care

Assessment

- There will be evidence of assessment of the patient's clinical condition, before admission and on admission, using relevant clinical assessment tools.
- The record will demonstrate on-going reassessment at regular and appropriate intervals
- The record will include diagnosis, or main condition treated.

Planning Care

- The record will provide evidence of the care or treatment which has been planned
- Data recorded or communicated on admission, handover and discharge should be recorded using standardised proformas

Evaluating Care

- The record will identify any problems which have arisen, and the action taken to rectify them
- Conversations with the family, friends or carers of the patient will be recorded
- The content of the clinical record will demonstrate that the best available evidence was used to inform care (for example, through the use of care pathways, or through reference to supporting documents describing best practice)
- Any important or relevant information will be recorded
- The record will show evidence of decisions made by clinicians, discussion with the patient, his or her carers, and any health care professional involved in the patient's care
- The record will show what care was delivered, what treatment was given and the response to that treatment.

Discharge Planning

- The record will contain evidence of assessment of the patient's home circumstances
- There will be a documented discharge plan commenced on admission or within 24 hours of admission
- Information given to the patient on discharge will be recorded

- When an acute hospital bed is no longer required for medical reason or treatment, this will be documented in the medical notes by the consultant team

Test Results

- Requests for investigations must be documented in the patient's notes to ensure that missing results can be tracked, and to avoid duplication of investigations
- Tests results available electronically will not be routinely printed and provided to clinical teams.
- The clinician responsible for the care of the patient at the time of the request must ensure review and sign off (file) of the electronic results
- If any investigation is requested electronically a process must be followed to ensure the result is viewed and filed. The responsibility for this process lies with the requesting clinician.
- Results must be reviewed and acted upon. The action taken must either be recorded in the notes or within the results filing system.

Section 4 – Ensuring Patient Safety

- The patient's location, name, NHS number and 10 digit unique hospital number will be on every page of the clinical record. As a minimum, each side must ensure the patient can be identified, usually three identifiers are therefore required.
- Clinical alerts such as allergies or adverse drug reactions will be clearly recorded in the appropriate places, i.e. on the medicines chart and in the case notes, in **black ink,** and will be signed and dated. Alerts can be recorded by medical, nursing staff or pharmacists. When new alerts or allergies are identified, clinicians will ensure that the information is added to the primary system for recording alerts (currently PAS, but will move to e-prescribing system). Medicine incidents will be recorded in the medical notes.
- The Trust expects clinical staff to use e-consent where possible, except in emergency circumstances. Consent forms will be signed after discussion with the doctor of the risks and benefits of proposed treatment.
- Health Care Professionals need to be confident that patients have capacity to understand treatments and options available to them. Assessment of capacity should be documented within the medical record. Refer to WAHT – CG – 752 Policy for assessing mental capacity. http://nww.worcsacute.nhs.uk/departments-a-to-z/mental-capacity/

Section 5 – The Written Clinical Record as a Public Record

- The record will not be amended at a later date (to retrospectively amend scanned notes, use annotations process).
- Deletions and alterations should be countersigned, dated and timed. A single line will be drawn through entries made by mistake, the error dated and initialled and a note made that the entry was made in error
- If an error is noted at a later time, the original error should not be amended. Another entry should be created in chronological order and referenced to the previous entry date.
- If an entry is found to be unsigned, it must be flagged and recorded as 'ABOVE ENTRY UNSIGNED' before the next entry is recorded
- If writing entries in the hospital record from rough notes, they should be recorded as 'WRITTEN IN RETROSPECT'
- Correction fluid will not be used anywhere in the clinical record
- A register will be kept at ward or department level which includes, for all staff (name, initials, full signature and designation). This register will be preserved in accordance with agreed retention schedule. Refer to Corporate Records Management Policy WAHT – CG – 127.
- Entries to the record by non-registered staff will be countersigned by registered staff. Where professional staff have undertaken a documented competency in record keeping, there is no need to countersign.
- All agency staff who write in clinical records will print and sign their name and add the agency for which they work

Section 6 – Patient Confidentiality

- All clinical records are confidential
- Paper Clinical records will not be removed from the trust except as specified in Section 7, and will not be shown to any persons other than those specified in Section 2
- Clinical records will not be left where unauthorised people can see them. Charts and daily care plans must be contained within folders if kept at the foot of the patient's bed.
- Computer screens displaying patient related information will not be left on public view. Users will log out of any program before leaving computers for multiple users unattended.
- Paper which contains any information which could be traced to any individual patient, and which requires disposal, will be disposed of as confidential waste

Section 7 - Patient Transfers

- When a patient is transferred to a local community hospital managed by Worcestershire Health & Care Trust, or a hospital within the Worcestershire Acute Hospitals NHS Trust, the complete paper notes for the event may, if necessary, be sent (documents are available electronically for these hospitals, so preference is to scan the documents).

- In the event of an emergency, when a patient is transferred to a hospital which is not a local community hospital, and which is not part of the trust, the KMR1 (if present) will be retained and all episode details completed before sending the KMR1 to the coders. Where time permits, a request for urgent scanning may be possible which will allow the original paper copies to be used for transfer or will allow electronic transfer of clinical information to the other hospital

- In all non-emergency transfers, the original Trust paper event notes should be retained in the Trust and copies sent to other non-trust organisations, unless scanned documents can be made available.

- Any transfer letter must state any follow up such as out-patient appointments or outstanding or pending investigations

Section 8 –Staff Competencies and Training

- Clinical records will be completed by registered health care practitioners, support staff or trainees working under their direction
- Clinical staff will be expected to complete the e-learning for record keeping
- Clinical record keeping summary will be given to all junior doctors at induction
- All staff likely to be transferring patients to other organisations must be aware of how to transfer electronic information. Training is available via the ICT training team or from the ICT exporting training guide
- All staff will be responsible for ensuring their own competence to use electronic records and adhere to the standards
- All leaders will be responsible for ensuring staff are competent to adhere to the standards within this policy

Section 9 – Audit and Outcomes

- Audit against these standards will take place annually.

Successful outcome from the delivery of the policy would be:

- High standards of clinical record keeping
- Clinical record keeping that supports communication and planning of care
- Clinical record content that supports complaints investigation
- Provision of evidence to support local and national standards e.g. CQUINs

References

1. Department of Health (2001) *The Essence of Care. Patient-focused benchmarking for health care practitioners*

2. HMSO (1998) *Data Protection Act 1998* ISBN 0 10 542998 8 The Stationary Office, London

3. NHS Executive Health Service Circular HSC 1999/053 (1999) *For the Record. Managing records in NHS Trusts and Health Authorities* Department of Health

4. Addenbrookes NHS Trust (2000) *Medical ethics and law: Good record keeping – a guide for medical staff at Addenbrooke's* (WWW) http://addenbrookes.org.uk/advice/medethlaw/goodrecords1.html (Accessed 16/03/01)

5. Health Quality Service Accreditation Programme (in association with the King's Fund) 15 Whitehall, London SW1A 2DD

6. NHS Litigation Authority (2000) CNST (Clinical Negligence Scheme for Trusts) *Health Record Standards*

7. The Royal College of Surgeons of England (Reissued 1994) *Guidelines for Clinicians on Medical Records and Notes*

8. Chartered Society of Physiotherapy (2000) *Core Standards of Physiotherapy Practice (Standard 14)*

9. *http://systems.digital.nhs.uk/infogov/records*

10. Information Governance Toolkit (2016/17)

11. British Standard for the Evidential Weight and Legal Admissibility of Electronic Information (BS10008:2008).

12. https://www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards

13. http://systems.digital.nhs.uk/infogov/iga/rmcop16718.pdf

Clinical Record Keeping

All entries to a clinical record MUST be:

Written in BLACK ink

Each entry must be SIGNED in full

Each entry must be DATED

Each entry must be TIMED

All entries must be LEGIBLE and CLEAR

Abbreviations should be avoided

All entries must be made in a timely manner

All entries in the electronic clinical record must be made using your unique username and password

1. Data Protection Act 1998

The Data Protection Act 1998 became law in March 2000. It sets standards that must be satisfied when obtaining, recording, holding, using or disposing of personal data.

There are 8 enforceable principles of good practice. Data should be:

? Fairly and lawfully processed
? Processed for limited purposes
? Adequate, relevant and not excessive
? Accurate
? Not kept longer than necessary
? Processed in accordance with the data subject's rights
? Secure
? Not transferred to countries outside the European Economic Area (EEA), without adequate protection

2. Freedom of Information Act 2000

The Freedom of Information (FOI) Act gives a general right of access to all types of recorded information held by public authorities, including NHS Trusts. The Act also sets out exemptions to that right and places certain obligations on public authorities.

In addition to providing information when asked to do so, FOI also requires public authorities to be proactive in the release of information.

Every public authority is required to adopt and maintain a publication scheme setting out how it intends to publish the different classes of information it holds, and whether there is to be a charge for the information disclosed. The Trust's FOI publication scheme is regularly updated and has been approved by the Information Commissioner.

3. Caldicott

In 1997, a committee chaired by Dame Fiona Caldicott produced a report about confidentiality.

Their brief had been to review the transfer of patient identifiable information within the health service; the result was a set of standards that became known as The Caldicott Principles.

The Caldicott Principles also allow for the secure transfer of sensitive information across other agencies, for example Social Services, Education, Police and Judicial System.

Each PCT, NHS Trust and Council has a Caldicott Guardian who is responsible for ensuring that the Caldicott Principles are adhered to. Each organisation has an Information Sharing Protocol which details what information can be shared and with whom. Please refer to the intranet under Policies and Procedures.

The Caldicott Guardian should be consulted before any patient identifiable information is shared.

The six Caldicott Principles relating to the use of patient identifiable information are:

? Justify the purpose(s) of using confidential information
? Only use it when absolutely necessary
? Use the minimum that is required
? Access should be on a strict need-to-know basis
? Everyone must understand his or her responsibilities
? Understand and comply with the law

4. Confidentiality

Confidentiality is about ensuring that sensitive / personal information is not disclosed or made available to any individuals or systems unauthorised to see it.

The Trust is committed to the delivery of a first class confidential service. This means ensuring that all patient information is processed fairly, lawfully and as transparently as possible so that the public:

? understand the reasons for processing personal information
? give their consent for the disclosure and use of their personal information, if necessary
? gain trust in the way the Trust handles information and
? understand their rights to access information held about them.

All health professionals owe their patients a duty of confidentiality, which arises out of the common law of confidentiality, professional obligations and contracts of employment. They also owe a duty of care to ensure that material of a personal, confidential and possibility personally damaging nature is treated with the appropriate degree of security.

5. Computer Misuse Act 1990

The Computer Misuse Act makes it a criminal offence for anyone to access or modify computer held data or software without authority, or to attempt to do so.

"Misuse" will include the unauthorised modification of a computer, software or system with the intent to impair the operation, to prevent or hinder access to any program or data held in any computer, or impair the operation of any such program or the reliability of any data.

6. Computer passwords guidelines

YOU are fully responsible for any accidental or unauthorised disclosure of your password to any other person and shall bear the risks of your password being used by unauthorised persons or for unauthorised purposes.

DO NOT SHARE your password with another member of staff or write it down anywhere accessible, e.g. passwords must not be printed or displayed on terminals. The passing on of your password is a serious matter, warranting consideration of disciplinary action.

CHANGE your password immediately if you think it may no longer be secret.

Should someone else GUESS or STEAL your password, he or she can masquerade as you, which means, that person would then have access to your files, your emails, your personal information, and more. This person will have the power to modify or destroy your files, to send inappropriate emails in your name or access undesirable web sites on the Internet in your name.

Legal Requirements for retaining records

Any records created by the Trust or by Xerox on behalf of the Trust remain the property of the Trust and will be retained for the legally required period should the registered provider close operations.

Information taken from Trust Information Booklet 'A guide to information governance'

Appendix 3– Health Records Retention Schedule Hospital patient case records retention guide (refer to Corporate Records Management Policy

Any reference to “conclusion of treatment" in the following recommended minimum retention periods, should be taken to include all follow-up checks and action in connection with the treatment.

The retention periods which are listed below reflect minimum requirements of clinical need. Personal health records may be required as evidence in legal actions; the minimum retention periods take account of this requirement. It is not necessary to keep every piece of paper received in connection with patients. NHS Trusts and Health Authorities should determine, in consultation with their health professionals, which elements should be considered as a permanent part of the record, and which should be transient and discarded as their value ceases.

Before any destruction takes place, ensure that:
(a) There is consultation with the relevant health professional body or records working group members and actions clearly minuted;
(b) Any other local clinical need is considered; and
(c) The value of the records for long-term research purposes has been assessed, in consultation with an appropriate place of deposit.

Pre-1948 records
Where a period longer than 30 years is required (e.g. to be preserved for historical purposes), or for any pre-1948 records, The National Archives should be consulted. Organisations should remember that records containing personal information are subject to the Data Protection Act 1998.

Children and young people
Retain until the patient’s 25th birthday or 26th if young person was 17 at conclusion of treatment, or 8 years after death. If the illness or death could have potential relevance to adult conditions or have genetic implications, the advice of clinicians should be sought as to whether to retain the records for a longer period

Donor records
30 years post transplantation. Committee on Microbiological Safety of Blood and Tissues for Transplantation (MSBT); guidance issued in 1996.

Maternity (all obstetric and midwifery records including those of episodes of maternity care that end in stillbirth or where the child later dies)

25 years after the birth of the last child

Mentally disordered persons (within the meaning of the Mental Health Act 1983)
20 years after the date of last contact between the patient/client/service user and any health/care professional employed by the mental health provider, or 8 years after the death of the patient/client/service user if sooner. Please be aware that old Kidderminster notes may contain green psychiatric notes.

Oncology
30 years

NB Records should be retained on a computer database if possible. Also consider the need for permanent preservation for research purposes Consideration may wish to be given to BFCO (96)3 issued by the Royal College of Radiologists

Patients involved in clinical trials

For trials to be included in regulatory submissions:
At least 2 years after the last approval of a marketing application in the EU. These documents should be retained for a longer period, however, if required by the applicable regulatory requirement(s) or by agreement with the Sponsor. It is the responsibility of the Sponsor/someone on behalf of the Sponsor to inform the investigator/institution as to when these documents no longer need to be retained

For trials which are not to be to be used in regulatory submissions:
At least 5 years after completion of the trial. These documents should be retained for a longer period if required by the applicable regulatory requirement(s), the Sponsor or the funder of the trial

In either case, if the period appropriate to the specialty is greater, this is the minimum retention period

General (not covered above)
10 years after conclusion of treatment or death

Notes on preservation of patient records for historical purposes
1. In the light of the latest trends in medical and historical research, it may be appropriate to select some of these records for permanent preservation. Selection should be performed in consultation with health professionals, and archivists from an appropriate place of deposit. If records are to be sampled, specialist advice should be sought from the same health professionals and archivists. If a NHS Trust or Health Authority has taken on a leading role in the development of specialised treatments, then the patient records relating to these treatments may be especially worthy of permanent preservation.

2.If a whole run of patient records is not considered worthy of permanent preservation but nevertheless contains some material of research value, then the option of presenting these records to local record offices and other institutions under s.3(6) of the Public Records Act 1958 should be considered. Advice on the presentation procedure may be obtained from the PRO's Archive Inspection Services.

3. If a whole run of patient records is considered worthy of permanent preservation but there is a lack of space in the relevant place of deposit to store these records, it may be appropriate to make a microfilm copy and then destroy the paper originals. Microfilms should be produced in accordance with the British and International Standard BS ISO 6199: 1991, copies of which can be purchased from the British Standards Institute.

Notes on the destruction of confidential patient records

1. Destruction of confidential records must ensure that their confidentiality is fully maintained. Normally destruction should be by incineration or shredding. Where this service is provided by a contractor, it is the responsibility of the NHS Trust or Health Authority to satisfy itself that the methods used throughout all stages including transport to the destruction site provide satisfactory safeguards against accidental loss or disclosure.

The National Retention Schedule includes:

The following types of record are covered by this retention schedule (regardless of the media on which they are held, including paper, electronic, images and sound, and including all records of NHS patients treated on behalf of the NHS in the private healthcare sector):

- patient health records (electronic or paper-based, and concerning all specialties, including GP medical records);
- records of private patients seen on NHS premises;
- Accident & Emergency, birth and all other registers;
- theatre, minor operations and other related registers;
- X-ray and imaging reports, output and images;
- photographs, slides and other images;
- microform (ie microfiche/microfilm);audio and video tapes, cassettes, CD-ROMs, etc;
- e-mails;
- computerised records; and
- scanned documents.

The full Retention and Disposal Schedule is an appendix to the Corporate Records Management Policy and is 119 pages long. For this reason it is not included as an appendix here
http://nww.worcsacute.nhs.uk/departments-a-to-z/information-governance/ig-documents/

Appendix 4 – scan turnaround times

http://nww.worcsacute.nhs.uk/departments-a-to-z/health-records/

No Collections on Bank Holidays or Weekends

Documents for Standard Service will be scanned and viewable within 24 hours of these collection times
(with the exception of Friday receipts which will be viewable within 72 hours)

Documents for Priority Service will be scanned and viewable within 3 working hours of these collection times
(Last priority scan will be collected at 2.30pm Mon-Fri)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday & Sunday CLOSED		Monday
received by	9:00am	9:00am	9:00am	9:00am	9:00am	all day	all day	
scanned by		9:00am	9:00am	9:00am	9:00am			9:00am
received by	11:00am	11:00am	11:00am	11:00am	11:00am	all day	all day	
scanned by		11:00am	11:00am	11:00am	11:00am			11:00am
received by	2:30pm	2:30pm	2:30pm	2:30pm	2:30pm	all day	all day	
scanned by		2:30pm	2:30pm	2:30pm	2:30pm			2:30pm

Supporting Document 1 - Equality Impact Assessment Tool
To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	No	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	No	
7.	**Can we reduce the impact by taking different action?**	No	

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval