Clinical Record Keeping Policy

Version 4

Summary:
This Policy provides statements and standards for the management of clinical information (electronic and paper) and assurance of compliance with national and legal requirements.

Associated standards, procedures and guidance:
SH IG 6 Approved Abbreviations Guidance
SH IG 8 Mental Health Act Documentation Procedure
- Procedure and Consent Form for Communicating via email or text
- Guidance on Lasting Power of Attorney
SH IG 12 Subject Access Request and Disclosure of Personal Data Procedure
SH IG 13 Information Lifecycle Policy
SH IG 18 Data Protection, Caldicott & Confidentiality Policy
SH IG 42 Procedure for the Management of Personal Information
All associated EPR Standard Operating Procedures and Service Specific Guidance

Keywords (minimum of 5): (To assist policy search engine)
Records; clinical; health; documentation; standards

Target Audience:
All staff who contribute or manage clinical information – both paper and electronic

Next Review Date:
February 2021

Approved and ratified by:
Clinical Effectiveness Group

Date of meeting:
26/02/18

Date issued:
March 2018

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## Clinical Record Keeping Policy

Version 4

March 2018

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### Version Control

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</tbody>
</table>
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record Keeping Core Standards (Rationale) and Quick Reference Guide</td>
<td>4</td>
</tr>
<tr>
<td>Assurance Statement</td>
<td>6</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>7</td>
</tr>
<tr>
<td>2. Who does this policy apply to</td>
<td>7</td>
</tr>
<tr>
<td>3. Definitions</td>
<td>7</td>
</tr>
<tr>
<td>4. Duties/ responsibilities</td>
<td>9</td>
</tr>
<tr>
<td>5. Main policy content</td>
<td>12</td>
</tr>
<tr>
<td>5.1: Clinical record creation and management</td>
<td>13</td>
</tr>
<tr>
<td>5.2: Basic Record Keeping Standards</td>
<td>13</td>
</tr>
<tr>
<td>5.3: Clinical Information Standards</td>
<td>15</td>
</tr>
<tr>
<td>5.4: Patient held records</td>
<td>15</td>
</tr>
<tr>
<td>5.5: Communicating with Service Users by Email</td>
<td>16</td>
</tr>
<tr>
<td>5.6: Child Deaths</td>
<td>16</td>
</tr>
<tr>
<td>5.7: Filing</td>
<td>17</td>
</tr>
<tr>
<td>5.8: Confidentiality &amp; Information Security</td>
<td>17</td>
</tr>
<tr>
<td>5.9: Management of Clinical Records of staff who are patients/service users</td>
<td>17</td>
</tr>
<tr>
<td>5.10: Patient Opt-Out</td>
<td>18</td>
</tr>
<tr>
<td>5.11: Gender Recognition Act 2004: Records Management</td>
<td>18</td>
</tr>
<tr>
<td>5.12: Access to Electronic Patient Records (EPRS)</td>
<td>18</td>
</tr>
<tr>
<td>5.13: Unqualified/non-registered staff using EPRs</td>
<td>19</td>
</tr>
<tr>
<td>5.14: Access to Trust EPRs by non-Trust staff</td>
<td>19</td>
</tr>
<tr>
<td>5.15: Personal Demographic Service (PDS)</td>
<td>19</td>
</tr>
<tr>
<td>6. Monitoring Compliance</td>
<td>20</td>
</tr>
<tr>
<td>7. Management of Mental Health Act Documentation</td>
<td>20</td>
</tr>
<tr>
<td>8. Subject Access Request – Access to Records</td>
<td>20</td>
</tr>
<tr>
<td>9. Litigation and Complaints Documentation</td>
<td>20</td>
</tr>
<tr>
<td>10. Training Requirements</td>
<td>21</td>
</tr>
<tr>
<td>11. Monitoring Compliance</td>
<td>21</td>
</tr>
<tr>
<td>12. Policy Review</td>
<td>21</td>
</tr>
<tr>
<td>13. Associated Documents</td>
<td>21</td>
</tr>
<tr>
<td>14. Supporting References</td>
<td>21</td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
</tr>
<tr>
<td>A1 Training Needs Analysis (TNA)</td>
<td>23</td>
</tr>
<tr>
<td>A2 Equality Impact Assessment</td>
<td>24</td>
</tr>
<tr>
<td>A3 Record Keeping Competencies</td>
<td>25</td>
</tr>
</tbody>
</table>
Record Keeping Core Standards

Rationale:

To provide an accurate, timely, relevant clinical record that facilitates the delivery of safe and coordinated care that involves the patient, carer and family.

All clinical and administrative staff creating or contributing to the patient record will provide an accurate and timely health record which can determine accountability; facilitate clinical decision making; improve patient care through clear communication of the assessment, treatment and care planning rationale; provide a consistent approach to partnership working; and help in the investigation of complaints or legal proceedings.

Refer to Section 5.3 for further information.

Quick Reference Guide

Health Practitioners have a duty to keep up to date with, and adhere to, relevant legislation, case law, Professional Bodies and professional standards, national and local policies relating to information governance and record keeping standards.

Health Practitioners are accountable for ensuring that they are aware of and know how to use information systems, for example electronic patient record systems and medical devices in accordance with local Trust policy and procedures.

Health Practitioners are accountable for any entry they make to a patient record and must ensure that any entry made is clearly identifiable and each entry must be checked for accuracy prior to signing (written or electronic equivalent) in accordance with local Trust policy.

All health records must comply with local policies and procedures, throughout the lifecycle of the record to include management, retention, review and disposal.

Handwriting must be legible and written in black ink to enable legible photocopying or scanning of documents if required.

Health records must be accurate and written in such a way that the meaning is clear (paper and electronic).

Health records must demonstrate a full account of the assessment made and the care planned and provided and actions taken including information shared with other health professionals.

All entries must be recorded as soon as possible after an event has occurred (contemporaneous), providing current information on the care and condition of the patient.

If the date and time differs from that of when the records are written, this must be clearly noted in the record.

All entries must be recorded, wherever possible, with the involvement of the patient/ client or their carer and written in language that the patient can understand.

Health records must demonstrate any risks identified and/ or problems that have arisen and the action taken to rectify them.
Health records should not include unnecessary abbreviations or jargon, meaningless phrases, irrelevant speculation or offensive subjective statements, irrelevant personal opinions regarding the patient.

Only approved abbreviations should be used – refer to SH IG 6 Approved Abbreviations Guidance.

Every Child and Adult receiving care must have a Next of Kin (NOK) recorded – refer to the EPR Standard Operating Procedures for guidance on how to record this (Section 8.3 of the OpenRiO SOP).

Any corrections in handwritten records must be clear, dated and signed. For electronic records – follow the procedure in the appropriate standard operating procedure or handbook.

Health Records must never be falsified.

Health Practitioners must develop communication and information sharing skills with other professionals and providers of care as accurate records are relied on at key communication points, especially during handover, referral and in shared care.

Legal requirements and local policies regarding confidentiality of health records must be followed at all times.

Health Practitioners remain professionally accountable for ensuring that any duties delegated to non-registered practitioners are undertaken to a reasonable standard.

The care delivered by non-registered practitioners (including students) will need to be overseen by a registered healthcare professional on a regular basis (determined locally based on the complexity and needs of the patients and their family) alongside a comprehensive review of the clinical records.

Health records held on any form of media must be protected by appropriate levels of security, for example, locked records room, lockable trolleys and smartcard access – refer to SH IG 42 Procedure for the Management of Personal Information.
The Trust is registered with the Care Quality Commission (CQC) which sets the standards of care expected of all NHS Trusts. This policy has incorporated a range of best practice and related legislative requirements to outline the organisation’s expectations for record keeping standards, both paper and electronic, including the following:

- Records Management: NHS Code of Practice 2016
- Relevant professional bodies
- Data Protection Act 1998
- General Data Protection Regulation 2018
- Information Governance Toolkit

The standards within this policy will:

- Maximise patient safety and quality of care by advocating accurate and contemporaneous record keeping.
- Promote patient involvement in the planning and recording of their care
- Ensure compliance with best practice across the Trust
- Facilitate nurses, allied health professional and medical staff to meet their respective professional records keeping standards
- Provide a framework for non-professional staff to comply with Trust record keeping requirements
- Enable the management of clinical and corporate risk
- Underpin the record keeping audit of health records in the Trust to monitor compliance with expected standards
- Allow for information sharing and communication across and between the patient, clinical teams and partner organisations

To achieve this, clinical records must be **timely, accurate, factual, concise and up to date** accounts of the assessment and treatment, plan of care and evaluation of individual patients.

**Accountability** – records are adequate to account fully and transparently for all actions and decisions, in particular to:

- provide rationale for clinical decisions
- protect legal and other rights of staff or those affected by those actions
- facilitate audit or examination by internal or external reviewers
- provide credible and authoritative evidence
- facilitate research and evidence based practice

**Interpretation** – the content of the record can be interpreted; i.e. clear and concise; identification of staff who created or added to the record and when; an objective account of care and how the record is related to other records.

**Quality** – records are complete and accurate and reliably represent the information that was actually used in, or created by, the delivery of care, and its integrity and authenticity can be demonstrated.

**Staff training** – all staff are aware of their responsibility for record keeping and where applicable are conversant and compliant in their professional standards and guidance.
1. **Introduction**

1.1 Good clinical record keeping is an integral and vital part of professional practice which contributes to:
- support clinical care and continuity of care, including the assessment and management of clinical risk
- support day to day hospital and community teams business which underpin delivery of care
- support evidence based clinical practice
- support the decision making process
- meet legal requirements
- assist clinical and other audits
- support improvements in clinical and social care practice
- ensure information is available, whenever and wherever there is a justified need, and in whatever media it is required
- patient involvement in their care

1.2 This policy outlines Southern Health Foundation Trust’s (the Trust) standards to underpin the provision of quality health care records, in all formats to mandate the way in which information is recorded, managed and used.

1.3 In services that use an electronic patient record, a Secondary Care Record may also be in use. The Secondary Care Record is for storing information that cannot be stored on the electronic patient record. Detailed guidance and standards for using the Trust’s electronic patient record are included in the relevant Standard Operating Procedures.

2. **Who does this policy apply to**

This policy applies to all staff who are engaged in the delivery of care to patients and refers to all information, in any media (but particularly paper and electronic), both active and inactive, that is recorded in relation to care provided to an individual.

This Policy must be read by all employees of the Trust, both permanent and temporary (e.g. those on secondment and on honorary contracts). It also applies to anyone contracted by the Trust, who, in the course of their work are required to access clinical records normally restricted to directly employed staff, and to students and trainees on placement.

- Electronic Information: Includes “data”, and is wider than just non-identifiable data used in business processes. This also includes all electronic information relating to a specific patient; e.g. activity; mental health act; contracts; demographic information; care plans; assessments; carers/significant others
- Paper records: All volumes and modules of a clinical paper record

3. **Definitions**

3.1 **Health Record**

The Data Protection Act 1998 describes the health record as “consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual”.
Paper Record

Any of the following documents which record aspects of care of a patient or client can be required as evidence before a Court of Law or before any regulatory body:-
- Diaries
- Incident forms
- Attendance books
- Messages relating to the care of a patient
- Clinic lists

This list is not exhaustive

Electronic Record

The Electronic Patient Record is a secure, real-time, point-of-care, patient centric information resource. Electronic Patient Record (EPR) is an official health record for an individual that can be shared among multiple departments and agencies.

Contemporaneous

Means records should be written at the time of or as close to the event described in the record.

Confidentiality

All staff have a duty to protect the confidentiality of the patient record. Access to a patients records and the information contained in them must only be for an appropriate reason and by appropriate staff. See Standards of Conduct and Disciplinary Policy (HRP1) and Code of Conduct guidance for further details.

Caldicott Guardian

The Trust's Caldicott Guardian has a particular responsibility for reflecting patients interests regarding the use of patient identifiable information by safeguarding the confidentiality of patient information

Access

Means the opportunity or right to see records, under The Data Protection Act 1998, patients have the right to access their health records, subject to certain safeguards.

Being open

A culture of openness within the Trust ensures communication is open, honest and occurs as soon as possible following an incident, or when a poor outcome has been experienced. It encompasses the communication between healthcare organisations, healthcare teams, and patients, their families and carers, and ensures that the Trust supports staff in Being Open.

Records Lifecycle

This describes the life of a record from its creation/receipt through the period of its “active” use, then into a period of “inactive” retention (such as closed files which may still be referred to occasionally) and finally either confidential disposal or archival preservation. Refer to SH IG 13 Information Lifecycle Policy for details.
Audit

Audit provides a method for systematically reflecting on and reviewing practice to ensure compliance with current standards

NHS Number

The NHS number is the only national unique patient identifier in operation in the NHS at this time. A ten digit number assigned to every individual registered with the NHS in England

Tracking

Creating, capturing and maintaining information about the secure movement and use of records

People/User/Client/Patient

These terms can be used interchangeably to represent user of services

4. Duties / Responsibilities

Chief Executive

The Chief Executive has overall responsibility for Records Management within the Trust. The Trust has a responsibility for ensuring that it corporately meets its legal responsibilities that affect the safe management of health records, this responsibility is delegated to the Associate Director of Nursing who leads the Records and Care Planning Work Stream, as part of the Quality Improvement Programme. This responsibility includes the on-going review, maintenance and upkeep of clinical documentation (both paper and electronic) and associated policies and procedures

Trust Board

The Trust Board have overall responsibility for ensuring that the Trust delivers high quality services that are efficient and effective. The Trust Board is made up of the Chairman, Chief Executive, Executive Directors, Medical Director and Non-Executive Directors. The Trust Board oversee the running of the Trust, make the decisions that shape future direction, monitor performance and ensure accountability

Quality and Safety Committee

The primary function of the Quality and Governance Committee is to provide assurance to the Board of overall compliance with all statutory and regulatory obligations and will ensure the effective management of Incidents, Complaints, Claims and Inquests and subsequent dissemination of lessons learnt, this includes the quality of health records. This group formally approves Trust Policies and the Information Governance Group reports to this committee.

Caldicott Guardian

The Caldicott Guardian within the Trust is the Medical Director. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.
The Guardian plays a key role in ensuring that the NHS, Councils with Social Services responsibilities and partner organisations satisfy the highest practicable standards for handling patient identifiable information.

This main role is to give advice when there is any uncertainty in the transfer of patient and service user information, seeking to clarify the purpose of the transfer, that it is justified; absolutely necessary; transferring only the minimum required; on a need to know basis and complying with the Data Protection Act 1998

**The SIRO (Senior Information Risk Owner)**

The SIRO for the Trust is the Chief Finance Officer and have the responsibility for the safe-keeping of all Trust records. The SIRO owns the Trusts overall information risk policy and risk assessment process ensuring we have a robust incident reporting process for information risks. The SIRO reports to the Trust Board and provides advice on the content of the Trust’s Statement of Internal Control in respect to information risk

**Information Governance Group**

The Information Governance Group reports to the Quality and Safety Committee. In particular, the duties will include:

- the review and monitoring of Trust’s compliance with the Information Governance Toolkit
- the review and monitoring of Information Governance risks and to escalate them when appropriate to the Quality and Safety Committee
- the review and monitoring of Information Governance guidance which is relevant to the Trust and escalate when appropriate to the Quality and Safety Committee

**Record Keeping and Care Planning Workstream:**

All clinical staff are accountable for their own record keeping performance as detailed within the record keeping policy, the relevant competency’s and professional codes of conduct. The Associate Director of Nursing & AHP role provides assurance that this process is compliant within their areas of responsibility and the monitoring of this process is undertaken by the Record Keeping and Care Planning Work stream which reports to the Clinical Effectiveness Group, which is a sib group to the Quality & Safety Committee.

**Records Manager**

- Ensuring that the Trust complies with various frameworks, working collaboratively clinical leaders
- Ensure that the requirements of this policy meet the external standards set out in the Care Quality Commission, NHS Litigation Authority and Information Governance Toolkit. This will be monitored by the Records and Care Planning Workstream, with regular reports to the Information Governance Group
- Overall responsibility for the Access to Records Requests received by the organisation ensuring compliance with the requirements of the Data Protection Act 1998 and the General Data Protection Regulation 2018.
- promoting compliance with this policy in such a way as to ensure the easy, appropriate and timely retrieval of information.
- Overall responsibility for the development and implementation of record management practices throughout the organisation.
- In collaboration with clinical leads, responsibility for the development of procedural documents and procedures that outline expected standards for managing the quality of health records within the organisation
In collaboration with clinical leads, responsibility for the development and delivery of record keeping training in line with the Trust Standards and requirements

**Divisional Managers have responsibility for:**

- Ensuring that the standard of record keeping within their Division comply with Trust Standards
- Have responsibility for managing identified risks in relation to record keeping standards in the service at Divisional Governance Groups
- The overall responsibility for monitoring mandatory staff training in relation to record keeping within their service in accordance with the Trust Training Matrix
- The overall responsibility for monitoring and implementation of action plans to improve quality of health records as required

**Service Leads:**

- Should ensure that all relevant staff in the service are compliant with this policy
- Should ensure that all relevant staff comply with Trust procedural documents and procedures that outline expected standards for managing the quality of health records
- Have responsibility for identifying and managing any risks in relation to record keeping standards in their service
- Their service complies with Trust record keeping audits
- Have responsibility for implementing recommended actions for the service following record keeping audits
- Should ensure that all relevant staff in the service attend mandatory training as outlined in the Trust Training Matrix

**The team leader/manager is responsible for ensuring:**

- All relevant staff in the team are compliant with this policy
- All relevant staff comply with Trust procedural documents and procedures that outline expected standards for managing the quality of health records
- Any risks in relation to record keeping standards in the service are identified and managed
- All relevant staff in teams attend mandatory training as outlined in the Trust Training Matrix their team comply with Trust record keeping audits have responsibility for implementing recommended actions following record keeping audits

**Individual Employees are responsible for:**

- Complying with this policy and Trust procedural documents that outline expected standards for record keeping
- Attending mandatory training to keep up to date with best practice
- Reporting clinical incidents and near misses
- Keeping up to date with relevant legislation relating to information governance and record keeping

**In addition clinical staff are responsible for:**

- Developing and updating personalised care plans
- Overseeing the quality of delegated care and related record keeping practice
- Demonstrating that the healthcare record is evidenced based
- Providing a copy of a personalised care plan, where appropriate
• For the safeguarding of confidential information held as paper records (in a structured filing system) and electronically (on computers and within information systems).

4.1 All staff are responsible for complying with the common law duty of confidentiality; that any personal information given or received in confidence for one purpose may not be used for a different purpose or passed on to anyone else without the consent of the individual. All staff with authorised access to clinical information have a duty to keep clinical information confidential, secure and in line with the standards and procedures as set out in this and other Trust policies; professional standards and Codes of Practice; NHS Codes of Practice and Data Protection Legislation.

4.2 Any unauthorised use of clinical information, e.g. searching for information about a friend, neighbour, relative etc. or any use of information outside of a “legitimate professional relationship” may lead to immediate disciplinary action. The Trust views any such breach of confidentiality seriously.

5. **Main policy content**

In this policy, records are defined as “a recorded document which forms part of a structured file that contains information, in any medium (including electronic, audio, visual, microfiche), created or received and maintained by the Trust in the transaction of its business or conduct of affairs and kept as evidence of such activity”.

Records management is a discipline which utilises an administrative system to direct and control the creation, version control, distribution, filing, retention, storage and disposal of records, in a way that is administratively and legally sound, whilst at the same time serving the operational needs of the Trust and preserving an appropriate historical record.

The key components of records management are:

• Creation
• Quality and accessibility
• Standards and maintenance systems
• Disclosure and information sharing
• Transfer and tracking of movements
• Storage
• Culling/reviewing, closure
• Retention
• Archiving
• Disposing

A health record, as defined in the Data Protection Act consists of “information relating to the physical or mental health or condition of an individual and has been made by or on behalf of a health professional in connection with the care of that individual”.

Under the Public Records Act 1958, the records created by governmental public bodies, which includes state education, local authority and NHS, are public records. This means that they are subject to both legal and professional obligations. They are not the property of the clinician or the team.

To ensure that consistent and appropriate policies and procedures that meet legal and moral obligations in respect of patient identifiable information, are in place and adhered to, such as:
• Caldicott Principles
• The Data Protection Act 1998
• Access to Clinical Records 1990
• Common Law Duty of Confidentiality
• Human Rights Act 1998
• Freedom of Information Act 2000

5.1 Clinical record creation and management:

5.1.1 All clinical records must comply with the standards for record keeping set out in the policy. (Links to professional body websites are provided.)

5.1.2 Diaries (paper and electronic) must not be used for recording clinical information. Any notes made during an unplanned visit, or in an emergency, must be transferred to the clinical record as soon as possible. Refer to SH IG 42 Procedure for the Management of Personal Information for further guidance.

5.1.3 The retention, archiving and destruction of clinical records will be managed via the Trust’s SH IG 13 Information Lifecycle Policy – Retention, Review & Disposal Schedule; Archiving Guidelines and Procedure.

5.2 Basic Record Keeping Standards

This section describes the organisation’s standards to ensure that information contained within the health record is correctly recorded, regularly updated, legible, factual, and easily accessible.

Health Professional Bodies also require registered staff to adhere to current professional record keeping standards as required by the following:-

• General Medical Council
• Health and Care Professions Council
• Nursing and Midwifery Council
• General Pharmaceutical Council

The important activity of making and keeping records is essential. These standards are to assist healthcare professionals to fulfil the expectations of the Trust and to promote the best interests of patients.

Health care professionals will promote respect, privacy, dignity and independence by placing the needs, wishes, preferences and decisions of people who use services at the centre of assessment, planning and delivery of care, treatment and support. This includes discussion on risks and benefits, while balancing the need for preference and choice with safety and effectiveness.

All staff must refer to and comply with the relevant Standard Operating Procedure for the system they are accessing.

Deviation from the Trust Policies and Procedures may lead to disciplinary action under HR guidance.

A percentage of clinical records will be audited during the year.
Basic Record Keeping Standards:

- Any pieces of paper must be identified with the patient’s full name and date of birth / NHS number
- The record needs to demonstrate an accurate chronology of the patient’s progress
- Completed in black ink/typed for all entries, do not use pencil, as must be readable on any photocopies
- Pharmacists may use green ink on prescription charts and scripts. All other clinicians/practitioners must use black ink
- Dated and timed, the 24 hour clock must be used. Entries should be contemporaneous i.e. made as soon as possible. If the time of recording varies significantly from the time of the contact this must also be noted.
- Accurately signed (validated) with the full name printed alongside each entry along with the designation / if electronic entries they need to be attributable to the author, including designation. When using paper records, staff must follow local procedures for signature management. When using paper records any entries provided by a non-registered professional staff member should be counter-signed by a registered professional as soon as is practicable, i.e. next working day or shift. When using OpenRIO: All staff have validation rights, including pre-registration students, as they will be working with a mentor who should be monitoring the record. All progress note entries must be validated. When entering a progress note on behalf of someone else then the originator should be selected when adding the progress note. The originator must validate the note within 24 hours. Refer to the OpenRIO SOP for details.
- Other EPRs – follow the SOP or service guidance for the system

To adhere to best practice the following should be observed:

- No use of erasers, liquid paper, or any other obliterating agents should be used to cancel errors; a single line should be used to cross out and cancel mistakes or errors and this should be signed and dated by the person who made the error. For electronic records – follow the procedure in the appropriate standard operating procedure or handbook. See Amending Inaccuracies Procedure.
- Do not include meaningless phrases and offensive subjective statements unrelated to the patient’s care and associated observations
- The use of abbreviations should be kept to a minimum, if using abbreviations; they must be written out in full at the beginning of each individual entry or can be pre printed in the footer of the documentation in use by the service. See SH IG 06 Approved Abbreviations Guidance (and the OpenRIO help screen).
- Any notes dictated and typed in records should include the name and position of the practitioner, be checked and corrected if necessary, dated and signed by the practitioner who dictated them. Letters may be reviewed by clinicians electronically using encrypted NHSmail or shared network drives with restricted access. They may then be marked “dictated and checked electronically but not signed personally to avoid delay”.
- Administrative staff may contribute to the clinical record, depending on agreed local procedures, e.g. the process for taking and recording messages. Where the record is available to the administrator, messages may be recorded, along with action taken to convey the message to the relevant clinician who is then responsible for any consequent action.

5.2.1 All sections of forms must be completed. If they are not applicable they should be struck through with a single line and marked “not applicable”. Forms on electronic systems must be completed according to the relevant standard operating procedure and/or Service Specific Guidance.
5.2.2 Pre-carbonated forms must be completed with a black ball-point pen.

5.3 **Clinical Information Standards**

Clinical Information will vary depending on clinical service provided and if relevant must:

- Include a record of initial assessment
- Include a record of any investigations and results
- Include a record of any medication prescribed, including benefits and potential side effects
- Include a record of treatment
- Include a management / care plan with goals that are specific and measurable
- Include a record of the patient’s comments and/or related expectations and goals related to their health and their perceptions of their anticipated treatment (which may influence treatment / management plan)
- Entries should be made for patients who are being cared for following every intervention (whether direct or indirect) by the health care professional and at any other time as necessary to record important facts.
- An entry per shift should be made as a minimum for patients who are being cared for in a hospital setting, to facilitate safe handover. This entry should summarise clearly the main elements of the care given and interaction with the patient over the course of that shift. If "aides memoires" are used for shift handover – these should not contain any information not already recorded in the clinical record and should be confidentially destroyed at the end of handover.

Information given to patients will vary needs according to clinical needs and can include:

- Personalised care plan / goals
- Risks and benefits of treatment and relevant options where applicable
- Information given to patient including leaflets (including source and year of production) and any other documentation
- Specific verbal advice and details of any discussion with patients /or authorised relatives and carers or representatives

Differentiation is required between information given to patients and carers and any other authorised representatives.

5.4 **Patient held records**

5.4.1 When clinical records are left in the patient’s home it is the responsibility of the member of staff leaving the record to explain to the patient (and/or their carer if appropriate) that the record is NHS property and must be kept securely and returned to the Trust on the conclusion of treatment. A brief summary should be kept at the base, and/or recorded on the appropriate electronic patient record, which should be amalgamated with the main record on conclusion of treatment.

5.4.2 Where care or treatment is likely to be delivered over a sustained period of time, it is good practice to regularly archive elements (according to defined local procedure) of the patient held record that are no longer required or relevant to the episode of care.
5.4.3 If it is considered that there is a significant risk of the health record being lost if left in the home, then the summary should be left in the patient’s home and the main record retained for secure storage at the base.

5.4.4 A Personal Child Health Record (PCHR) commonly known as the “Red Book” is issued to children at birth. Although this remains NHS property, it is kept at the family (carers) home and normally retained by the young person or family when the child becomes an adult. Relevant information will also be recorded in the electronic OpenRiO record by the Practitioner. The “Red Book” is a clinical record and can be requested at any time.

5.4.5 Social Care Patient Records: The Social Care Directorate must comply with the National Minimum Standards and Regulations for both Registered Care Homes and Domiciliary Care Services as described in the Care Standards Act 2000. Further guidance can be found in the Care Homes Regulations 2001 and the Domiciliary Care Agencies Regulations 2002.

5.5 Communicating with Service Users by e-mail

Before agreeing to communicate with the patient or their carer/s via e-mail, the risks must be discussed with them, and a disclaimer/consent signed. Any e-mail communication with the patient/carer must be either printed off and filed in the paper record / secondary care record; and/or copied and pasted into progress notes in the Primary EPR to ensure the exchange forms part of the formal documentation and correspondence, and to maintain an audit trail of communications. See Consent Form for Email or Text.

5.5.1 Communicating with Service Users by Text: Where this is agreed between the patient and practitioner, the risks must be explained, and they must sign a consent form which will be filed in the record. See Consent Form for Email Text.

5.5.2 Deceased patients: Once a patient has died, all information relating to the delivery of care prior to the death must be recorded on the record. The cause of death, if known, should also be recorded. In the event of a retrospective entry needing to be recorded, staff should raise this with their Manager, and follow local service specific guidance. Additional information may need to be recorded in the deceased patient records (e.g. bereavement follow-up) and staff should follow local service specific guidance.

5.6 Child Deaths

Staff receiving information of a child’s death should notify the Safeguarding Children’s Single Point of Contact (SPOC) on 02392 372780. Staff should follow the Safeguarding Children’s relevant policy.

Details of the death notification should be recorded into the Electronic Patient Record within 24 hours of notification. SPOC can support and give advice on any recording.

Where the death has been unexpected a Rapid Response will be supported by Southern Health Foundation Trust Safeguarding Team. The Safeguarding Children Specialist Nurse leading the Rapid response will document in the child’s Electronic Patient Record and the dates and times of attendance at the:

- Immediate Response Meeting (Phase 1)
- Scene and or Home Visit
- Interim Response Meeting (Phase 2)
- Final Case Discussion Meeting (Phase 3)
5.7 **Filing**

5.7.1 Each volume of the paper clinical record must contain the agreed index and clear instructions regarding filing of documents. Refer to the appropriate Standard Operating Procedure for details.

5.7.2 All documentation in a paper record must be hole-punched and filed chronologically, according to the index.

5.7.3 Folders with “back pockets”, or “plastic wallets” must not be used. “Post-it notes” must not be used.

5.8 **Confidentiality & Information Security**

5.8.1 All clinical information, whether created and stored as an electronic or paper record, must be kept secure. Each individual staff member is responsible for the information that is in their care and disciplinary processes will be followed if information is inappropriately accessed or lost.

5.8.2 Unavailable, mislaid or lost clinical records are a serious risk to the Trust and it is therefore vital that tracking/tracing procedures are in place and followed at all times. Refer to: SH IG 13 Information Lifecycle Policy for detail.

5.8.3 If, however, clinical records are unavailable, mislaid or lost, it is vital that appropriate action is taken to manage the potential loss of the information. Refer to: SH IG 13 Information Lifecycle Policy for detail.

5.9 **Management of Clinical Records of staff who are patients/service Users**

5.9.1 Only staff who have a legitimate professional/clinical, administrative, managerial or reporting reason or relationship with the patient are authorised to access information held by the Trust on electronic or paper clinical records. Information contained in clinical records is confidential and must be handled in line with NHS Code of Confidentiality; i.e. all client information, in whatever format, must not normally be disclosed outside of the care team without the consent of the client.

There are three exceptions to this:

- Where the relevant client has consented;
- where there is a risk of serious harm and/or disclosure is in the public interest; or
- Where there is a legal duty, for example, a court case

Unauthorised access may contravene the Computer Misuse Act 1990, the Data Protection Act 1998 and other legislation that may result in prosecution and disciplinary proceedings. Experience has shown that storing staff records separately or failing to enter data electronically increases the risk of:

- Missed contacts or appointments;
- Failure to share information appropriately;
- An adverse incident not being dealt with appropriately.

5.9.2 Therefore, all clinical staff records (electronic or paper) should be kept in line with usual practice and not be held in a different format or location.
5.9.3 Any member of staff or a relative of a member of staff who receives care from the Trust must be advised at the outset that:

a) All staff working in the Trust have a legal duty to keep information they obtain about a patient confidential. Anyone who receives information from the Trust is also under a legal duty to keep it confidential.

b) The Trust needs to keep clinical records about the care and treatment provided to individual patients. They are vital in ensuring the provision of good quality and timely care.

c) Such records will be kept manually (in the form of case notes) and/or electronically (e.g. OpenRiO).

d) Information about their care may be shared with other professionals and services on a need to know basis and consent may be required as part of this process.

Staff must only login to the Trust’s electronic patient record using their own access details and must not share their login details with anyone else. This may be via a Smartcard, and staff must comply with the Registration Authority Policy.

Staff must not login to the Trust’s electronic patient record using someone else’s login details, or make entries in the electronic patient record via someone else’s log-in or via someone else’s Smartcard.

All staff should be aware that the Trust performs comprehensive system access audit trails on a monthly basis.

Abuse of Smartcards and/or logins is a serious issue, which will result in disciplinary action which could lead to dismissal.

Refer to SH IG 18 DPA, Confidentiality and Caldicott Policy.

5.10 Patient Opt-out

Patients have the right, under Section 10 of the Data Protection Act, to request to “opt-out” of having an electronic patient record. This decision is based on clinical risk assessment, and impact on the individual.

Refer to the EPR Opt-out Procedure for detail and process.

5.11 Gender Recognition Act 2004: Records Management

Refer to Addendum 1 for record keeping/management issues with regard to Gender Recognition Act 2004. For further information regarding supporting Transgender Service Users, please refer to the Trust website for the guidance.

5.12 Access to Electronic Patient Records (EPRs)

In order to be given access to the Trust's EPR staff must be working in a role that requires access to clinical records.

Staff must have a legitimate reason for accessing an EPR. This includes:

- Recording clinical information
• Reading clinical information of clients referred to the clinician / team where there is a legitimate relationship with the client
• Reading clinical information about clients that present to the service without a referral
• Monitoring and auditing the completeness and quality of the record
• Undertaking reviews and investigations
• Providing support, assistance and guidance to staff

Any unauthorised use, for example searching for information about a friend, neighbour, relative, famous person, accessing their own record, etc, or the use of information that is not directly related to the provision of care to the client (i.e. legitimate relationship) will be referred to the Director of Operations to commission an investigation. If unauthorised use is identified this will lead to disciplinary action being taken. Findings from investigations may also be referred to the relevant professional body.

5.13 Unqualified/non-registered staff using EPRs

All unqualified or non-registered clinical staff will have access to appropriate EPRs. The quality of their entries remains the responsibility of the Lead Clinician for the service, and clinical supervision should be used to ensure that the staff member has the competence to complete clinical records.

5.14 Access to Southern Health NHS Foundation Trust (SHFT) EPRs by Non-Southern Health NHS Foundation Trust staff

For services that are provided in partnership by SHFT and non SHFT staff, approval must be given by the Caldicott Guardian / Senior Information Risk Owner via Information Governance Group.

Refer to the “Request for Access to Southern Health NHS Foundation Trust EPRs” procedure for further information.

5.15 Personal Demographic Service (PDS)

(This section will only apply to spine enabled systems. Please refer to the system Standard Operating Procedure for further information).

The PDS is a national database of personal demographic information and is also known as the National Spine. Anyone who has received any service from the NHS in England will be recorded on the PDS. It is not possible to opt-out of the PDS. A PDS record marked by a ‘sensitive flag’ will not display the client’s address and GP details.

The PDS holds the following information:

• NHS number
• Name
• Address
• Telephone number(s)
• Date of birth
• GP

The PDS does not hold any clinical information.

Demographic information can be pulled down onto an EPR from the PDS and pushed up (apart from GP information) from an EPR to the PDS.
Demographic information relating to clients must be checked regularly to ensure that it is kept up-to-date. This process is known as synchronisation. It is everyone’s responsibility to ensure that the electronic record is synchronised with the spine, whenever prompted to do so.

High quality information means better care and safety. If service user information is inaccurate, there could be consequences for care, treatment and safety, for example, there could be problems in contacting that service user to arrange a necessary appointment/meeting.

6. **Monitoring Compliance**

   To monitor compliance with the Trust’s record keeping standards the following checks will be undertaken –
   
   - Staff Access audits – undertaken by the System Support Team and reported to the Information Governance Group
   - Record Keeping audits
   - Quality and Governance reports
   - CQC Inspection reports
   - The peer review programme
   - Thematic reviews

   The Quality Programme work stream – Record Keeping & Care Planning will monitor developments, incidents and CQC report outcomes and any concerns or elevated risks will be reported to the Patient Safety Group

7. **Management of Mental Health Act Documentation**

   This is specific to patients who are subject to the Mental Health Act and the process is administered by Mental Health Act Administrators. These records are not part of the clinical record but clear standards and procedures are required in order to comply with the CQC. See **SH IG 08 Mental Health Act Documentation Procedure** for detail.

8. **Subject Access Request – Access to Records**

   Under the Data Protection Act 1998 (DPA) and the General Data Protection Regulation 2018 individuals (data subjects, staff or patients) have the right to review and receive copies of their own records. See **SH IG 12 Subject Access Requests and Disclosure of Personal Data Procedure** for details on how to manage a request.

9. **Litigation and Complaints Documentation**

   Clinical records must not contain information (inc. correspondence, reports, statements emails) relating to complaints, critical incident reviews or litigation. This includes inputting or uploading into electronic patient record systems (OpenRiO). Information relating to these processes must be maintained in a separate file, according to the Records Management Code of Practice.
10. **Training Requirements**

10.1 All clinical staff and clinical support staff as identified on the TNA (appendix 1) will be required to complete an e-assessment on record keeping principles every three years.

10.2 A programme of optional clinical record keeping training courses will be available for clinical staff, as part of their continuing professional development requirements. See Leadership, Education and Development LEaD webpage on the Trust intranet.

10.3 The completion of a record keeping self-assessment competency (appendix 3) is required by all Health Care Professionals and this should be used for discussion during each employee’s appraisal, this can also be used for revalidation evidence.

11. **Monitoring Compliance**

11.1 Compliance with this policy will be monitored by the Records and Care Planning Quality Work Stream via a programme of clinical audit.

11.2 This policy will be used to ensure compliance with:
- CQC Standards
- Information Governance Toolkit – Clinical Information Assurance criteria (400s)
- NHS Records Management – Code of Practice 2016

11.3 The process for monitoring compliance with statutory and mandatory training requirements is outlined in the Trust’s Learning and Development Policy.

12. **Policy Review**

This policy will be reviewed in three years, or earlier if necessitated as a result of changes to legislation, codes of practice or national standards.

Associated guidance, procedures and templates will be updated as required, and signed off by the Records and Care Planning Work Stream, and the Information Governance Group (as required).

13. **Associated Documents**

Please refer to the Trust website.

14. **Supporting References**

- The Public Records Act 1958
  - [http://www.nationalarchives.gov.uk/](http://www.nationalarchives.gov.uk/)
- NHS Code of Practice: Records Management 2016
- The Data Protection Act 1998
  - [https://ico.org.uk/](https://ico.org.uk/)
- Access to Health Records Act 1990
- NHS Code of Practice: Confidentiality 2003
- NHS Health & Social Care Information Centre
- Information Governance Toolkit
o https://nww.igt.hscic.gov.uk/Home.aspx
• Care Quality Commission
  o http://www.cqc.org.uk/
• Nursing & Midwifery Council
  o http://www.nmc.org.uk/
• General Medical Council
  http://www.gmc-uk.org/
• Common Law Duty of Confidentiality
• The NHS Care Record Guarantee
• Human Rights Act 1998
• Freedom of Information Act 2000
• Caldicott Principles
• Care Quality Commission
Training Needs Analysis

If there are any training implications in your policy, please complete the form below and make an appointment with the LEaD department (Louise Hartland, Quality, Governance and Compliance Manager or Sharon Gomez, Essential Training Lead on 02380 874091) before the policy goes through the Trust policy approval process.

<table>
<thead>
<tr>
<th>Training Programme</th>
<th>Frequency</th>
<th>Course Length</th>
<th>Delivery Method</th>
<th>Facilitators</th>
<th>Recording Attendance</th>
<th>Strategic &amp; Operational Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Record Keeping – The Importance of good record</td>
<td>Every 3 years</td>
<td>0.25 hour</td>
<td>e-assessment</td>
<td>Liz Bega and Clinical Trainers</td>
<td>Is recorded on staff’s LEAD record</td>
<td>Associate Directors of Nursing – lead for clinical records</td>
</tr>
<tr>
<td>Keeping</td>
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</table>

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Service</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/LD/OPMH</td>
<td>Adult Mental Health</td>
<td>All clinical staff, including administrative involved in direct care delivery</td>
</tr>
<tr>
<td></td>
<td>Specialised Services</td>
<td>All clinical staff, including administrative involved in direct care delivery</td>
</tr>
<tr>
<td></td>
<td>Learning Disabilities</td>
<td>All clinical staff, including administrative involved in direct care delivery</td>
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<tr>
<td></td>
<td>Older Persons Mental Health</td>
<td>All clinical staff, including administrative involved in direct care delivery</td>
</tr>
<tr>
<td>ISD’s</td>
<td>Adults</td>
<td>All clinical staff, including administrative involved in direct care delivery</td>
</tr>
<tr>
<td>ISD’s</td>
<td>Childrens Services</td>
<td>All clinical staff, including administrative involved in direct care delivery</td>
</tr>
<tr>
<td>Corporate</td>
<td>All</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

SH CP 221 Clinical Record Keeping Policy
Version 4
March 2018
Appendix 2: Equality Impact Assessment

The Equality Analysis is a written record that demonstrates that you have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by the Equality Act 2010.

Stage 1: Screening

<table>
<thead>
<tr>
<th>Date of assessment:</th>
<th>20/11/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person completing the assessment:</td>
<td>Liz Bega</td>
</tr>
<tr>
<td>Job title:</td>
<td>Records Manager</td>
</tr>
<tr>
<td>Responsible department:</td>
<td>Information &amp; Technology</td>
</tr>
</tbody>
</table>

| Intended equality outcomes: | |

Who was involved in the consultation of this document? | Clinical Records Leads; Associate Directors of Nursing

Please describe the positive and any potential negative impact of the policy on service users or staff.

In the case of negative impact, please indicate any measures planned to mitigate against this by completing stage 2. Supporting Information can be found be following the link: [www.legislation.gov.uk/ukpga/2010/15/contents](http://www.legislation.gov.uk/ukpga/2010/15/contents)

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Positive impact</th>
<th>Negative impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>This policy outlines the record keeping systems and processes that are in place to ensure the integrity of clinical records used to provide clinical care to patients.</td>
<td></td>
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<tr>
<td>Disability</td>
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<tr>
<td>Gender reassignment</td>
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<tr>
<td>Marriage &amp; civil partnership</td>
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<tr>
<td>Pregnancy &amp; maternity</td>
<td>No adverse or potentially adverse impacts have been assessed.</td>
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<tr>
<td>Race</td>
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<td>Religion</td>
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<tr>
<td>Sex</td>
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<tr>
<td>Sexual orientation</td>
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</table>

Stage 2: Full impact assessment

<table>
<thead>
<tr>
<th>What is the impact?</th>
<th>Mitigating actions</th>
<th>Monitoring of actions</th>
</tr>
</thead>
</table>
Appendix 3

Core Record Keeping Clinical Competencies

<table>
<thead>
<tr>
<th>Name:</th>
<th>Role:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base:</td>
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</tbody>
</table>

### Competency Statement:

The participant demonstrates clinical knowledge and skill in record keeping without assistance and/or direct supervision (level 3 - see level descriptors). Self- assessment or assessment by a Registered Clinician who demonstrates competence at level 3 or above.

<table>
<thead>
<tr>
<th>Performance Criteria</th>
<th>Assessment Method</th>
<th>Level achieved</th>
<th>Date</th>
<th>Assessor/self assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Participant will be able to demonstrate accurate, timely, relevant clinical record that facilitates the delivery of safe coordinated care that involves the patient, carer and family:</td>
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<tr>
<td>1. Standard 1: Clinical records (paper and electronic) are:</td>
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<tr>
<td>a) documented in accordance with service specific guidance</td>
<td>Observation</td>
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<tr>
<td>b) recorded in the right place, and include signposting to other documents where appropriate</td>
<td>Observation</td>
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<tr>
<td>c) concise and clear, providing accurate, relevant and appropriate information</td>
<td>Observation</td>
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<tr>
<td>d) recorded as soon as possible after an event has occurred (contemporaneous), providing current information on the care and condition of the patient</td>
<td>Observation</td>
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</tr>
<tr>
<td>e) dated and timed (24 hour clock), if the date and time differs from that of when the records are written, this must be clearly noted and explained why entered retrospectively in the record</td>
<td>Observation</td>
<td></td>
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<tr>
<td>f) able to demonstrate a full account of the assessment</td>
<td>Observation</td>
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<tr>
<td>g) able to demonstrate completion of a risk assessment and action plan(s) in place to address risk</td>
<td>Observation</td>
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<tr>
<td>h) are able to demonstrate completion of care planning and goal setting (using care pathways where appropriate) and actions taken including information shared with other health professionals</td>
<td>Observation</td>
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<tr>
<td>i) are able to demonstrate on-going evaluation and planned review of care, including the validation of electronic patient records and</td>
<td>Observation</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Performance Criteria</td>
<td>Assessment Method</td>
<td>Level achieved</td>
<td>Date</td>
<td>Assessor/self assessed</td>
</tr>
<tr>
<td>----------------------</td>
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<td>outcome all patient appointments within required timescales</td>
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<td>j) recorded, wherever possible, with the involvement of the patient/client or their carer and written in language that the patient can understand</td>
<td>Observation</td>
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<td>k) Proof read and therefore do not include jargon, meaningless phrases, irrelevant speculation or offensive subjective statements, irrelevant personal opinions regarding the patient</td>
<td>Observation</td>
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<td>l) required to use only approved abbreviations</td>
<td>Observation</td>
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<td>m) able to demonstrate corrections in paper/manual records that are clear, dated and signed; for electronic records – follow the procedure in the appropriate standard operating procedure or handbook</td>
<td>Observation</td>
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Date all elements of Competency Tool completed to level 3

Name _____________________ Signature _______________ Status __________ Date _______

I confirm that I have assessed the above named individual and can verify that he/she demonstrates competency in record keeping

Assessor _______________ Signature _______________ Status __________ Date _______

**Review Dates:**

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<th>Competent Yes / No</th>
<th>Registered Nurse Signature</th>
<th>Verifier signature</th>
<th>Comments</th>
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SH CP 221 Clinical Record Keeping Policy
Version 4
March 2018