

RECORD KEEPING GUIDELINE

Guideline Reference	G435
Version Number	1.0
Author/Lead Job Title	Lisa Davies, Head of Legal Services and Information Governance, Data Protection Officer Sam Faine, Clinical Competency Programme Manager Mel Barnard, Professional Education Lead
Date of Last Changes	19 October 2023
Date of Next Review	October 2024
Approved by: Date	Quality and Patient Safety Group 19 October 2023

VALIDITY – Guidelines should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.0	19/10/2023	<i>New guideline. Approved at Quality and Patient Safety Group (19 October 2023) and to be reviewed again in a year.</i>

Contents

1. INTRODUCTION	3
2. SCOPE	3
3. PROCEDURES.....	4
3.1. Professional Record Keeping Core Standards.....	4
3.2. Training.....	5
3.3. Audit and monitoring.....	5
4. REFERENCES/DEFINITIONS	6
5. RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES.....	6
Appendix 1 - Equality Impact Assessment (EIA) Toolkit	7

1. INTRODUCTION

Record keeping is an integral part of professional practice and informs all aspects of patient care. They are legal documents that record the intended and actual care and treatment of patients. High standards of record keeping is fundamental to the delivery of safe effective care. All individuals who work in an NHS organisation are responsible for any record that they create or use in the course of their duties. They also enable effective communication with other professional involved in a patients care. Patients have a legal right to see their medical records if they wish to (see access to Health Records Policy N-11).

Records include anything that refers to the care of the patient and records can be called as evidence as part of:

- Coroner's inquest or criminal proceedings
- Clinical negligence claims
- Safeguarding and Local Authority investigations
- Nursing and Midwifery Council Fit to Practice Committee hearings
- Humber Teaching NHS Foundation Trust's Patient Incident Investigations
- Humber Teaching NHS Foundation Trust's disciplinary investigations
- Humber Teaching NHS Foundation Trust's complaints investigations

Often a Court will request the patient's medical records. If entries are missing from the records the judge/panel members may ask the clinician to explain why they did not make appropriate records. Good record keeping shows how decisions related to patient care were made, while poor record keeping increases the risk of harm when making decisions.

Clinical information is vital to the NHS and for the delivery of high-quality evidence based care on a day-to-day basis. Clinical records are a valuable resource because of the information they contain. Such information is only usable if it is correctly recorded in the first place, regularly updated, and is easily accessible when needed.

2. SCOPE

This guideline applies to all staff who are engaged in contact and delivery of clinical 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 guidelines must be read by all employees of the Trust, both permanent and temporary, for example, bank, locum, agency, those on secondment or 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. The guidelines should be issued as part of the induction programme for all new staff.

For Registered Nurses, Midwives and Health Visitors this guidance is intended to be used alongside the NMC Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (NMC, 2018).

For Allied Health Professionals this guidance is intended to be used alongside the Health and Care Professionals Council: Standards of Conduct, Performance and Ethics (HCPC, 2016).

For Social Worker Professionals this guidance is intended to be used alongside the Professional Standards for Social Workers (Social Work England, 2019).

3. PROCEDURES

This guideline is to promote consistency in providing accurate, timely and relevant clinical records that reflect the delivery of safe and coordinated care, involving the patient, carer and family.

3.1. Professional Record Keeping Core Standards

- All Health and Social Care 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.
- All Health and Social Care Practitioners are **accountable** for ensuring that they are aware of and know how to use information systems, for example electronic patient record systems or any other clinical system used by the team in accordance with Trust policy and procedures.
- All Health and Social Care Practitioners are **accountable** for entries they make to a patient record and must ensure that all entries made are clearly identifiable and each entry must be checked for accuracy prior to signing (written or electronic) in accordance with 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 documents if required.
- Health records must be accurate and written in such a way that the meaning is clear and unambiguous (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 at the time of event or as soon as possible after an event has occurred (contemporaneous), within 24 hours. The time and date of when the event happened must be clear so there is no doubt when the event being documented occurred.
- All entries must identify any risks or problems that have arisen, and the steps taken to deal with them, so that colleagues who use the record have all the information they need.
- All Health and Social Care Practitioners must complete records accurately without any falsification, taking immediate and appropriate action if you are aware that someone has not kept to these requirements.
- Healthcare records must not include any unapproved abbreviations, jargon, meaningless phrases, irrelevant speculation, offensive subjective statements or irrelevant personal opinions regarding the patient.
- If the date and time differs from that of when the records are written, this must be clearly noted in the record, and rationale given.
- All entries must be recorded, whenever possible, with the involvement of the patient/client or their carer and written in a language that the patient can understand.

- Health records must demonstrate any risks identified and/or problems that have arisen and the actions taken to rectify them.
- Every service user must be asked for their Next Of Kin details and those details should be recorded in the patient record. If a patient refuses to provide these details this should also be recorded.
- The service user should also be asked for their consent to share information with their Next of kin or significant other, with the outcome of this being recorded in the patient record, specifying any limitations on the information they wish to share if this information is provided.
- Any corrections in healthcare records must be clear, dated and signed. For electronic records, follow the procedure in the appropriate procedure or handbook.
- Healthcare records must never be falsified.
- Healthcare 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 healthcare records must always be followed.
- Healthcare practitioners remain professionally accountable for ensuring any duties delegated to non-registered practitioners are undertaken to a reasonable standard.
- The cares 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 patient and their family, alongside a comprehensive review of the clinical record.
- Health records held on any form of media must be protected by appropriate levels of security, for example, locked record room and trolleys, and smartcard access.
- In line with the Data Protection Act and General Data Protection Regulations, care records and information concerning patients must not be left accessible, or in public places, and must not be unlawfully shared with anyone directly involved in the patient's care.

3.2. Training

The Trust's Essential Record Keeping training is currently under development and will be bookable via ESR when available.

Further bespoke Defensible Documentation / Inquest training is available from the Legal Team and is bookable by direct request to the team.

3.3. Audit and monitoring

Record keeping audits will be undertaken by each team/service. The standard is a minimum of 5 audits per month per team. If teams/services are small or have few patients on the caseload, then the standard of 5 may not apply however this will be through prior agreement at the relevant Clinical Network Group.

A quarterly record keeping audit report is presented to the Quality and Patient Safety group (QPAS) each quarter.

4. REFERENCES/DEFINITIONS

Data Protection Act (2018)

[Data protection: The Data Protection Act - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/legislation/the-data-protection-act-2018)

General Data Protection Regulations (2018)

[General Data Protection Regulation \(GDPR\) Compliance Guidelines](https://www.gov.uk/government/guidance/general-data-protection-regulation-gdpr-compliance-guidelines)

HCPC (2016) Standards of Conduct, Performance and Ethics

[Standards of conduct, performance and ethics | \(hcpc-uk.org\)](https://www.hcpc-uk.org/standards-of-conduct-performance-and-ethics)

NMC (2018) The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates

[The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council \(nmc.org.uk\)](https://www.nmc.org.uk/standards-of-practice-and-behaviour-for-nurses-midwives-and-nursing-associates)

Social Work England (2019) Professional Standards for Social Workers

[Professional standards - Social Work England](https://www.socialworkengland.org/professional-standards)

5. RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

[Access to Healthcare Records Policy \(N-011\)](#)

[Managing Health Records for Transgender Patients \(SOP22-022\)](#)

[Caldicott and Data Protection Policy \(N-027\)](#)

[Confidentiality Code of Conduct \(N-061\)](#)

[Data Quality Policy \(F-021\)](#)

[Electronic Communications and Internet Acceptable Use Procedure \(Proc451\)](#)

[Information Governance Policy \(N-008\)](#)

[Records Management and Information Lifecycle Policy \(N-044\)](#)

[Safe Haven Procedure \(Proc452\)](#)

Appendix 1 - Equality Impact Assessment (EIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Record Keeping Guideline**
2. EIA Reviewer (name, job title, base and contact details): **Mel Barnard - Professional Education Lead**
3. Is it a **Policy**, Strategy, Procedure, Process, Tender, Service or Other? - **Guideline**

Main Aims of the Document, Process or Service		
To set out the requirements that must be met for approval, ratification and dissemination of all Humber Teaching FT policies.		
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma		
Equality Target Group 1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern (Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? 1. who have you consulted with 2. what have they said 3. what information or data have you used 4. where are the gaps in your analysis

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people, Young people, Children, Early years	Low	These guidelines are consistent regardless of age
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory, Physical, Learning, Mental Health (and including cancer, HIV, multiple sclerosis)	Low	These guidelines are consistent regardless of disability
Sex	Men/Male, Women/Female	Low	These guidelines are consistent regardless of chosen identity
Married/Civil Partnership		Low	These guidelines are consistent regardless of legal status
Pregnancy/ Maternity		Low	
Race	Colour, Nationality, Ethnic/national origins	Low	These guidelines are consistent regardless of ethnic origins
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	These guidelines are consistent regardless of religion or beliefs
Sexual Orientation	Lesbian, Gay Men, Bisexual	Low	These guidelines are consistent regardless of age
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	These guidelines are consistent regardless of patients gender identity

Summary

<i>Please describe the main points/actions arising from your assessment that supports your decision above</i>			
All patient records should be treated in the same way regardless of any protected characteristics			
EIA Reviewer	Melanie Barnard		
Date completed;	11/10/2023	Signature	M.J. Barnard