University Hospitals of Leicester NHS
NHS Trust

Patient Health Records - Documenting UHL Policy

*previously called 'clinical records'

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

Review March 2023:
This policy has undergone a full review with the addition of changes to the audit process in section 5 and to supporting reference documentation updated.

Review March 2024:
This policy has undergone a full multidisciplinary review, specific references to nursing or medical documentation have been replaced with inclusive statements that relate to any healthcare professional contributing to the health record. The Trust is quickly moving to an Electronic Patient Record, therefore considerations and procedures related to this method of information capture have been included. Details of the required Nursing documentation have been removed as this information only pertained to a select professional group and only to the inpatient cohort. Readers have been directed to local policy to guide them to the documentation requirements.

It is recommended this policy is reviewed in one year, due to the rapid evolution of the electronic patient record and documentation requirements.

INTRODUCTION

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

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

1.3 Guidelines and best practice principles have been published by several professional bodies, including but not limited to the General Medical Council (GMC), Nursing and Midwifery Council (NMC), Chartered Society of Physiotherapy (CSP), Health Care Professions Council.

1.4 A good standard of record keeping is both a legal and professional requirement essential to the delivery of high-quality care and effective risk management.

1.5 Patients' health records have historically been paper based, however the Trust is in the process of deploying an Electronic Patient Record using Nervecentre which will eventually become the main repository of information for UHL patients' health records. Other electronic systems currently in use within the Trust include Euroking E3 (Maternity) Badgernet (Neonates); ORMIS (Theatres); Proton (Renal); CITO Document Management Store; Medisoft (Ophthalmology); Clinical Workstation (Medicine), TIARA for allied health professionals.

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

1.7 Business Continuity for digital patient records in the event of system downtime is to revert to paper version. Business Continuity boxes are available on all wards.

1.8 It is the responsibility of the Manager in Charge of the clinical area to ensure that the Business continuity box is maintained with sufficient quantities of appropriate paper documentation.

2 POLICY AIMS / STATEMENT OF INTENT

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

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

3 POLICY SCOPE

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

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

4 DEFINITIONS

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

4.2 A **paper health record** is commonly referred to as 'case notes'.

NB: Paper copies of this document may not be most recent version. The definitive version is held on the Trust intranet

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

5 ROLES AND RESPONSIBILITIES

5.1 Executive Responsibilities

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

The Medical Director will, in addition be responsible for overseeing the level of compliance by medical staff with the standards in this Policy and for referring any areas of concern to the relevant Clinical Management Group (CMG) Director for action.

5.1.2 **The Chief Nurse**, is responsible for overseeing the level of compliance by nursing, midwifery and allied health professional staff with the standards in this Policy and for referring any areas of concern to the relevant CMG Heads of Nursing or professional leads for action.

5.2 CMG Managers, Directors, Heads of Nursing, Clinical Leads, Heads of Profession responsibilities:

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

5.2.2 Reviewing results of the documentation audit for their CMG

5.3 CMG Medical, Nursing and Clinical Leads responsibilities:

5.3.1 Supporting the CMG Leads/Heads of Service, Managers with the dissemination of these policy standards to all staff within their CMG

5.3.2 Identifying a documentation audit lead for the CMG

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

5.4 CMG Documentation Audit Leads responsibilities

5.4.1 Co-ordinating, in collaboration with the Clinical Audit team, the annual audit of this policy within their CMG.

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

5.5 All Staff responsibilities

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

5.5.2 Identifying any training needs with their line manager

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

5.6.1 Setting Standards and Challenging Poor Practice to include:

a) Setting a good example with their own documentation
b) Making staff in their clinical area aware of the importance of good documentation
c) Providing access to training opportunities as identified through the appraisal process and staff's Personal Development Plans
d) Taking action where staff's practice does not meet the standards set in this policy.
e) Ensuring objectives to improve record keeping are written into annual appraisal personal development plan and monitored accordingly

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

5.6.3 **Clinical IT Facilitator Team** to audit Business Continuity Box compliance and feedback results

to CMG Managers, Directors and Heads of Nursing.

6 EDUCATION AND TRAINING REQUIREMENTS

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

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

7 POLICY STATEMENTS AND PROCEDURES

7.1 General Documentation Standards for both electronic and paper clinical records

7.1.1 Legibility and Readability

a) All entries must be legible

b) All handwritten entries must be in black ink.
   - Red ink can be used for operation/procedure notes and for emergency operations/procedures recorded in the theatre register
   - Pharmacists can use green ink on paper prescription charts

c) All entries must be concise and easy to understand

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

e) Electronic corrections will be captured as part of the systems audit trail, some systems may require additional IT or system administrator input to enable a correction and users should escalate this need to IT via the service desk.

f) Within electronic clinical records in Nervecentre, the strike out/clear option should be used

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

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

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

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

7.1.2 **Identification Data** (patient and staff)

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

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

c) Student entries must be countersigned by a registered practitioner within the same

shift period that the entry is made.

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

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

f) Electronic records where required, have the ability to apply alerts- see user guide on the Trust intranet.

g) Staff should only access electronic clinical records using their own personal account credentials. Sharing of account passwords and data entry in another user's name are against Trust policy and National IT governance guidelines.

7.2 Clinical Content

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

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

b) The patient's health record should enable multi-disciplinary team to communicate effectively.

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

a) To include use of appropriate assessment proformas as appropriate for the patient's condition (for example VTE, Falls, Nutrition, Pressure Ulcers, Physio, OT, SALT, Dietetics etc)

b) Symptoms causing admission / Working Diagnosis

c) Investigations requested and reviewed.

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

7.2.2 Plan of Care

a) Review and confirmation of diagnosis and plan

b) Treatment options and investigations agreed.

c) Agreed clinical plans of care and goals and relevant consent obtained (see UHL Consent Policy for further information and advice Trust Reference A16/2002)

7.2.3 Delivery of Care

a) Medicines prescribed and administered (see Leicestershire Medicine Code on PAGL and/or available through the LLR APC)

b) Investigations carried out.

c) Operations and/or interventions carried out.

d) Anaesthesia given, where applicable

e) Care delivered by all members of the multidisciplinary team.

7.2.4 Review

a) Review and record investigation results together with actions taken.

b) Evaluation of care and response to treatment

c) Further care plan drawn up, where applicable

d) Review of EDD and discharge plans as applicable

e) Allergies, diagnosis, operations and procedures should be SNOMED coded and recorded in the appropriate EPR fields.

7.2.5 Delegated Documentation

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

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

7.2.6 Documentation requirements

a) Required and expected documentation varies across disciplines, professions, and patient episode type. Local policies and procedures should be referred to.

7.3 Communication between staff and patients

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

a) Between members of the multidisciplinary team

b) With the patient

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

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

7.4 Transfer of Care / Discharge

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

a) Discharge Planning template

b) Medical Discharge Letter

c) Follow up arrangements.

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

e) District Nurse Referral Letter (where appropriate)

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

7.5 Continuing Healthcare Needs (in Adult Patients)

a) All patients with on-going healthcare needs following discharge should have a Continuing Health Care Checklist completed.

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

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

8 EQUALITY IMPACT ASSESSMENT

8.1 As part of its development, this policy and its impact on equality have been reviewed

and no detriment was identified.

9 PROCESS FOR MONITORING COMPLIANCE

9.1 Audit Frequency

Responsibility for auditing compliance with this policy lies with CMG Triumvirate and identified CMG Audit Leads, using Quality and Safety data received e.g., Datix summary reports, Serious Incident reports, Nursing Quality Metrics, Deteriorating Patient Dashboard and as an element of other audits.

Remedial action plans developed to address any areas of non-compliance should be presented to and monitored by CMG Quality and Safety Boards.

10 DEVELOPMENT AND CONSULTATION PROCESS

This policy has been reviewed and revised with input from Nursing, Medical, AHP and administrative staff.

It has been circulated to all CMG medical, nursing and AHP leads for comments.

11 DOCUMENT CONTROL, ARCHIVING AND REVIEW OF THE DOCUMENT

This policy will be stored and archived through UHL Trust intranet Documents

This policy will be reviewed yearly or sooner in response to clinical need.

12. EVIDENCE BASE AND RELATED POLCIES

Sources usedto Inform the Documentation Policy

NHSLA Risk Management Standards 2013-14- Standard 1.7 Health Records management 4.2

Royal College of Physicians – Generic medical record-keeping standards RCP London (2015)

Nursing and Midwifery Council – (2018) The Code: Professional Standards of Practice and behaviour for Nurses, Midwives and Nursing Associates.

Healthcare Safety Investigation Branch (HSIB) (2021)

General Medical Council – Keeping Records-ethical guidance summary- GMC

Royal College of Physicians– Standards for the clinical structure and content of patient records

British Dietetic Association- professional guidance- Record Keeping

Health Care Professions Council HCPC (2016) Standards of conduct, performance and ethics: 10 Record keeping.

British Psychological Society- Practice Guidelines (2017) 7-Managing data and confidentiality

The Leicestershire Medicines Code

APPENDIX 1a POLICY TEMPLATE (leicestershospitals.nhs.uk)

Discharge and Transfer of care Policy (Going Home Policy) for adults leaving hospital V8 B2/2003 updated 2023

CQC Guidance (2023) Regulation 17: Good governance

Records Management Code of Practice –A guide to the management of health and care records (2023)

Consent to Examination or Treatment UHL Policy ref A16/2002 updated (2022)

Health Records management Policy V7 B31/2005 updated (2023)