Policy Document Control Sheet

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Title	Clinical Record Keeping & Healthcare Records Management Policy						
Version number	3.5						
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	Trust-wide Guideline		Local Guideline				
Originating Directorate or Care Group	Corporate Nursing and Health Records						
Department	Clinical Standards and Health Records						
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Executive Sponsor's Signature	
Name & Job title of Executive Sponsor	Jeremy Cundall, Executive Medical Director
Master copy held at:	Corporate Records Office, Trust Headquarters, Darlington Memorial Hospital

Version Control Table

Date Ratified	Version Number	Status
12/03/2013	1.0	Superseded
09/04/2013	1.1	Superseded
18/10/2016	2.0	Superseded
11/05/2017	2.1	Superseded
20/11/2018	3.5	Approved

Table of Revisions

Date	Section	Revision	Author
12/03/2013	All	Version 1.0 of this policy is a new policy that replaces the old Clinical Record Keeping Policy V5 and the Health Records Keeping Policy V6.3	Paul Fish Mark Herkes Nichola Stefanou
09/04/2013	9	Standards for record keeping – additional bullet point added: • For digitally dictated documents managed by the DictateIT system, the authorisation will consist of a printed identification on the document supported by the systems audit trail.	Julie Race Nick Black
23/06/2016	All	Full review of policy and transfer to new format.	Mark Herkes Julie Race
11/05/2017	5.1	New wording of bullet point to read: • All entries will be made in black indelible ink	Mark Herkes Julie Race
18/10/18	All	Review re CQC finding G44. Review re General Data Protection Regulation.	Associate Director of Nursing & Head of Health Records

Contents

1 Introduction

This policy will outline the intended principles and practice of all health records practice. In particular the policy will outline:

1. Principles
2. Creation
3. Content
4. Standards for record keeping
5. Storage, Retrieval, Transfer, Retention & Destruction

2 Purpose

The purpose of this policy is to ensure all staff comply with the secure management of all trust clinical records and outlines the process of health record management from creation to destruction, the content of the record and standards for record keeping.

This policy also applies to persons who, although not employed by The Trust, have authorised access to computers owned or managed by The Trust. This includes staff working for County Durham and Darlington NHS Services (CDD NHS Services).

3 Scope

This policy covers all aspects of clinical record keeping and the management of clinical records across County Durham and Darlington NHS Foundation Trust (CDDFT). It applies to all staff that handle and input into the clinical records and includes allied health professionals, nurses, doctors and persons who, although not employed by The Trust, have authorised access to clinical records.

This policy is the overarching policy for all CDDFT Records and must be complied with at all times. Each service must have a local procedure for the management of the records held by the service.
This policy applies to all staff that create, access, update or destroy clinical records.

The General Data Protection Regulation (GDPR) defines 'Data concerning health' in Article 4 (15) as:

'*data concerning health' means personal data related to the physical or mental health of a natural person, including the provision of health care services, which reveal information about his or her health status;*

A clinical record can be electronic and/or paper based.

4 Definitions

ECS	Electronic Clinical Systems
GDPR	General Data Protection Regulations
IQAC	Integrated Quality Assurance Committee
SAR	Subject Access Record

5 Duties

Chief Executive
The Chief Executive is ultimately responsible for ensuring that there are effective corporate governance mechanisms in the organisation. They have overall accountability for the management of records within the trust.

Integrated Quality Assurance Committee (IQAC)
This will be the approving body for this policy. IQAC will seek assurance about the implementation of this policy on an annual basis.

Clinical Standards & Therapeutics Committee & Data Security and Protection Committee
These groups will be the reviewing bodies for this policy and jointly share responsibility for the approval of the content of the clinical record.

Staff working in a leadership role
Staff working in a leadership role are responsible for ensuring that the content of this policy is implemented at individual and team level. This will include giving 1-1 feedback about performance where colleagues are failing to follow the principles described here.

Clinical & Administrative Staff
All staff have a legal duty of care and are responsible for any records (both paper and electronic) they may create or use. Health care professionals also have a duty to comply with the standards of their regulatory body. This responsibility is established and defined by the law. Safeguarding confidentiality of records is detailed in the GDPR and data protection act (2018) and an individual's responsibility to information governance is highlighted in the trusts data security and protection policy documentation.

6 Clinical Record Keeping

It is a requirement of good professional practice that accurate and contemporaneous records are maintained about patient care. These standards are detailed in:

- Caldicott Report (2013)
- Human Rights Act (1998)
- Good Medical Practice (2013, updated 2014):Working with doctors Working for patients, GMC
- General Data Protection Regulation (GDPR)
- The Data Protection Act 2018

- Professional Standards for Occupational Therapy Practice, College of Occupational Therapists, (2011)
- Guidelines on Patient Records, The Society of Podiatrists & chiropodists, (2004)
- Chartered Society of Physiotherapy, Standards of Practice (2005)
- Guidelines for Records & Record Keeping, NMC (2005)
- Department of Health (2006): Good Doctors, Safer Patients
- Generic Medical Record Keeping Standards, RCP (2009)
- The Mental Capacity Act (2005)
- Access to Health Records Act (1990)

All staff who are involved in the creation, management or use of clinical records must, at all times, ensure that the content of the record is treated with the strictest confidentiality. They must never discuss the content of a clinical record with another person that is not directly involved in the care of the patient unless legally required to do so.

Basic Record Keeping Standards

- All entries will be legible
- All entries will be made in black indelible ink
- All entries will be written clearly
- Entries will be signed, dated and timed using 24 hour clock
- The professionals name will either be printed alongside the first entry in the record or printed on an authorised signatory sheet at the front of the clinical record.
- Any alterations must be scored through with a single line, dated, timed (using the 24 hour clock) and initialed so that the initial entry can still be read clearly.
- Should be a contemporaneous, consecutive account of the patients journey and pathway of care
- Where an entry is being made into an electronic clinical system (ECS) the entry should be made before the end of that period of duty.
- An entry should be updated in the patient records as soon as possible after each contact or intervention

Best Practice Record Keeping Standards

- Be written, where possible, with the involvement of the patient or client or their carer. This includes details of any information communicated to the patient's family and/or carer.
- Use terminology that supports clinical process but is explained to the patient or client in terms they can understand
- All abbreviations must be medically and internationally accepted.
- The record must not include jargon, meaningless phrases, irrelevant speculation and offensive subjective statements

They should include;

- Relevant clinical findings
- The decisions made and actions agreed, and who is making the decisions and agreeing the actions
- Any drugs prescribed or other investigation or treatment

Professional Requirement

Students will have all entries they make into the clinical record countersigned by a registered healthcare professional in compliance with their regulatory body

Digitally Dictated Documents

For digitally dictated documents managed by the Trust Dictation system, the document printed has the author's identification on it and this can be tracked electronically.

Digital Records

Not all records in CDDFT are stored in a paper format during an inpatient episode. Some of these are stored within Clinical Systems (including, but not limited to Nervecentre and iCM).

The standards for these records remain the same as found in section 6.1 & 6.2 set out earlier in the policy, with the additions that:

- Staff must only update records when logged into systems under their own credentials (username/password);
- Locum/agency staff must follow CDDFT processes to access these records which keeps an audit trail of their personal information for traceability purposes;

7. Records Management

7.1 Record Creation

All records used within County Durham and Darlington NHS Foundation Trust need to be created in line with this policy and the locally agreed departmental procedure for the creation of records. This applies to both paper based and electronic records.

7.2 Record Storage

All paper and electronic records must be stored in accordance with the County Durham and Darlington Foundation Trust Corporate Records Management Policy and comply with Data Protection legislation.

If records need to be scanned for storage or archiving purposes this must be completed in accordance with the County Durham and Darlington Foundation Trust scanning procedure.

Contemporaneous records relevant to the current admission may be accessed by the patient. As a reminder ensure the records consist of factual, relevant and proportionate information.

Staff should ensure they do everything to protect the sensitive personal information whilst the patient is in their care.

In ward settings, the live, contemporaneous component of the clinical record is currently held in both apaper and digital systems. All paper based records should be stored at the end of the patient's bed for inpatient bed areas. This should be discussed with the patient and their agreement noted in the nurse admission documentation. However, there are some caveats/exceptions to this:

- Where the patient **has capacity** and the patient does not want any third party to look at their case notes, store this information in a secure notes trolleys at Nurses stations .

  In these cases staff must complete the **consent form (attached in appendix 1)** and store this in the contemporaneous record.

- Use of secure notes trolleys for storage of case notes also applies to **paediatrics**, patients who **lack capacity** and where other organisations e.g. TEWV input sensitive information into the contemporaneous notes. At present TEWV only add a brief summary and not the full details which, could have an impact on the clinical care of the patient.

- Where a patient has capacity but the clinician deems the information to be particulary sensitive and in the patients best interest (ie safeguarding issues) the contemporaneous notes with sensitive information must be stored in a notes trolley.

All notes trolleys must be secured, this is ensuring locks and / or covers are in place at all times and the trolley is stored at the Nurses station, not in any corridors.

Observation sheets (ie vital signs, fluid balance) can be kept at the end of beds.

The Trust need to assess the associated risks and justify a balance based on security of personal infromation and any clinical risks therefore, local procedures at ward level are required to comply with the policy if deemed necessary to trace the whereabouts of a patients contemperaneous record. See 7.3 below.

Whereby patient records are held within a clinical system this will be locked to only be available to those with appropriate rights to see the information. Clinial data will be available at the bedside by using either mobile devices or computers (depending upn the system).

A consistent approach across the Trust must be implemented; this will assist in reducing incidents, risks, and ensure all staff wherever they come into contact with contemporaneous notes, comply with the Trust policy.

This must be reviewed on a six monthly basis by the Information Asset Owners within each area. Compliance reports must be sent to the Senior Information Asset Owners to report into the Data Security and Protection Committee.

7.3 Record Tracking

At any point in time CDDFT must know the location of all of its records to respond to day to day service requests, this includes all contemporaneous records.

Each department should ensure that their agreed departmental procedure for tracking clinical records is followed at all times.

7.4 Record Transfer

Any transfer of clinical records from one department or team to another should be completed in line with the CDDFT Transfer of Personal Identifiable Information Policy.

7.5 Record Retention

Retention is the requirement of the organisation to store clinical records for a specified period of time following its last use, before destruction of the record can be undertaken. This is in accordance with the department of health's guidelines.

The Department of Health and social care retention guidelines are published by the Information Governance Alliance and are available from Records Management: Code of Practice for Health and Social Care 2016.

7.6 Record Disposal

Disposal involves the permanent deletion of the paper or electronic patient record. All staff must ensure the agreed departmental procedure is followed when any records are being destroyed.

All documentation and information which contains or may contain content pertaining directly or indirectly to the sexual abuse of children or to child protection and care needs to be retained in its original form until the Independent Inquiry into Child Sexual Abuse has concluded.

7.7 Access to Historical Clinical Records

Patients may request access to their care records. In these circumstances the agreed Subject Access Request (SAR) process must be followed.

8 Record Content

8.1 Content of the Clinical Record

As a minimum, the content of the patient's clinical record should contain the following components.

- NHS Number
- Name
- Date of Birth
- Address
- Contact details
- Next of Kin
- Sex
- A detailed account of the patients assessment

- A diagnosis and details of identified care requirements
- A treatment plan and care plan
- Appropriate risk assessment's
- Consent for treatment forms where appropriate
- A comprehensive discharge plan & medical discharge summary
- Evidence of a comprehensive medicines assessment

8.2 Approval of documentation to be filed in Clinical Record

Prior to submission to the Data Security and Protection Committee for final ratification all documentation for inclusion within the Clinical Record must be approved for use by the Clinical Standards & Therapeutics committee.

All paper based documentation will be registered and numbered; only these documents can be used within CDDFT.

9 Monitoring

9.1 Compliance and Effectiveness Monitoring

Compliance with this policy will be monitored as outlined in the table below.

9.2 Compliance and Effectiveness Monitoring Table

Monitoring Criterion	
Who will perform the monitoring?	Ward Teams/Care Groups will perform Quality Matters audits.
What are you monitoring?	That there is an accurate and legible clinical record for every patient/user, which provides a factual, consistent and chronological account of the patient/user's care. The record content enables the patient to receive effective continuing care and to be identified without risk or error. It enables the health care team to communicate effectively, facilitates the collection of data for research, education and audit, and can be used in legal proceedings. The criteria apply to paper and electronic records.
When will the monitoring be performed?	At least quarterly.
How are you going to monitor?	An audit of the clinical records as per the Quality Matters audit schedule.
What will happen if any shortfalls are identified?	Ward managers, designated service leads, Matrons and medical staff will be responsible for developing and implementing an action plan to address shortfalls.
Where will the results of the monitoring be reported?	Integrated Quality Assurance Committee Integrated performance reports Care Group Governance meetings

	Senior Nurse Leader meetings Staff meetings
How will the resulting action plan be progressed and monitored?	Improvement plans will be monitored: Within the clinical teams Care Group governance meetings Integrated Quality Assurance Committee
How will learning take place?	Outcomes will be shared via: Senior Nurse Meetings, Nurse Leader Away Days & Care Group Governance Meetings. Any Trust wide key messages will be disseminated by the Integrated Quality Assurance Committee and any other appropriate meetings

10 Associated Documentation

This policy refers to the following CDDFT Trust policies and procedures:

- Data Protection Policy (POL/HI/0005)
- Corporate Records Management Procedure (PROC/CA/0003)
- Scanning Procedure (PROC/IG/0030)
- Transfer of Personal Identifiable Information Policy (POL/HI/0029)
- Information Risk Management Procedure (PROC/HI/0028)
- Confidential Waste Policy (POL/HI/0015)
- Moving Non Electronic Records Policy (POL/FM/0007)

This policy is referenced from the following CDDFT Trust policies and procedures:

- Discharge and Going Home Policy (POL/NG/0005A)
- Subject Access Request Procedure (PROC/HI/0003)
- Clinical Audit and Effectiveness Policy (POL/NQ/0025)
- Safe Haven Procedure (PROC/HI/0002)

11 References

- Audit Commission. (1995). Setting the Records Straight: A Study of Hospital Medical Records
- Audit Commission. (1999). Setting the Record Straight: A Review of Progress in Health Records Services
- Data Protection Act 2018
- Department of Health. (2003). Improvement, Expansion and Reform: The Next 3 Years. Priorities and Planning Framework 2003-2006. London: Department of Health.
- Department of Health. (2003). Delivering the HR in the NHS Plan 2003. London: Department of Health.
- Department of Health. (2001). Assuring the Quality of Medical Practice. Implementing Supporting Doctors, Protecting Patients. London: Department of Health.

- Department of Health. (2010). The Essence of Care. Patient-Focused Benchmarking for Health Care Practitioners. London: Department of Health.
- Department of Health. (2000). An Organisation with a Memory. Report of an Expert Group on Learning from Adverse Events in the NHS. London: Department of Health.
- Department of Health. (2000). Harold Shipman's Clinical Practice 1974 - 1998 A Clinical Audit Commissioned by the Chief Medical Officer. London: Department of Health.
- General Data Protection Regulation (GDPR) - Article 4 (15)
- Information Governance Alliance (2016). Records Management Code of Practice for Health and Social Care.
- NHS Executive. (1999). Quality and Performance in the NHS: Clinical Indicators. London: Department of Health.
- NHS Executive. (1998). Information for Health. An Information Strategy for the Modern NHS. 1998-2005. London: Department of Health.
- Nursing and Midwifery Council. (2009). Guidelines for Records and Record Keeping. NMC.
- Department of Health. (2002). Command paper CM 5363. London: The Stationery Office. Learning from Bristol: the Department of Health's Response to the Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995.
- Nursing and Midwifery Council. (2004). Nursing and Midwifery Council: the Nursing And Midwifery Code Of Conduct: Standards For Conduct, Performance And Ethics. NMC
- Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. London: RCOG Press. Available at: www.rcog.org.uk
- Health & Care Professions Council (2012) Standards of Performance, Conduct and Ethics. HCPCList any relevant legislation and other sources referred to.

12 Appendices

Appendix 1 – Consent for Accessing Contemporaneous Records
Appendix 2 – Equality Impact Assessment

12.1 Appendix 1 – Consent for accessing contemporaneous records.

Consent form for storage of contemporaneous records in notes trolley

(Attach Patient ID Sticker)

Full Patient Name		**DOB:**
NHS Number		
Ward number:		**Date:**

Complete where notes will be stored in secure notes trolley at nurses station at patients request.

I understand that my health records whilst I am on the ward may be stored at the end of my bed.

There is information within these notes I do not want anyone other than the healthcare professionals accessing and **request the notes are stored in the ward secure notes trolley at the Nurses station.**

Patient Signed:

Nurse Print name and signature:

Date:

12.2 Appendix 2 - Equality Analysis/Impact Assessment (v4/2018)

Division/Department:	Corporate Nursing and Health Records
Title of policy, procedure, decision, project, function or service:	Clinical Record Keeping & Healthcare Records Management Policy
Lead person responsible:	Associate Director of Nursing and Head of Health Records
People involved with completing this:	Associate Director of Nursing Head of Health Records Head of Data Security and Protection & Trust Data Protection Officer

Type of policy, procedure, decision, project, function or service:

Existing	☒
New/proposed	☐
Changed	☐

Date Completed:	30/08/2018

Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

The purpose of the Clinical Record Keeping & Healthcare Records Management Policy is to ensure that the Trust complies with the guidelines set out relating to the management of health records and the clinical entries into records.

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Service users to ensure that the records are managed and recorded to support patient care.

What barriers are there to achieving these outcomes?

Compliance with the policy and practice currently in place.

How will you put your policy, procedure, project, decision, function or service into practice?

Introduction of the policy to the Trust with email update when approved in the organisation. Audits completed by Care Group leads will monitor the compliance with the policy.

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

N/A

Step 2 – Collecting your information

What existing information / data do you have?

None

Who have you consulted with?

Clinical Standards and Therapeutics Committee Health Records Steering Group Information Governance Steering Group

What are the gaps and how do you plan to collect what is missing?

No gaps were identified

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

No impact identified

Sex/Gender

No impact identified

Age

No impact identified

Disability

No impact identified

Religion or Belief

No impact identified

Sexual Orientation

No impact identified

Marriage and Civil Partnership (applies to workforce issues only)

No impact identified

Pregnancy and Maternity

No impact identified

Gender Reassignment

No impact identified

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills etc.

No impact identified

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

None identified

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?

Yes ☐ **No** ☒

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

Recommendation from auditors and consultation with the Clinical Standards and Therapeutics Committee and & Data Security and Protection Committee

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

The Policy will be reviewed every 3 years in line with the trust policy for policies guidelines and the standards within the policy will be monitored according to the monitoring table within the policy.