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PORTSMOUTH HOSPITALS NHS TRUST

DRAFT 1 August 03

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Originator: Record Keeping Working Party

Approved by:

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1. **Item:**
   Policy for the completion and management of health care records at ward/departmental level

2. **Policy statement**

   Health care records are required to provide a basis for the assessment, planning and delivery of clinical care. Poor record keeping undermines patient care, makes health care professional vulnerable to legal and professional problems and has the potential to increase workloads for clinical and support staff. Record keeping is a tool of professional practice, which assists in the delivery of a high standard of care and is not an optional extra to be fitted in when time allows. Variation in the quality of record keeping in unacceptable. This policy will clearly describe the roles and responsibilities of clinical and non-clinical staff in the maintenance of adequate health care records.

3. **Scope**

   This policy with associated guidelines and protocols, applies to all Portsmouth Hospitals NHS Trust staff involved in:
   - the completion of health care records
   - the management of records at ward/departmental level

   This includes, but is not exclusive to, doctors, nurses and midwives, pharmacists, radiographers and ward clerks.

4. **Core policy**

   Effective record keeping underpins the delivery of a high standard of care. Adequate and appropriate completion of health care records is essential. The following principles must be applied.

   Health care records must:
   - Prompt the delivery of high quality health care
   - Be consecutive, following a logical and methodical sequence with clear milestones and goals
   - Be factual, consistent and accurate
   - Written clearly and legibly, in a manner that cannot be erased
   - Have all entries timed, dated and signed, with the full name and job title of the person entering the details against the first entry
   - Completed as soon after the event/intervention as possible, providing information on the care and condition of the patient
   - Only include agreed abbreviations as per appendix
   - Not include jargon, speculative statements or offensive subjective statement
   - Be written wherever possible with the full involvement of the patient
   - Be written in term the patient can understand
   - Identify clinical problems, deviations from an agreed plan of care and the actions taken to resolve them
   - Provide clear evidence of
     - The clinical care planned
     - The decisions made with times of decisions recorded

- The care delivered
- The information shared with the patient and other health care professionals

- Be maintained in such a way that information is available to inform clinical decision making (i.e. include recent results, referrals and reports from visiting health care professionals

5. Definitions

Health care record	A record related to the health of an individual which has been made by or on behalf of a health care professional in connection with the care of that individual

6. Forums for discussion

Record Keeping Working Party
Sub-group of the clinical governance committee
Nursing Documentation Group
Surgical Divisions Clinical Governance and Quality Group

7. Education and training

Education and training related to completion and management of health care records will specific to professional and staff groups, and identified in associated guidelines and protocols

8. Audit

Audit related to completion and management of health care records will be undertaken

a) as part of the CNST standards assessment managed by the Controls Assurance manager
b) be profession/staff group specific and identified in the associated guidelines and protocols to this core policy

9. Risk Management

Effective overall management of health care records contributes to the reduction of risk to patients by providing evidence of care planned and delivered as well as meeting legal requirements.

10. Associated documentation

NMC (a) Guidelines for records and record keeping (2002) Nursing and Midwifery Council
NMC (b)Code of professional conduct (2002) Nursing and Midwifery Council

PROTOCOL FOR THE COMPLETION AND MANAGEMENT OF HEALTH CARE RECORDS BY REGISTERED NURSES AND NURSING STAFF.

Protocol:

ACTION	RATIONALE	EVIDENCE
All entries will be legible and completed in blue or black ink	To ensure easily read and can be photocopied	NMC 2002 (a)
All entries will be a factual accurate record of event or intervention	To provide facts to inform clinical decision making	NMC 2002 (a)
All entries will be completed as soon after event as possible. (Minimum requirement is prior to handing over care to another nurse or health care professional)	To ensure timely availability of clinical information related to nursing care	NMC 2002 (a)
All entries will dated, timed and signed with full name and job title printed next to first entry . Any alterations or additions will be dated, timed and signed so that the original entry is still clear.	To ensure time of intervention/recording is available and nurses can be identified	NMC 2002 (a)
Entries by non Registered Practitioners (e.g. health care support workers, student nurses) must be countersigned by RN responsible for care of the patient	RNs are professionally accountable for ensuring that any duties delegated to a member of the inter-professional health care team who are not registered are undertaken to a reasonable standard. RNs are responsible for the consequences of any entry	NMC 2002 (a) NMC 2002 (b)
Entries will be written when ever possible in collaboration with the patient and be written in terms the patient can understand	To ensure patients are involved in decision related to their care and records reflect their understanding of any intervention	NMC 2002 (a)
Nursing records must contain a full account of assessment, the care planned and provided as result of assessment.	To provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.	NMC 2002 (a) NMC 2002 (b)
Nursing problems will be identified in each entry and action taken to rectify included	To provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.	NMC 2002 (a)
Nursing records will be kept where possible in a secure position by the patient care space	To facilitate involvement of patients in record keeping process	NMC 2002 (a) NMC 2002 (b)
Nursing records will be maintained in a tidy manner, will no loose leaves.	To minimise risk of loss of parts of record	
On completion of patient episode, nursing record will be completed and returned to main notes folder	To ensure availability for future admission or episodes	

Education and training

All RNs will receive training in the completion of nursing records as part of a pre-registration programme based on the NMC Guidelines for records and record keeping

All new RNs to PHT will be informed of local policies and protocols as part of induction by their line manager.

Audit
Audit will be undertaken in accordance with the PHT Nursing and Midwifery Audit Plan and audit standards (see attachment)

Risk Management
All RNs have both a professional and legal duty of care to maintain clear records of care, interventions and information sharing. Adequate and appropriated nursing records reduce the risk to patients by providing clear concise information on clinical status and care planned and provided.

Associated documentation
NMC (a) Guidelines for records and record keeping (2002) Nursing and Midwifery Council
NMC (b)Code of professional conduct (2002) Nursing and Midwifery Council

PROTOCOL FOR THE COMPLETION OF HEALTH CARE RECORD BY PHARMACISTS

Rationale:

- Improving the method of communicating the advice/information given to medical staff by the patient's pharmacist with the aim of optimising patient medication
- How to communicate urgent advice which requires the prompt action of a doctor when the medical team cannot be contacted. Writing in medical notes is *not a substitute for verbal communication*, which should always be the first line of contact.
- Providing a written summary in the notes ensures that
  a) Verbal advice is not forgotten
  b) Permanent record is available to all members of the team, for future reference and helpful to e.g. on call doctor
  c) Complex and/or confusing verbal advice is documented to ensure accurate interpretation.
  d) Important but not urgent advice can be appropriately imparted via the notes, avoiding interrupting a doctor

Protocol:

ACTION	RATIONALE
All entries will be legible and completed in black ink	To ensure easily read and can be photocopied
All entries will dated, timed, titled and signed with full name, job title and bleep number.	To ensure time of intervention/recording is available and that originator can be identified
All entries will be a factual, accurate record of event or intervention	To provide facts to inform clinical decision making
All entries will be completed as soon after an event as possible	To ensure timely availability of clinical information
Important but not urgent information can be communicated via an entry in the medical notes	To avoid unnecessarily to interrupting a busy doctor
Urgent information which requires prompt attention must be communicated verbally	Cannot guarantee immediate action in response to an entry in the medical notes
Junior pharmacists will seek advice from a senior colleague who will countersign the entry	Pharmacists are professionally accountable and are responsible for the consequences of any entry
Where possible, pharmaceutical issues will be discussed with the patient and the record should be written in terms the patient can understand	To ensure patients are fully informed of any pharmaceutical issues that have been raised and records reflect their understanding of any intervention

Education and training

All pharmacists will receive training before being able to write in medical records.
All new pharmacists to PHT will be informed of local policies and protocols as part of induction by their line manager.

Audit

Audit will be undertaken to measure compliance with the above guidance.

Risk Management

All pharmacists have a professional and legal duty of care to maintain clear records of care, interventions and information sharing. Adequate and appropriate records reduce the risk to patients by providing clear concise information on clinical status and care planned and provided.

Notes

To be read in conjunction with Pharmacists Enabling Policy and Ward Pharmacy Standards.
This guidance is also applicable to pharmacy technicians with ward-based roles.
Adapted from Guidelines for writing in patients' medical records. London Regional Pharmacy Services, Apr 2001

PROTOCOL FOR THE ADMINSTRATIVE MANAGEMENT OF HEALTH CARE RECORDS

Rationale:
The effective administrative management of a patient health care record facilitates timely access to information and results which will inform clinical decision making. To ensure that results and clinical information is readily available to members of the clinical teams, the following protocol must be adhered to.

Scope:
This protocol applies to predominantly ward based clerical and administrative staff but also applies to members of the clinical team undertaking clerical and administrative tasks associated with health care records. It is the responsibility of all members of the clinical team and clerical and administrative staff to ensure health care records are maintained in a satisfactory condition.

Protocol

Action	Rationale	Evidence
All letters and other types of correspondence must be filed in chronological order, with the most recent at the top		
Clinical history sheets must be filed in chronological order, with the most recent at the back of the health care record.		
Every clinical history sheet must be numbered and have a patient ID label attached. Each side of every page must have a patient label.		
Loose clinical history sheets must be repaired and filed back in chronological order.		
All clinical results must be mounted on the correct colour coded clinical report		
Consent forms and previously used prescriptions sheets (i.e. those from previous episodes of care) mus be inserted near the relevant patient episodes by the use of treasury tags		
All previously used dedicated nursing or AHP notes, fluid charts, observation charts and routing cards must be inserted into the rear pocket of the health care record and made secure		
All health care records must be kept in secure storage at all times ensuring unauthorised individuals are not able to access them whilst enabling patients and members of the clinical team adequate and appropriate access.		
Health care records must be returned to the Health Record Library for filing with the minimum delay		

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Clinical Report Sheets

RED	Haematology
YELLOW	Microbiology/Cytology
GREEN	Biochemistry
BLUE	Radiology

PROTOCOL FOR THE COMPLETION OF HEALTH CARE RECORDS BY MEDICAL STAFF