GENERIC CLINICAL RECORD KEEPING STANDARDS AND GOOD PRACTICE HANDOUT

All Health Care Professionals responsible for making clinical entries in a patient's Health Record MUST adhere to the following:-

Hand Written Records:-

- Every page in the health record must include: the patient's name, NHS number, identification number e.g. Hospital Number.
- Every entry must be signed, name printed and designation recorded.
- Every entry in the health record must be dated, timed using 24 hour clock and in chronological order to reflect the continuum of patient care.
- All entries must be legible. **Lesson learnt following an Incident**: - ***It is most important for entries to be legible when recording observation results findings and subsequent actions, if applicable.***
- Entries must be clear, relevant and unambiguous.
- Entries must be written using indelible black ink.
- White correction fluid must not be used.
- An incorrect entry must be crossed out with a single line but remain visible, signed, countersigned, dated and timed using the 24 hour clock.

Allergy/Attention Markers:

- The pre- printed Allergy / Attention Card filed in section 1 within a patient's Acute Health Record must be used to record:
    - Advance Directives
    - Adverse Reactions
    - Anti-Thrombotic Treatment
    - Blood Group Warnings
    - Disability and Communication Awareness
    - Drug Allergies
    - Drug Trials
    - Infection Risk
    - Research
    - Separate Health Records
    - Significant Events

Refer to Health Record – Recording Alerts and Attention Warnings Procedure - COPR/PROC/445.

GENERIC CLINICAL RECORD KEEPING STANDARDS AND GOOD PRACTICE HANDOUT

Author:

- Every entry in the health record must clearly identify the author. The author must ensure that when making their first entry into a patient's health record they complete the Staff Record Sheet. Some pre-printed documentation has a designated section to facilitate the capture of the author's information on the individual document; this is used instead of completing the Staff Record Sheet e.g. Obstetric Record, Community Records and Care Pathways.
- As good practice healthcare professionals should record their GMC registration number whenever they write an entry into a patient's health record.

Refer to Health Records – Clinical Record Keeping Standard - Recording the Author Procedure – CORP/PROC153.

Abbreviations:

- All entries must be written in full. Abbreviations must not be used unless they have first been written in full (followed by the abbreviation stated in brackets) either in the content of the document or in an abbreviation box provided on pre-printed documentation.

Electronic Records:-

- Every page in the health record must include: the patient's name, NHS number, identification number e.g. Hospital Number.
- Every entry in the health record must be dated, timed using 24 hour clock and in chronological order to reflect the continuum of patient care.
- All free text entries must be legible.
- Entries must be clear, relevant and unambiguous when inputting in the free text fields
- An incorrect entry must be "Greyed Out" (highlighted with a grey block to signify an error) or by an equivalent method.
- Attention / Alerts, Allergies, Advance Directives etc. must be recorded in the fields provided.

Author:

- Electronically created documentation e.g. MAXIMS ED facilitates the capture of the author's information as an electronic signature. A valid electronic signature can only be created as a result of the author of the record logging in with a valid user identification i.e. user name and password.

Abbreviations:

- All entries must be written in full. Abbreviations must not be used unless they have first been written in full (followed by the abbreviation stated in brackets) when inputting in the free text fields.

GENERIC CLINICAL RECORD KEEPING STANDARDS AND GOOD PRACTICE HANDOUT

Process for ensuring a Contemporaneous Complete Record of Care is completed for both Paper and Electronic Records:-

- The Healthcare Professional must ensure a chronological record of care is recorded within the patient's health record.
- Information must be recorded as soon as possible after the episode of care or event.
- Records must be an accurate record of what took place. The time and date that the entry is being recorded must be clearly documented.
- The time and date that the event occurred must be clearly documented in the content of the entry, so that there is no doubt exactly when the event being documented occurred.
- If there is a delay in recording an entry in the health record, the date and time (use 24 hour clock) of both the event and the entry must recorded, and state the reason for the delay.

ROPE Test:

Managers and staff within Community Health Services can assess the quality of their own clinical record keeping by using the simple spot check tool below. Within each entry of the clinical record of a recent episode of care, does the record provide the following information:

Do YOUR records pass the ROPE test?

Reason	Reason for contact, contact type- phone, home visit, clinic, time, location (patients home, care home, which clinic) Who present- name and relationship to patient-did patient consent to their presence, consent to treatment.
Observation	**Subjective-** history-what the patient/carers said. **Objective-**what you assessed , measured, observed, witnessed: Written on standard assessment templates if available.
Plan	**Who** is going to do **what, how often** starting **when**? Use available care plans, charts, None available? Be clear, concise, and descriptive. Referring elsewhere? Who to, what for and when was it done.
Evaluation	**What** happens next. Reasons for any changes to care plan, who /how to monitor. Details of advice given or leaflets issued and if contact details were given, date/time of next expected contact, or if it is a final contact, reasons for discharge.

For more information please refer to:

Health Record – Generic Clinical Record Keeping Standards Procedure - CORP/PROC/567