CLINICAL RECORD KEEPING POLICY

1. INTRODUCTION

The aim of this document is to outline the policy and standards for the recording of information within health records. This policy applies to all staff directly involved in patient care.

Health records act as an information base for health professionals and as a medico-legal record of the care provided. Health records are an essential element in patient care and enable health professionals to maintain a record of diagnoses made, treatment given and the patient's progress.

All staff need to be aware of the importance of the health record and record keeping; this is an integral part of professional practice. Good record keeping helps to protect the welfare of patients and clients by promoting:

- High standards of clinical care
- Continuity of care
- Better communication and dissemination of information between members of the multi-disciplinary health care team
- An accurate account of treatment and care planning and delivery
- The ability to detect problems, such as changes in the patient's condition at an early stage
- Recognition of the patient's wishes and consent to treatment

The content of the health record can also enhance KGPC's and individuals' liability against:

- Negligence claims, including indemnity for damages and costs
- General Medical Council proceedings
- Disciplinary proceedings relating to professional misconduct or incompetence
- Inquests
- Complaints
- Criminal matters arising from professional practice

2. GENERAL GUIDELINES

In their publication "Good Medical Practice", the GMC says you 'must record your work clearly, accurately and legibly.' Clinical records fulfil several important functions:

- A reminder of what happened during a consultation, actions, steps taken and outcomes

- Informing colleagues who may see the patient subsequently and supporting continuity of care.
- Providing evidence if the standard of your care is called into question.

3. Recording a consultation

To fulfil their primary purpose of supporting patient care, your consultation notes should be made as soon as possible either during or immediately after each consultation and should include the following details:

- relevant history and examination findings (both normal and abnormal)
- your differential diagnosis and any steps taken to exclude it
- decisions made and agreed actions
- information given to patients, including the different treatment options and risks explained during the consent discussion
- the patient's concerns, preferences and expressed wishes (this will also be valuable should they lose capacity)
- drugs or other treatment prescribed and advice given
- investigations or referrals made
- the date and time of each entry and your identity
- correct clinical coding

As well as face-to-face consultations, you should record all interactions with patients and any information relevant to their care, including:

- notes of telephone conversations and home visits
- discussions with clinical colleagues and third parties
- test results
- photographs and X-rays
- correspondence, eg referral letters (the exception is complaints correspondence, which should be kept separately from the clinical record; it is not directly relevant to the patient's clinical care)

4. The integrity of records

Make every effort to preserve the integrity of your records so they support patient care and you are not vulnerable to criticism in the event of a complaint or claim. Ensure that your notes are:

Complete: As described above, ensure your notes are an accurate reflection of what took place during a consultation and that all relevant information is filled with the patient's record.

Contemporaneous: Write notes as soon as possible while events are still fresh in your mind. Timely record keeping is important if colleagues need to see the patient again soon afterwards.

Clear and legible: When you need to make a note by hand, take a little extra time and care to write legibly so you and others can read it later.

Entered for the correct patient: Double-check that you are saving notes into the correct patient record, especially when they have a common surname or the whole family is on your practice list.

Do not include ambiguous abbreviations: Some abbreviations for conditions and medication are open to misinterpretation and can confuse other members of the healthcare team.

Avoid jokey comments: Offensive, personal or humorous comments could undermine your relationship with the patient if they decide to access their records and damage your professional credibility if the records are used in evidence.

Not tampered with: Never try to insert new notes or delete an entry. In written notes, errors should be scored out with a single line so the original text is still legible and the corrected entry written alongside with the date, time and your signature. If you remember something significant you can make an additional note, but it should be clear when you added the information and why. Computerised entries will have an audit trail of all entries and deletions, so if something is deleted there should also be a clear record as to why that was done.

Checked: If notes have been dictated and transcribed by a third party, review them for transcription errors and sign entries before they are added to a patient's records. You should also check, evaluate and initial printed results, reports or letters before they are filed in the patient's records and document any appropriate action.

5. MONITORING ARRANGEMENTS

An audit of clinical record keeping (including compliance with this policy) will take place as outlined in the Audit Policy.

CLINICAL RECORDS AUDIT FORM

Name of auditor:

Name of clinician:

Unique patient identifier (e.g. EMIS/NHS number)

Date of consultation:

	Yes	No	Comments
Are the notes coherent and well-structured and include all contacts?			
Presenting issue appropriately summarised and Read coded?			
Is there a record of the history of the presenting complaint with documentation of relevant positive features?			
Is there a record of the history of the presenting complaint with documentation of relevant negative features?			
Is there a record of any relevant clinical examination findings?			
Have appropriate diagnostic decisions been made based on the information acquired, including referral, with a recording of the working diagnosis?			
Is the prescribing for this consultation within current acceptable guidelines? If not, is there a recorded rationale for deviating from guidance?			
Is there a record of advice given regarding common side effects/interactions?			
Is there a record of referrals made/directions to patients' registered practice to make a referral?			
Is there a record in sufficient detail of the continuing care arrangements and / or safety net plan?			
Where relevant, is there a record of capacity assessment and outcome?			