HEALTH RECORD CONTENT & MANAGEMENT

1. INTRODUCTION

Health records are central to the provision of safe and effective clinical care. They provide a description of the service user's condition at a specific point in time for assessments, planned care or treatment, what care or treatment that has been provided and the evaluation of the outcome of care or treatment. In addition they are a tool to record the advice given to service users, and the service user's wishes regarding their care or treatment (consent). Health records should be sufficiently comprehensive for a colleague to have a clear picture of a service user's condition, treatment and wishes. They are a vital communication tool for high quality professional practice.

In addition, health records are not only used for primary clinical purposes but also for secondary purposes including reporting the activity of hospital services, monitoring performance of hospitals and for research. They remain the most important focus of any patient complaint or litigation.

PiC services will maintain accurate health records on all of its patients / residents. This will enable them to receive effective continuing care and the health care team to communicate effectively thus allowing another doctor or clinician to assume the care of a patient / resident at any time. The Health Record enables the patient / resident to be identified without risk or error, facilitates the collection of data for research, education and audit and will be available for legal proceedings.

PiC uses CAREnotes, an electronic patient records system. It should be noted that the key elements and content of the health record remain the same.

This policy applies to all PiC services and should be read in conjunction with:

- Good Psychiatric Practice 3rd edition – Royal College of Psychiatry (2009)
- Record keeping: Guidance for nurses and midwives – Nursing and Midwifery Council (2009)
- Standards for Medical Record Keeping – Royal College of Physicians
- Records Management: NHS Code of Practice – The Department of Health (2006)
- Risk Management Standard 1.8, Governance – Clinical Records Management and 4.4, Clinical Care – Clinical Record-Keeping – NHS Litigation Authority
- PiC Operational Policy – *Assessment & Management of Clinical Risk*
- PiC Operational Policy – *Communication*
- PiC Operational Policy – *Confidentiality*
- PiC Operational Policy – *Access to Health Records & Disclosure*
- PiC Operational Policy – *Data Protection Act*
- Requesting amendments to health and social care records – National Information Governance Board

2. DEFINITION

The Department of Health, Records Management: NHS Code of Practice 2006 defines a health record as “A single record with a unique identifier containing information relating to the physical or mental health of a given patient who can be identified from that information and which has been recorded by, or on behalf of a health professional in connection with the care of that patient”.

A health record may comprise text, sound, image and/or paper and must contain sufficient information to support the diagnosis, justify the treatment and facilitate the ongoing care of the patient to whom it refers. This definition therefore includes information stored electronically or on media such as video / DVD, tapes, photographs or x-ray.

3. DOCUMENTATION AND PROFESSIONAL ACCOUNTABILITY

All healthcare practitioners and staff involved in clinical care or undertaking research are professionally accountable for keeping clear, legible, accurate and contemporaneous clinical records which record all the relevant clinical findings, any decisions made, information given to patients and any drugs or other treatment prescribed. All clinicians have both a professional and a legal duty of care to patients. All professional organisations will expect that you maintain and deliver high quality standards of care and this includes record keeping. Record keeping standards are an indication of your professional practice.

A health record should inform any clinician who has a responsibility for the patient of all the key features which might influence the treatment proposed. It should also provide a contemporaneous and clear record of the patient's treatment and related features. A good record speaks volumes about the care a patient has received, and has a vital role in minimising clinical risk.

Good record keeping safeguards both patients and professionals from unsafe practice through misrecording or misunderstanding of health record information.

Good record keeping ensures that:

- Staff can work with maximum efficiency without having to waste time searching for information
- Any record entry or alteration can be traced back to a named individual at a given date / time
- Those that are caring for the patient can see what has been done, and still needs to be done and the reasons for this
- Any decisions made can be justified or reconsidered at a later date if the situation changes

4. HEALTH RECORD CONTENT

4.1 Key Elements of Health Records

Health records should contain the following key elements:

- They should be accurate
- Enable the patient / resident / service user to receive effective continuing care
- Enable the Health Care Team to communicate effectively
- Enable the patient to be identified without risk or error
- Facilitate collection of data for research, education and audit
- Will be available for legal proceedings

4.2 Patient / Resident Information

The following information should be included in the Health Record to ensure that:

- A chronological account of the patient / resident's care is provided
- There is a summary in the record that contains all the patients' / residents' demographic details and all administration details relevant to the admission. The summary will include:

    - Dates of admission / discharge
    - Responsible Clinician (RC)
    - Diagnosis
    - Previous admissions

The record will contain the following patient identification data:

- Unique patient / resident number on every page of the continuous record
- Name in full on every page of the continuous record
- Home address and postcode
- Date of birth
- General Practitioner
- Gender
- Ethnic origin
- Family contacts
- Referral contacts
- Religion (if any)
- An up-to-date photograph

4.3 Clinical Information

The record will include the following clinical information:

- The diagnosis and reason for admission
- Risk formulation
- Patient / resident history
- A report on the initial physical examination performed by the GP

- Regular and timely progress notes, observations and consultation reports by all health professionals
- A record of any therapeutic orders
- A record of any orders for diagnostic tests
- All results of investigations (e.g. pathology, E.E.G)
- Details of verbal instructions / information given to patients / residents
- A system of alert notation in place e.g. to allergies
- A copy of the discharge communication
- Cause of death where death has occurred and a copy of the post mortem report
- A review of the clinical diagnosis and findings of the post mortem examination
- All communications with and information given to patients or relatives / carers.

4.4 Incidents

Incident reporting is a fundamental part of our clinical governance arrangements. When a patient safety incident occurs, the facts must be documented in IRIS. IRIS forms part of the Incident Reporting procedures and Governance arrangements within PiC.

4.5 Record Entry

Entries into records should:

- Be made only by authorised staff
- Be confirmed (dated, signed and timed)
- Be typed (if made in ink these must be legible)
- Include only approved abbreviations / symbols
- Be factual
- Ensure all dictated and typed notes are signed by author
- Be countersigned by a registered professional when these are made by student practitioners

4.6 Error Correction Procedure

There will be times when problems or mistakes occur and changes or clarifications to documentation will be necessary. Proper procedures must be followed in handling these situations.

- Draw a single line through the entry (thin pen line)
- Date, time and sign the entry
- Document the correct information

Always make sure that the inaccurate information is still legible. Do not obliterate or otherwise delete the original entry by blacking out with marker, using correction fluid or writing over it.

For errors or omissions on electronic systems, contact the IT Helpdesk.

4.7 Handling Omissions in Documentation

At times it may be necessary to make an entry that is late (out of sequence) or provide additional documentation to supplement or clarify entries previously written. When a pertinent entry has been missed, requires further clarification or not written in a timely manner, an appropriate entry should be used to record the information within the health record.

4.8 Patient Amendments to Their Health Record

A patient can apply for inaccuracies in the record to be corrected. The health professional should either make the necessary correction or a note can be made in the relevant part of the record of the matters alleged to be inaccurate. Care must be made not to simply obliterate information that may have significance for the future care and treatment of the patient or for litigation purposes. Consideration should also be given as to whether it is appropriate to note any associated records.

If the health professional does not agree to the patient's claim that their record is inaccurate and refuses to make such alterations, then the patient should be asked to provide a written statement detailing what they consider to be inaccurate and why (if they have not already done so – help might also be offered with this by nursing staff) and a copy of that statement must be filed in CAREnotes supported by a clinical entry. Helpful guidance is contained within the linked document published by the National Information Governance Board for Health and Social Care: http://www.nigb.nhs.uk/guidebooklet.pdf[1].

5. HEALTH RECORD MANAGEMENT

5.1 Management and Staffing

- A qualified person is responsible for managing the service. The senior manager of the Health Record Service should be a member of the Institute of Health Record Information and Management and should ideally hold the Diploma in Health Record Management or other suitable qualification. In parts of the organisation where the employment of a Health Record Manager on a full-time or part-time basis is not justified, arrangements should be in place to obtain ongoing consultation from a qualified person.
- A Health Record Committee should be established or integrated into the responsibilities of the Senior Management Team or other similar committee at a senior level
- Responsibilities of the Health Record Committee / Senior Management Team (SMT) include:
    - Setting the standard and policy for the format of patient health records.
    - Reviewing / revising record forms.
    - Procedures for the local management of health records.
    - Auditing content to ensure recorded information facilitates the provision and evaluation of patient care.

[1] Requesting amendments to health and social care records – National Information Governance Board

  - Auditing the standard of record entry.
  - Reviewing all audit activities related to health records.
  - Health record staff should be involved in evaluation activities for the organisation i.e. compiling patient care statistics for utilisation, reviews and clinical audit
- Systems ensure health records are maintained for every patient
- A filing system should be in operation which enables rapid retrieval of records and prevents misfiling. This may involve colour coding.
- There should be a standard health record folder which is secure, allows insertions to be made and has clearly indicated contents. All entries are filed in chronological order.
- There should be provision for 24 hour access to records.

5.2 Policies and Procedures

These should be in place for:

- Patient numbering including the NHS Number
- Format of record
- The filing order of documents in record
- Record entries
- Safeguarding information in the record against loss, damage or use by unauthorised persons
- Confidentiality and release of information
- Retention of records – including multi media
- Destruction of records
- Document scanning and microfilming of records when these are used.
- Compilation and merging of duplicate records (this should designate who is authorised to merge records)
- Transferring records around the organisation and via the internal and external postal and electronic mail systems
- Storage of records held separately from main records e.g. social work
- Health records / policies / procedures should be made available to all relevant staff
- All records should be coded at discharge or within 14 days using ICD 10
- A tracer system for records removed from storage
- Records should be checked systematically for misfiling
- Patients' / residents' details on record summary sheet should be checked against corresponding information on a master index as necessary
- A signature bank should be maintained which includes an updated register of signatures and designations

5.3 Facilities and Equipment

- The location of the department should enable records to be retrieved and distributed rapidly
- Staff should have the proper space to read and work with records
- Filing space should be sufficient to meet current / future needs
- The active storage area should include all records in use
- Active and inactive records should be secured to protect against loss, damage or use by unauthorised persons
- The department should be fitted with smoke alarms

5.4 Quality Improvement

- The following performance and outcome indicators should be reviewed on a service-wide basis:
    - Missing notes
    - Time taken to retrieve notes
- A designated individual should be responsible for monitoring the content of the Health Records in accordance with local policies and procedures
- An annual health record audit is reviewed by the Health Record Committee / Senior Management Team (SMT) Data will be provided from CAREnotes in services that have implemented the electronic patient record.